

ADOCARE (*) – A preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems

Brussels
December 2015

(*) ADOCARE: service contract with the European Commission to implement a preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems - Service contract SANCO/2013/C1/005 – S12.668919



With the support
of the



COLOFON

ADOCARE: Service contract **SANCO/2013/C1/005 – S12.668919**

The European union represented by the European Commission, DG Health and Consumers
Directorate-General – Directorate C – Public Health

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List of abbreviations

ACE	Adverse childhood experience
AMHC	Adolescent mental health care
CAMHC	Child and adolescent mental health care
GDP	Gross Domestic Product
GP	General Practitioner
LGBTQ	Lesbian, gay, bi, transgender and questioning youth
WHO	World Health Organisation

List of definitions

Terms such as availability, accessibility, and acceptability are widely used but there is no consensus on their definitions (Harbers, Verschuuren, & de Bruin, 2015; WHO, 2008). In the light of this text, we define them as follows:

- Adolescents: *young people between 12- 24 years old*
- Acceptability: *“judgments by laypersons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem of the client” (Kazdin, 1981, p. 262)*
- Accessibility: *the direct service and organizational mechanisms that facilitate a person’s ability to enter into, navigate, and exit the appropriate services and supports as needed (Inniss et al., 2009)*
- Availability: *having acceptable services and supports in sufficient range and capacity to meet the needs of the target populations (Inniss, Nesman, Mowery, Callejas, & Hernandez, 2009)*
- Balanced care: *a comprehensive mental health system including different types of mental health facilities so that each person is able to receive the type of care that matches with his preferences and needs (Thornicroft & Tansella, 2013b; Thornicroft & Tansella, 2004).*
- Cyberbullying: *being cruel to others by sending or posting harmful material or engaging in other forms of social aggression using the internet or other digital technologies (Willard, 2007, p. 265).*
- End-user: *young adolescents who use(d) mental health services, their relatives, people who know or are in close contact to young adolescents with mental health problems, young people in general, representatives of patient organisations, etc.*
- Experts: *academics, researchers, child and adolescent psychiatrists, etc. who are expert within the field of adolescent mental health care.*
- Good practice: *a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it (United Nations, 2014).*
- Integrated care setting: *a MHC service that not only provides medical and psychological treatment, but that supports adolescents to reintegrate as good as possible into society. Such a service takes into account other needs, such as the need for education, the need to find good housing or a good job, the need to build trustful relationships with others, etc., and collaborates with other organisations within a broader network the address these different needs.*
- Policy maker: *governmental representatives, directors of care services, ombudsmen for children, etc. operating within the field of adolescent mental health.*
- Policy plans: *a detailed scheme for action on mental health which includes setting priorities for strategies, and establishing timelines and resource requirements (WHO, 2005b, p. 17).*



- Policy legislation: *specific legal provisions that are primarily related to mental health* (WHO, 2005b, p. 18).
- Professional: *child and adolescent psychiatrists, psychotherapists, mental health nurses, directors of care services, etc. working as a clinician within the field of adolescent mental health care.*
- Psychosocial interventions: *a variety of interventions, including counselling/psychotherapy, social support, education, provision of information or training.*
- Quality indicator: *a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care, and hence change in the quality of care provided* (Legido-Quigley et al., 2008).
- Quality of care: *a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice* (WHO, 2003).
- Sexting: *the act of sending sexually explicit or suggestive photographs via text message* (Benotsch et al., 2013, p.2).
- Stakeholders: *persons and organisations with interest in improving adolescent mental health care. They include youngsters with mental health problems, family members, patient organisations, academics, professionals, policy makers, and other interested parties.*
- Treatment gap: *the absolute difference between the true prevalence of mental health problems among adolescents and the treated proportion of adolescents with mental health problems* (Kohn et al., 2004).

Executive summary

Introduction

In Europe, 15 to 20% of adolescents have at least one psychological or behavioural problem and there is a real risk that mental health problems developed during adolescence continue in adulthood or even become chronic (WHO, 2005). About half of the mental health problems in adults are estimated to have their onset during adolescence (Kessler et al., 2007a; Patel, Flisher, Hetrick, & McGorry, 2007). Mental health problems do not only affect young adolescents and their surroundings, they also have profound implications for their social development and the global economy (Sawyer et al., 2012). A yearly loss of 4% of the European gross national product is linked to the effects of mental health problems (due to absenteeism, reduced performance at work, etc.) (LSE, 2012).

Today, young people and the network that supports them often fail to find adequate help for mental health problems. This is due to a lack of specialised mental health care (MHC) facilities. As emphasised by the WHO, adolescents have other care needs than adults and children as they are right in the middle of their maturation process (WHO, 2002). For example, adolescents need more information and psycho-social support (Gulliver, Griffiths, & Christensen, 2010) and – in their view – the ethos of care services is more important than its technical qualities (WHO, 2002). A number of issues put adolescents off from asking for help. These issues include public, perceived and self-stigmatising attitudes to mental illness, concerns about the confidentiality of services regarding the provided care, limited access (e.g., time, transport, cost), and their general lack of knowledge about mental health services (Gulliver et al., 2010).

All adolescents are entitled to grow up to be healthy and responsible adults who are able to fully participate in society (both socially and economically). To achieve this, urgent action is needed. A decade ago, a statement was issued by the WHO that European Union member states are required to deliver tailored and adequate MHC to adolescents in need of help. More specifically, member states need to ensure “age-sensitive MHC services (i.e., primary and specialised health care services and social care services) operating as integrated networks” (WHO, 2005).

Mission and objectives of ADOCARE

The overall mission of ADOCARE was to create a European Union expert network to promote and sustain the creation of adapted and innovative care structures for adolescents with mental health problems. The general objectives of the network of experts were to conduct research and to stimulate awareness-raising, exchange and consultation, capacity building, dissemination and promotion activities.

To achieve this mission, ADOCARE:



- Collected relevant information, innovative ideas and insights on AMHC.
- Assessed the availability and quality of AMHC services in the participating member states.
- Developed guidelines and recommendations for governments and services to improve AMHC.
- Established an innovative, cross-sector, collaborative network of European researchers, psychiatrists, psychologists, policy makers, caregivers and care users to centralise experience and expertise in the field of AMHC.
- Raise awareness, organise exchange and consultation, capacity building, dissemination and promotion.

Practically, the project of ADOCARE was split into two work packages. Work package 1 consisted of everything that was related to research and addressed the first three objectives. Work package 2 involved everything that was related to gathering the information and expertise through the network, communication, awareness-raising, capacity building and dissemination and addressed the latter two objectives.

ADOCARE network

Ten countries were involved in the ADOCARE research: Belgium, Finland, France, Germany, Hungary, Italy, Lithuania, Spain, Sweden, and the UK. The aim was to have representatives of the different EU regions: the British Isles, Eastern Europe, Mediterranean Europe, the Nordic region and Western Europe. The network today consists of 239 stakeholders with various profiles from the participating member states: researchers, policy makers, governmental representatives, directors and managers of mental health services, psychologists, psychiatrists, nurses, professional caregivers, youngsters, family members, etc.

Awareness-raising and capacity building activities

In order to stimulate awareness on the necessity of integrated AMHC, to facilitate the exchange of knowledge and expertise between the different stakeholders and to build capacity, ADOCARE organised different events that brought together experts with multidisciplinary backgrounds as well as parent- and youth organisations: 2 high level conferences, 4 workshops. The valuable field information and expertise gathered at these events were implemented in the ADOCARE research.

ADOCARE also actively participated in different events organised by third parties in order to disseminate information on the project and to promote integrated AMHC.

Research objectives



In its research ADOCARE aimed at collecting the latest and most relevant information, ideas and insights on AMHC and aspired to answer the following research questions:

- What is the overall state of adolescent mental health in Europe? Can vulnerable groups be identified?
- How is AMHC organised in Europe?
- How available are AMHC services in the participating member states and how good is the quality of AMHC services?
- What are strategies to improve both the availability and the quality of AMHC services?
- What are strategies to prevent mental health problems and how can one promote mental well-being for adolescents?
- Which policies and legal frameworks regarding AMHC exist in the participating member states?

Research method

Information was collected using a multifaceted approach. A combination was made of literature reviews, survey consultations, panel discussions and workshops with different stakeholders (i.e., policy makers, professionals, experts and end-users). More specifically, relevant reports and articles on AMH and AMHC were reviewed to develop research instruments and procedures for the ADOCARE research activities and to find answers to the research questions. Multiple surveys were conducted questioning five different stakeholder groups in the 10 participating member states: policy makers, experts, professionals, adolescents suffering from mental health problems and youth in general including their entourage. The questionnaires aimed to:

- Collect information on existing policies and legal frameworks regarding AMHC, the organisation of AMHC and the training of professionals;
- Identify best practices and integrated care settings for adolescents with mental health problems;
- Identify strengths and weaknesses concerning AMHC;
- Assess the quantity and quality of AMHC services;
- Explore the needs of young people with mental health problems.

In addition, during the first High Level Conference two plenary discussions were held to share thoughts, opinions and insights on AMHC in Europe. Subsequently, four two-day workshops took place across Europe with four different groups of stakeholders (policy makers, experts, professionals and end-users). The workshops focused on key themes, targets and recommendations to be included in the final guidelines.

The state of adolescent mental health in Europe



The overall state of adolescent mental health

Globally, one in four to five adolescents have at least one mental disorder in any given year. The most common disorders in adolescents are: anxiety disorders (31.9%), behavioural disorders (19.1%), mood disorders (14.3%) and substance use disorders (11.4%) (Kessler et al., 2007a; Kessler et al., 2007b; Paus, Keshavan, & Giedd, 2008). A recent literature study on young people's mental health reviewing 19 epidemiological studies across 12 countries shows a partial increase in the incidence of mental health problems in adolescents over the past decade (Bor, Dean, Najman, & Hayatbakhsh, 2014). Externalising problems appear to be stable whereas internalising problems seem to be on the rise – especially among girls. This gender disparity can be linked to several factors. Girls are exposed earlier to sexualisation (i.e., being regarded as sex objects and evaluated in terms of physical characteristics and sexiness). They experience more and more pressure to be successful both at school and in their private lives. In addition, they are subject to changing media and cultural expectations (Bor et al., 2014; Carli et al., 2014). One needs to note that the increased awareness and recognition of mental health problems among adolescents in recent years may have contributed to this partial increase as well (Bor et al., 2014).

In many adults with a mental disorder, problems started in childhood or adolescence, mostly between age 12 to 24 (Paus et al., 2008). Half of the people who meet the criteria for a major DSM-IV diagnosis at the age of 26, had a first diagnosis between the age of 11 and 15 and almost 75% of them had a first diagnosis before the age of 18 (De Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). Of all psychiatric disorders, those that have their onset in childhood or adolescence tend to be more severe. Therefore, it is crucial to diagnose mental health problems at an early stage so treatment can be initiated before problems escalate (De Girolamo et al., 2012). According to a cohort study by Patton and colleagues (2014) effective treatment during one's adolescence not only affects the duration of mental health episodes early on, it also reduces morbidity later in life.

Yet, research shows that adolescents and young adults with a psychiatric disorder do not receive adequate care or get no treatment at all (Copeland et al., 2015; Farmer, Burns, Phillips, Angold, & Costello, 2003; Horwitz, Gary, Briggs-Gowan, & Carter, 2003; Leslie, Rosenheck, & Horwitz, 2001). According to one study, only 18 to 34% of young people with severe depression or anxiety symptoms seek professional help (Gulliver et al., 2010). In a more recent study, only half of adolescents meeting DSM-IV diagnostic criteria received some treatment in the past three months. In young adulthood, the situation is even worse, merely one in three received treatment (Copeland et al., 2015). Various barriers contribute to the low accessibility of AMHC: (anticipated/perceived) stigma, lack of parental support, structural and cultural failures within the existing care systems. Apparently, society does not seem to realise the importance of mental health in adolescents and hence fails to invest sufficiently in AMHC (McGorry, Goldstone, Parker, Rickwood, & Hickie, 2014). In addition, many adolescents show poor help-seeking behaviour and are reluctant to access MHC (Breland et al., 2014).



The organisation and typology of AMHC

Although the organisation of child and AMHC is heterogeneous across EU member states, the following four types of services can generally be distinguished: (1) residential care services (hospital and non-hospital), (2) day care services, (3) home-based services and outreaching care, and (4) outpatient ambulatory care services (Remschmidt & Belfer, 2005). Across Europe, the prevalence of private psychiatric practices for children and adolescents strongly depends on country and local circumstances. Also, there is a tendency to establish specialised services working with highly qualified staff addressing a narrow range of more complex disorders. Currently, a growing number of services and treatments are under evaluation, but more progress is needed. Even though collaboration between services is starting to increase, coordination and integration of care remains insufficient (Remschmidt & Belfer, 2005).

The availability and quality of AMHC

In the ADOCARE project experts evaluated on a 5-point Likert scale both the availability and the quality of the following four types of AMHC services in 10 European countries: (1) residential care, (2) day care, (3) home-based and outreaching care, and (4) outpatient ambulatory care.

Availability of AMHC

Except for Hungary and Lithuania, all participating member states have MHC services specifically dedicated to adolescents. The availability of these facilities, however, is rated as poor. In many countries, services are oriented either to children or adults. Few services aim exclusively at adolescents. Overall, the availability of each of the four types of AMHC services rates from very poor, poor, mediocre to unclear. Finland is the only exception, all four types of services receive a good rating. These results confirm earlier findings stating that European member states still have a long way to go (Remschmidt & Belfer, 2005). Moreover, within a country the availability of AMHC services varies widely across regions: in some regions demand and availability of care are quite in balance whereas in other regions demand exceeds availability.

Quality of AMHC

The survey findings show that the quality of AMHC is rated good to very good in Belgium, Finland, France, Germany, and Hungary. In Italy and Sweden, experts found it hard to determine the quality of services. In Lithuania, Spain and the UK, the quality was rated mediocre to poor. Lithuanian experts stated that in their country the biomedical paradigm is still dominant which jeopardizes the quality of AMHC services. This situation endures as the Lithuanian health insurance system is reluctant to cover psychosocial interventions. Finally, within countries the quality of services varies widely.

Strategies to improve availability of AMHC



Balanced care

Within a comprehensive mental health system, a balanced care model ought to be established. This is a network linking different types of MHC facilities so that each person gets access to a type of care that matches his preferences and needs (Thornicroft & Tansella, 2013; Thornicroft & Tansella, 2004). In particular, the following types of services are considered necessary:

Primary health care services for persons with common mental health problems. These services conduct case finding and assessment, short psychological and social interventions as well as social treatments and pharmacological treatment.

General MHC services for persons with more complex problems and consisting of five components: outpatient/ambulatory clinics, community mental health teams, acute inpatient care, long-term community-based residential care and support in work and occupation.

A series of specialised MHC services in each of the five categories of general MHC services to provide more intense/expert interventions (e.g., autism, schizophrenia, eating disorder, addiction, severe depression and suicidality).

A balanced care model also implies that both community and hospital care are available and provided in a pragmatic and balanced way (Thornicroft & Tansella, 2013; Thornicroft & Tansella, 2004). This means that in countries with many residential services, the number of beds will need to decrease in favour of more community-based care and mental health promotion.

The evolution towards more balanced care goes hand in hand with a more important role for primary care in mental health. For example, general practitioners and other primary care services are encouraged to recognise, assess, and manage adolescent mental health problems (Vallance, Kramer, Churchill, & Garralda, 2011). This way the principles of stepped care are applied more frequently. According to these principles appropriate generalist psychological interventions, monitoring and assessment are provided in primary care and people only step up to a more specialised level of care when necessary (Silva & de Almeida, 2014).

Treatment in primary care

During the ADOCARE research both professionals and adolescents indicated that young people are sometimes referred to specialised services too quickly. Professionals and parents should realise that not all mental health problems require specialised care and that primary or community-based care offer adequate treatment. However, for this approach to be successful two conditions need to be met: (1) primary care workers are well-trained, and (2) specialised services are available for referral. Assessment tools for primary care workers may help them decide whether or not specialised care is needed. Governments can stimulate primary mental health care and discourage unnecessary use of specialised care.

Epidemiological and administrative data



Epidemiological data tell us something about the prevalence of AMH problems, the mental health needs of adolescents, and the use of MHC services by adolescents. These data are necessary information for governments to estimate the need for services in their (sub)regions and they provide insight in a possible treatment gap (Wittchen & Jacobi, 2005). Furthermore, they raise awareness and help policy makers set priorities and develop programmes, interventions and services to deal with gaps and needs (Wittchen & Jacobi, 2005).

Yet, epidemiological findings are rarely taken into account by governments because of three reasons. First, epidemiological data are often inadequate for effective policy and service planning (Bielsa, Braddick, Jané-Llopis, Jenkins, & Puras, 2010; Patton et al., 2012; Wittchen & Jacobi, 2005). A lot of data are based on administrative records and these data tend to be incomplete (data do not comprise all types of MHC services or all regions in a country), unreliable (data are not entered properly into the systems) and difficult to link (different services use different data systems). Second, many countries have no financial or human resources to analyse these data. Third, findings resulting from epidemiological research are usually not 'received' by governments because they are not communicated clearly to policy makers and the public in general (ADOCARE, 2015).

The collection of administrative data of service users via well-developed (preferably international) data registration systems and the analysis of these data sets can only be encouraged. The InterRAI Community Mental Health and the InterRAI Mental Health are examples of well-known international standardised assessment instruments for clinicians working in community mental health settings and in-patient psychiatric settings respectively.

The treatment gap

The limited availability of MHC services for adolescents is a problem in most countries. A first step in improving the availability is quantifying the treatment gap which is defined as *"the absolute difference between the true prevalence of mental health problems among adolescents and the treated proportion of adolescents with mental health problems"* (Kohn, Saxena, Levav, & Saraceno, 2004). For that purpose, epidemiological data are essential.

Once the required number of AMHC facilities and professionals per 100,000 adolescents is determined, governments provide the budget and do what is needed in order to close the gap. In doing so, governments need to bear in mind that the four types of MHC services represented in the balanced care model should be minimally available.

Strategies to improve the quality of AMHC

Quality of care can be considered as a complex and multidimensional construct which is defined according to several inter-related dimensions: access to service, relevance to need, effectiveness,



equity, social acceptability, efficiency and economy (Maxwell, 1992). Several strategies to enhance the quality of AMHC emerged from the research conducted by the network of experts.

A developmental approach

Adolescence is a phase of life that is characterised by transition. This requires a developmental approach which acknowledges that each adolescent has different and changing needs depending on one's age, level of maturity and context (Remschmidt, 2001; Remschmidt & Belfer, 2005). Hence, professionals need to have knowledge of the (social, mental, physical) developmental stage of adolescents and supposed to be familiar with the socio-cultural environment in which youngsters live today (e.g., their interests and concerns, the things they do in their spare time) in order to draw up a personalised treatment plan. Moreover, professionals should be aware that every clinical diagnosis and all assessed needs are subject to constant change, as adolescents undergo rapid changes over a brief period of time (WHO, 2005). The treatment plan is to be seen as work-in-progress.

Early detection of mental health problems

In adolescents, mental health problems often remain undetected until they start to escalate. Adolescents are sometimes reluctant to share their worries and concerns with adults. Adolescence is a period in which young people discover autonomy, prefer to do things their way and keep things to themselves. Also, adolescents sooner report somatic than psychological problems to the professionals they are in contact with. This is why the latter sometimes underestimate the severity of psychological problems and/or attribute them to somatic problems.

In short, professionals need to be well-trained and need to enquire about the following areas: Home environment, Education and employment, Eating, (peer-related) Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence (Cappelli et al., 2012; Klein, Goldenring, & Adelman, 2014). These areas can be easily remembered by the acronym "HEEADSSS". On the internet, a web-based tool is available for professionals to use when assessing the HEEADSSS areas. Moreover, professionals need training to truly connect with adolescents, to uncover possible mental health problems, and to recognise signs of mild suffering, which might be a precursor to severe pathology. (ADOCARE, 2015).

Bio-psycho-social approach

Adolescents with mental health problems need an appropriate and effective combination of psychosocial and medical treatments in order to meet their often complex and multiple needs (mental, social, physical, and functional needs) (Remschmidt, 2001; Remschmidt & Belfer, 2005).

Psychosocial interventions are generally considered as the first line of professional treatment (Bohlin & Mijumbi, 2015). Psychosocial interventions refer to a variety of interventions, including help in one's social situation (such as financial support, education, employment, and housing), psycho-education, coaching and counselling, and information or training. Each intervention aims



at improving behaviour, overall development or specific life skills and this without the use of medication (Reichow, Servili, Yasamy, Barbui, & Saxena, 2013; Uitterhoeve et al., 2004). Psycho-education is a crucial psychosocial intervention. Especially, psycho-education in parents has proven to be beneficial: it increases parents' knowledge about symptoms and problems, stimulates greater use of appropriate services, strengthens problem solving skills, and induces positive emotions and family interactions (Lucksted, McFarlane, Downing, & Dixon, 2012).

Psychotherapy is also an important intervention when treating severe mental health problems. A critical overview of psychotherapies and their evidence-base for children and adolescents is presented in the book "What Works for Whom" (Fonagy et al., 2014).

Undoubtedly, serious mental disorders sometimes require medication. Yet, throughout the ADOCARE research project, it frequently came up that in some countries, doctors resort to medication rather quickly for certain types of mental health problems. For some disorders there is an on-going debate concerning the use of medication: what type of medication is appropriate, at what point during treatment medication is best started up, what is the optimal dosage, etc. (Bohlin & Mijumbi, 2015). Professionals need to be aware of the importance of appropriate usage of medication and they should study new evidence on the effectiveness of medication. Furthermore, it is recommended that medication is combined with psychotherapy and/or other psychosocial interventions and one needs to follow the current medicine-based guidelines (e.g., British Association for Psychopharmacology, the NICE guidelines on mental health, "What works for whom" by Fonagy et al., 2014).

Web-based interventions

A large number of e-health interventions, web-based interventions and mobile applications (i.e., m-health) have recently been developed. Many adolescents daily connect to the internet, so this medium has enormous potential to inform them about mental health care, increase access to care, engage them more actively during treatment (follow-up, planning, additional support, information, etc.), initiate after-care and provide web-based treatment. (Price et al., 2014)

These days, several web-based mental health tools for depression, anxiety, and suicide prevention in children, adolescents, and young adults are being developed. However, findings as to their effectiveness are mixed. More research is definitely needed (Boydell et al., 2014; Reyes-Portillo et al., 2014; Ye et al., 2014). During the ADOCARE research, adolescents pointed out that a quality label for websites and apps would be helpful. They find that it is not up to them to determine whether a website or app is trustworthy or not. Another point they made was that professional support is essential to help them interpret the information that is provided on the internet and to guarantee personalised treatment.

Shared decision making (SDM)

As stated in the Convention on the Rights of the Child, adolescents have the right to participate in all decisions that affect them. Adolescents confirm this during the ADOCARE research: "Young people should be actively involved when decisions about their treatment are being made –



nothing should be decided about them without them.” Professionals of the ADOCARE network, on the other hand, argued that an adolescent’s maturity determines to what extent they are involved in treatment decisions.

Training in shared decision making (SDM) is recommended by the ADOCARE network.

Professionals should learn how to optimise adolescents’ involvement in defining treatment goals and in choosing suitable interventions. Shared decision making in clinical practice implies a three-step model. The first step, referred to as choice talk, introduces the notion that choices need to be made. The second step, referred to as option talk provides detailed information about the possible options. The third step, decision talk, supports patients in making a decision (Elwyn et al, 2012). Of course, this can only succeed if the clinician is willing to let young people co-decide, if he applies shared decision making skills in a flexible way and if he shows trust in young people (Abrines-Jaume et al. (2014). Needless to say, mutual agreement is not always possible. A case in point is when hospital admission is unavoidable for reasons of safety and the adolescent does not see it this way.

Evidence-based practices (EBP)

Evidence-based practice can be defined as *“practices that are consistently science-informed, organised around client intentions, culturally sensitive, and that continually monitor the effectiveness of interventions through reliable measures of the adolescent and caregivers’ responses, contextualised by the events and conditions that impact on treatment”* (Fonagy et al., 2014, p. 4). As stated by the WHO (2013), the use of EBP’s by professionals will lead to good-quality mental health services as EBP’s yield better results than non EBP’s (Weisz et al., 2013). Professionals can use guidelines that provide an overview of existing evidence-based interventions for the treatment of different kinds of mental health problems (Hopkins, Crosland, Elliott, & Bewley, 2015). In the UK the NICE guidelines (National Institute for Health and Care Excellence) are a source of information for clinicians when dealing with specific conditions for adolescents. For low and middle income countries, the WHO (2010) developed the Mental Health Gap Action Intervention Guide (mhGAP-IG). This guide presents an overview of evidence-based interventions to manage a number of prioritised conditions (e.g., depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents).

Despite the fact that many EBP’s are available, professionals of the ADOCARE network reported that they are under-used. This is due to the difficulty to put EBP’s into practice. Professionals often vacillate between offering a flexible and personalised treatment, on the one hand and providing standardised interventions guided by protocol, on the other hand. Hence, it is a good idea to provide more support on how to implement EBP’s in a standardised yet personalised manner. EBP’s aside, professionals stressed that promising and innovative interventions – even if they haven’t been validated yet – should also be taken into account.

Parental involvement



ADOCARE professionals agree that parents are crucial partners in the network of a young person. The standard should be that professionals inform and involve parents as soon and as often as they can. At the start of a treatment, this is one of the first issues to discuss with the adolescent. The general idea is to obtain a sound balance between respecting the privacy of adolescents and involving parents and family.

Actually, family members – in particular parents – who live with an adolescent with mental health problems, often experience problems themselves (Vermeulen, Lauwers, Spruytte, & Van Audenhove, 2015, <http://caringformentalhealth.org>). Sometimes professionals uncover dysfunctional relationships within the family. This is why it is important to support the adolescent's family even when adolescents do not want their parents to be involved. The review of Kaslow, Broth, Oyeshiku and Collins (2014) provides an overview of effective family-based prevention programmes, psychotherapies and psycho-educational interventions. Research does confirm that involving family in therapy can be beneficial for adolescents (Young & Fristad, 2015).

Continuity, integration, and coordination of care

Continuity of care is defined as the quality of care over time from the perspective of both the patient and the care provider (Gulliford, Naithani, & Morgan, 2006). It includes both longitudinal continuity (i.e., uninterrupted series of contacts over a long period) and cross-sectional continuity (i.e., coherence of interventions between and within different service providers) (Bruce & Paxton, 2002; Thornicroft & Tansella, 1999).

Continuity of care is also closely related to integrated care which is defined as: *“a coherent set of methods affecting funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between different sectors”* (Kodner & Spreeuwenberg, 2002). For adolescents with mental health problems providing integrated care is very important. Young people mostly have multiple needs (psychological, medical, social, educational, vocational). They require a mix of services provided sequentially or simultaneously by multiple care providers often employed by different facilities in various sectors. In order to provide high quality care, integration of these various levels of care is a must.

Translating continuity of care and integrated care into practice requires strategies at various levels, ranging from macro to micro level (Gröne & Garcia-Barbero, 2001; Kodner & Spreeuwenberg, 2002; Mur-Veeman, Hardy, Steenberg, & Wistow, 2003; Thornicroft & Tansella, 2003; Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). At macro level, integration is strongly determined by the broader organisation of mental health services and by the way government departments and ministries either opt for a common or separate framework for sectors involved (WHO, 2005). Sadly, legislation and funding systems mostly hinder coordinated care. Collaboration is often based on ad hoc arrangements made by clinicians. Hence, it is important to point this out to governments so that they provide a suitable framework for collaboration. It is their task to highlight the benefits and advantages of working together and to



address people's fears and resistance of change. Collaborative activities such as meetings attended by professionals from various organisations involved in the treatment can be reimbursed. Other strategies are creating local committees to supervise the quality of care and to steer collaboration across services and centralising information on different initiatives on one website (WHO, 2005).

At meso level, MHC services and professionals can improve coordination and collaboration for example by co-locating and merging services, organising joint training programmes to obtain shared competences, and establishing a common data infrastructure for collecting and sharing patient information. Multidisciplinary teamwork can be facilitated by initiating joint care planning so the team of professionals shares a common care plan and feels responsible for the implementation of it and by setting up intensive case management (d'Amour et al., 2008; WHO, 2013). According to the experts of the ADOCARE network, it is up to the professional care givers to coordinate and integrate care. It is definitely not the responsibility of the adolescent or his parents.

The transition from AMHC to adult MHC services

In Europe, many countries make a difference between adult MHC on the one hand and child/adolescent MHC on the other hand. This means that persons with mental health problems in their early life – at some point in their care pathway – can be transferred from child/adolescent MHC services to adult MHC services. During this transition period, young people often get lost because the quality of transitional care is low (Singh et al., 2010a; Singh et al., 2010b). The main barriers that disrupt transition are: system fragmentation, a lack of leadership, a lack of prioritisation of this target group, poor communication, stigma, a policy-practice gap, lack of studies, a lack of joint transition protocols, and a general paucity of information about services (Paul, Street, Wheeler, & Singh, 2014; Royal College of Psychiatrists, 2013). Also, transition often fails because clinicians of adolescent MHC services fail to refer or adult services refuse to accept referrals or discharge young people who did not attend the first appointment offered (Paul et al., 2013). Yet, not all barriers to quality transitional care are linked with the service system. Transition can also fail due to young people's refusal to accept referral to adult services (Paul et al., 2013).

Interruption of care due to transition has a negative impact on the health and well-being of adolescents so it is a matter of high priority. The TRACK study (Singh et al., 2010) generated the following recommendations to improve transitional care:

- When developing and implementing protocols to improve transition, the needs of the adolescent are at the core of every decision made. In order to achieve that, a number of basic rules need to be respected. The time frame and everyone's responsibility are clearly defined. Adolescents are well-prepared. There is a backup plan in case adult MHC services are unable to accept the transition. Finally, services should be flexible when it comes to the age of clients.



- An adolescent switches to an adult service at a moment his/her condition is stable. Services avoid multiple, simultaneous transitions. Adolescent and adult MHC services collaborate closely, either they work together across services or they provide periods of parallel care. Adult services are actively involved before the adolescent service discharges a case. Services need a standardised record keeping system so they can easily transfer all correspondence and contact information.
- Local adolescent and adult MHC services and voluntary services are mapped and regularly updated (their scope of operation, communication networks and key contacts).
- Professionals truly understand how to get this transition of care right. Training addresses issues concerning referrals to other services, increases knowledge of other services and focuses on self-efficacy and skills.
- Policy plans contain strategies to improve transitional care.
- Four criteria are used to evaluate transition: perceived continuity of care, parallel care, a transition planning meeting, and information transfer.

Actually, the Milestone project (i.e., Managing the Link and Strengthening Transition from Child to Adult Mental Health Care, a collaborative research project funded by the European Commission) is currently drawing up and testing new transitional care models for EU services. More specifically, transition specific outcome measures are being developed and validated, as well as guidelines for improving care and outcomes and training packages for clinicians (De Girolamo, 2014).

Bridges to the real world

During the ADOCARE research, adolescents emphasised that each intervention should – at some point – connect with the real world: “It is important to build bridges between the therapy setting and the real world”. Thus, when hospitalised, professionals should immediately develop strategies to help an adolescent reintegrate into society. For instance, help an adolescent finish school/education, find good housing or a proper job and build trusting relationships with others, bring the outside world into the residential care settings (for example, through an activity accessible for the neighbours, friends).

Outreaching

Young people seldom access clinical services on a voluntary basis. This is why it is important for professionals to visit places where young people hang out such as coffee bars, popular sport venues or places where homeless adolescents temporally reside (ADOCARE, 2015). Outreaching methods are also a valuable way to determine the interests and needs of adolescents. When outreaching, it is essential to primarily focus on young people with multiple problems. The latter are often neglected by professionals, as they mostly don’t meet the criteria for programmes targeting specific groups.

Ethical considerations



Generally speaking, each service is supposed to follow the three major ethical principles outlined in the Belmont Report (Michaud, Berg-Kelly, Macfarlane, & Benaroyo, 2010): the principle of autonomy (i.e., individuals are treated as autonomous agents and persons with diminished autonomy are entitled to protection); the principle of beneficence (i.e., do no harm, minimise harm, and maximise possible benefits); and the principle of justice/equity (i.e., make sure resources are equally accessible to all). In addition, the Barcelona declaration proposes that in clinical care, some other important values need to be present such as participation, dignity, integrity, confidentiality, and vulnerability (Michaud et al., 2010). Such principles must be clearly stated in service charters developed in collaboration with adolescents. In addition, as far as care and treatment are concerned, ethical dilemmas ought to be addressed using a deliberative approach as every situation is different and unique. During this process, professionals should have access to feedback from an objective, ethical committee consisting of professionals and experts (Michaud et al., 2010).

Gender disparities

Research demonstrates that adolescent boys have less knowledge about mental health and MHC services, and are less willing to use these services (Chandra et al., 2006). Reportedly, they are less inclined to look for help as they are afraid to be considered weak. Moreover, parents find it harder to accept mental health care for their sons, it is easier for them when their daughters are in need of help. Gender differences can be tackled by better mental health education and by providing MHC services in middle school. It is clear that we need to actively engage parents if we want to minimise stigmatising attitudes toward boys (Chandra et al., 2006). Importantly, gender-related differences as to treatment needs, were neither mentioned during the ADOCARE research nor did we find references to them within the literature. We can easily assume that a personalised approach taking into account the needs of each individual client will be gender-appropriate.

Training and education

For professionals to respond more effectively and with greater sensitivity to the needs of adolescents, they need proper training and education (WHO, 2002). This means that mental health professionals working with adolescents (i.e., adolescent psychiatrists and adolescent psychologists) receive specific training on topics such as: legislation and policies regarding AMH; normal and problematic adolescent development and specific psychopathological issues; services providing AMHC; communication and shared decision making with adolescents and their family members; evidence-based psychosocial interventions; aspects related to coordination, collaboration, and transitional care; assessment of mental health problems in adolescents.

Results of the ADOCARE research show that the profession of adolescent psychiatrist is recognised by law in only 5 out of 10 participating member states (Finland, Germany, Hungary, Italy, and Lithuania). The profession of adolescent psychologist isn't formally recognised as a separate profession anywhere. It is important to note that, across Europe, the education and training programmes of mental health professionals differ significantly and abide by different



standards (Union Européenne des Médecins Spécialistes, 2014). This means they are difficult to compare. A common EU model for the education and training of professionals and teams in AMHC might be helpful without neglect of the local education needs. The European Federation of Psychiatric Trainees (EFPT) and the Union of European Medical Specialists (UEMS) each formulated recommendations for training programmes for psychiatrists in general and child and adolescent psychiatrists in particular.

Professionals that receive a more generic training and are only confronted with AMH problems when employed in a particular setting, should also be educated on AMH issues as part of their basic training. Or they could opt for in-depth training when taking a postgraduate degree. We think in this respect of general practitioners, hospital nurses, school nurses, youth workers, public health workers, social workers and teachers.

Youth friendly MHC services and staff

Often the design of services and the attitude of professionals do not particularly suit the developmental and cultural needs of young people (Ambresin et al., 2013; Breland et al., 2014; McGorry, Bates, & Birchwood, 2013; Tylee et al., 2007). In order to improve accessibility, equity and acceptability, services and staff should become more youth friendly. Different studies examined the prerequisites for youth friendly healthcare services and professionals (Ambresin et al., 2013; Harper, Dickson, & Bramwell, 2014; McGorry et al., 2013; Tylee et al., 2007; WHO, 2002). Within the ADOCARE research, a similar inquiry was conducted focusing in particular on the prerequisites of youth friendly MHC services. Adolescents were asked what a youth friendly service should look like and what qualities a professional should have. These are the results:

- Actively involve young people in service design, care delivery (e.g., peer support, group therapy, self-support groups), evaluation and monitoring of a service (Bielsa et al., 2010). In some services, adolescents are involved in the development of the service charter on confidentiality, opening hours, treatment programme, rights of adolescents, ethical aspects and so on.
- Be easy to access so adolescents experience few barriers. This implies drop-in services, convenient opening hours, access without the permission of parents, low cost or free services, reduced waiting times, convenient location near public transport, availability of e-health tools, an appealing and welcoming environment, discrete entrance, positive image.
- Invest in activities/communication that raise awareness (leaflets, posters, website, etc.) and strengthen mental health literacy. Adolescents often do not know what to do or where to go to when they need help.
- Provide clear information on legal (confidentiality) and economic (affordability) aspects. Amongst other things, it should be clearly explained what adolescents can expect when they are under 18 and they reach out to a service unbeknownst to their parents.



- Make an effort to guarantee continuity in therapeutic relationships with professionals for instance by minimizing staff turn-over. Adolescents are in a turbulent phase in their life. Hence, professionals should try to provide stability.
- Engage good role models (i.e., adolescents who experienced similar problems in the past) as they have a beneficial effect on the well-being of adolescents.

Adolescents attach a lot of importance to the attitude, level of competence and motivation of the professional staff. Professionals ideally have the following characteristics (ADOCARE, 2015; Ambresin et al., 2013; Tylee et al., 2007; WHO, 2002):

- They are motivated, honest, passionate, enthusiastic, supportive, easy to connect with and respectful.
- They adopt a developmental approach and have knowledge of the many changes in life that adolescents experience.
- They provide teen-oriented (down-to-earth) health information so adolescents can make free and informed choices.
- They truly believe that adolescents have a promising future and convey this belief to their clients.
- They are sensitive for hierarchical differences to avoid a “we versus them” attitude and do not treat adolescents as helpless individuals.

Quality Indicators

In order to provide good MHC, it is important that services continuously invest in quality improvement. This is achieved by an on-going, iterative process of developing policies, designing standards, establishing accreditation, and monitoring services (WHO, 2005, p. 35). Measuring the quality of certain elements of the care provided (i.e., quality indicators) is an essential prerequisite for quality improvement. Within the literature, a quality indicator is defined as: *“a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care, and hence to change the quality of the provided care”* (Legido-Quigley, McKee, Nolte, & Glinos, 2008).

Quality indicators can be subdivided into macro, meso, and micro level indicators (Gaebel et al., 2012). Macro level indicators refer to the provision of structural quality at a national level (e.g., education, monitoring, and the general organisation of mental health services within a country). Meso level indicators refer to aspects that relate to the internal structure of mental health systems (e.g., structural requirements to meet the needs of patients, multi-disciplinarity of services, availability of technologies, workforce). Micro level indicators guide structures and processes within individual service units. Within each level, indicators can be further subdivided into structural, process, and outcome indicators. Structural indicators constitute the features of services such as facilities, equipment, human resources and organisational structures. Process



indicators comprise activities related to giving and receiving care, including the activities of healthcare providers and outcome indicators relate to the effects of care.

The User-generated Quality Standards for Youth Mental Health in Primary Care developed by Graham et al. (2014) and the Service Standards (seventh edition) constructed by the Quality Network of Inpatient Care of the UK (Thompson & Clarke, 2015) both formulated quality standards specifically for AMHC services. In table 1 we list the quality indicators that were put forward by the experts, professionals and policy makers that participated in the ADOCARE research activities. The indicators relate to individual AMHC units (micro level) and are organised into structural, process, and outcome indicators.

It is up to policy makers to define overarching standards for each of the indicators and to develop instruments to evaluate the extent to which these standards are met. In order to allow comparison, the same instruments are best used across services, regions and countries. The evaluation of services can either be carried out by the service itself or by an independently funded research organisation (WHO, 2002). Having evaluated, results should be communicated to services in a constructive manner with recommendations and assistance for improvement (WHO, 2002).

Table 1: List of quality indicators generated by the ADOCARE stakeholders

Structural quality indicators	The service is accessible: adolescents have access to health care, in time, irrespective of income, physical location, and cultural background. There are no waiting lists; the service is affordable and easy to reach.
	Resources are used in a cost effective way.
	Services are sustainable in terms of facilities, workforce and equipment.
	Professionals are capable and skilled and follow trainings on adolescent related topics on a regular basis.
	The service has an improvement plan that is implemented and the progress that is made is followed up.
	Structural requirements are implemented to ascertain the patients' dignity and
Process quality indicators	The provided care is appropriate in the sense that the interventions are relevant to adolescents' needs and are based on established standards.
	There is a balanced use of psychosocial, medical and other interventions.
	There is continuity and coordination of care (i.e., uninterrupted, coordinated care across programmes, practitioners, organisations and levels over time).
	There is collaboration with other services in order to provide integrated care.
	Services are able to be innovative.
	Professionals have a positive attitude toward adolescents. They act in a respectful, honest, supportive, friendly and trustworthy manner.
	Services and professionals apply the principles of shared decision making during

	Services and professionals empower adolescents by teaching them how to cope with their problems and by encouraging them to ask for help when they are
	Services address ethical principles and respect the human rights of adolescents.
Outcome quality indicators	The provided treatment has a positive impact on the symptoms of adolescents, on their everyday life (e.g., days at school, coming home before midnight, fighting behaviour, etc.) and on their quality of life.
	The positive effects resulting from the provided treatment are preserved in the long run (e.g., after one year).
	The desired outcomes are achieved within a reasonable time frame.
	The level of dropout is reduced to a minimum.
	Professionals are satisfied with their work. There are low staff turn-over rates, the number of sick-leave days among professionals is low and the incidence of burn-out is low.

Prevention of mental health problems and promotion of mental well-being

Across countries there is a huge difference in the amount of funding available for prevention and mental health promotion (Jané-Llopis & Anderson, 2005). In a study conducted by Samele, Frew, and Urquia (2013), sixteen countries spend less than €30 per capita on prevention of ill health and public health, whereas six countries spend €100 or more per capita. Current programmes for adolescents differ widely in terms of aims, target groups, and approaches. More than half of the programmes studied (63%) focus on the prevention of mental health problems, whereas only 17% focus on promoting mental well-being. In most cases, programmes address bullying or stigma (Samele et al., 2013).

Each European member state should have a country-based action plan to prevent mental health problems and to promote mental well-being for adolescents (NHS England, 2015). Such programmes aim at reinforcing protective factors so as to prevent the development of mental health problems. For instance one can: build resilience, stimulate adequate help-seeking behaviour, support parents in raising their child, create good school environments, positive peer groups, stimulate spirituality, increase empowerment, increase mental health literacy. But there is more, programmes can also address risk behaviours that contribute to the development of mental disorders such as bullying, domestic violence, harmful substance use, etc. (Jané-Llopis & Anderson, 2005). Actions particularly target children and families at risk. When putting together a prevention and mental health promotion action plan, it makes sense to look at strategies and programmes that appeared successful in other countries. In this respect, it needs to be pointed out that a Joint Action for Mental Health and Well-being was recently set up. It consists of 51 partners from 28 EU member states and 11 European organisations. This network of experts collaborates in order to develop a framework for action in mental health policy at a European level. Its agenda is the promotion of mental health and well-being, the prevention of mental



disorders, the improvement of care and the social inclusion of people with mental disorders. Promotion of mental health in schools is one of the five key areas. (www.mentalhealthandwellbeing.eu).

Strategies in a school setting

Adolescents spend a lot of time in school. This is why schools are well-placed to promote mental well-being, prevent mental health problems, recognise problems early on and make an appropriate referral (Farmer et al., 2003; Paternite & Johnston, 2005; Rones & Hoagwood, 2000; Weist & Paternite, 2006). During the ADOCARE research, experts proposed different strategies to enhance mental well-being of young people in a school context.

Provide basic training to teachers in mental health. Teachers are constantly present in the life of adolescents. They are in a position to detect problems at an early stage and they can give valuable support. Therefore, it is important that teachers receive basic training in mental health promotion, in mental health problems and in ways to prevent and recognise these problems.

Engage mental health professionals at school. During the ADOCARE research, it was pointed out not to burden the teachers unnecessarily with providing support and care to adolescents given their high workload. Besides, some mental health problems require experienced professionals. In these cases, teachers should be able to rely on mental health professionals working in the school setting (e.g., school nurse, school counsellor, school psychologist). These professionals can advise teachers on how to manage students with mental health problems, they can provide direct support to adolescents or they can refer the student to an expert.

Collaborate with external mental health professionals. In some cases, the support provided by teachers and school mental health professionals is not sufficient and thus an external professional needs to be engaged. School mental health professionals should have the opportunity to collaborate with mental health professionals working outside the school setting. For instance, community mental health clinicians can be placed on-site in schools. A recent study shows that this formula has a positive influence on suspension rates, school attendance, and emotional and behavioural symptoms in adolescents as perceived by parents and teachers (Ballard, Sander, & Klimes-Dougan, 2014).

Organise classes on mental health. Adolescents do not only need to know how their body works, they also need to understand how their mind works (ADOCARE, 2015). Classes, integrated in the curriculum, should focus on mental health issues such as building resilience, respecting others, teaching social skills, managing difficult situations, promoting help-seeking as a personal strength, promoting family involvement, expressing emotions, and developing personal strengths (Vidal-Ribas, Goodman, & Stringaris, 2015). These classes can either be given by care teachers or health educators, but it is also an option to invite a mental health professional as a guest speaker. Meeting a professional in the classroom possibly lowers the threshold for adolescents to visit a professional later on when needed. It is highly recommended that classes on mental health adopt an innovative approach based on interaction. As such, the main focus lies on acquiring knowledge,



attitudes and skills simultaneously. During the ADOCARE research adolescents pointed out that classes on mental health may evoke bullying and teachers should be very much aware of this.

Organise health care check-ups. Generally, prevention and screening programmes are regarded favourably within the school context. Such programmes require: gathering and screening of data, using the results in a multidisciplinary school team, establishing protocols stating interventions based on screening profiles and collaboration with external stakeholders when specialised care appears necessary (Dowdy et al., 2014). Within the context of the “Saving and Empowering Young Lives in Europe” (SEYLE) project a school-based professional screening procedure was developed (Wasserman et al., 2015) and appeared effective in identifying students in need of MHC (Kaess et al., 2014a). However, during the ADOCARE research it became clear that screening only makes sense when a country can offer sufficient MHC. If a country lacks sufficient MHC services, screening programmes may have a detrimental effect as they create a demand for help that cannot be met.

Attend to risk behaviours among students. Schools should pay attention to risk behaviours that are strongly associated with mental health problems, such as substance abuse, sensation seeking, delinquent behaviour, excessive use of media, self-injury and truancy (Kaess et al., 2014a). In the case of truancy, it ought to be standard practice for a school counsellor or youth worker to reach out in order to establish contact with the adolescent. Another important school-related phenomenon that needs to be addressed is bullying. A study conducted in an adolescent in-patient group suffering from severe mental health problems shows that almost 43% of adolescent patients had been bullied at least once (Kalmakis & Chandler, 2015; Ryttilä-Manninen et al., 2014).

Policies and legal frameworks related to AMHC

In 2009, hardly any European country had a mental health policy specifically targeting adolescents (Vieth, 2009). Since then, we have seen some progress. The ADOCARE results show that 6 out of 10 participating member states (Belgium, Finland, Italy, Spain, Sweden, and the UK) do have a mental health plan specifically for adolescents. Moreover, in three of these countries (Finland, Italy, Sweden), policies on mental health are regularly evaluated and monitored. Although most countries are moving in the right direction, there is still room for improvement. A point of concern is that most countries have no clear idea of the budget allocated to AMH (ADOCARE, 2015). The UK is a rare exception, 11% of the total health care budget is spent on mental health, of which less than 1% is spent on children and AMH. The allocation of funding to AMH might be equally low in the other member states.

Challenges regarding adolescent mental health policy

Develop a clear vision on AMH. In most countries AMHC is no priority because policy makers are not aware of the mental health needs of adolescents. It is imperative to consider adolescents as a specific target group with distinctive needs. Understanding the needs of adolescents and informing policy makers are a shared responsibility of the EU Commission, lobby groups, researchers, professionals and adolescents and their families.



Develop and implement specific AMH policies and plans. The WHO developed a guidance package for policy makers. It describes the successive steps to take and helps policy makers develop and implement AMH policies and plans (WHO, 2005). During the policy making process, it is highly recommended to closely involve adolescents and their parents as they know best what their needs and pitfalls are. Of course, attention should also be paid to evaluation. These evaluations need to be scientifically sound and are preferably published so that other countries may benefit from the work carried out. For the evaluation of policies and plans, there are easy to use checklists developed by the WHO (2009).

Implement clear legislation on the rights of young people. The Universal Declaration of Human Rights and the Convention on the Rights of the Child are good sources of inspiration for the development and design of new policies, legislation and frameworks for action. Moreover, governments are advised to draw up clear legislation on the following topics: how adolescents can claim help without their parents' permission, the right of youngsters to co-decide in their own treatment plan, the rights and duties of parents, restraining order procedures (although they should be kept to a minimum), the registration and access of patient records, and the use of e-health.

Define a core package of basic services available for adolescents across the EU member states (WHO, 2002). Countries are stimulated to move the balance of care away from established institutions and to advocate better community-based systems of support and treatment (Knapp, McDaid, Mossialos, & Thornicroft, 2006). All over Europe, investment in MHC services exclusively developed for adolescents is urgently needed. The age range of these services should be broad and flexible and should preferably span from the age of 9 to 25.

Allocate sufficient financial resources to AMH. Policy plans need to state clearly how much of the gross national product is allocated to mental health in general and how much is spent on AMH in particular. As recommended by the WHO (2005), the budget for child and AMHC services equals the budget spent on adult mental health. During the ADOCARE research it was stated that increased funding for prevention, mental health promotion, and targeted treatment for adolescents actually saves money in the long term. Mental health problems can be intercepted early on. In doing so, clients do not develop complex mental health problems in adulthood requiring expensive long term treatment.

Stimulate cooperation between sectors and professions. As referred to earlier, it is a good idea for governments to work out a generic framework to facilitate collaboration and integration between sectors, services and professions.

Foreword

In 2009, to respond to an urgent need for adapted, integrated and multidisciplinary care for adolescents with mental health problems, a group of psychiatrists and experts in the field of adolescent mental health, linked to various hospitals in Europe, decided to set up a European network, *Action for Teens*, under the legal form of an INPO (International Non-Profit Organisation).

In December 2013, Action for Teens, in consortium with Lucas, signed a two year service contract with the European Commission (*), called ADOCARE, to create an EU network of expertise to promote and sustain the creation of adapted and innovative care structures for adolescents with mental health problems.

ADOCARE marks an important milestone in the mobilisation that Action for Teens has been leading for several years, so that the mental well-being of teenagers and young adults in our societies get the needed attention of public authorities, actors of the socioeconomic field, the public opinion and the professionals, and so that they receive the quality of support in line with the challenges they face ahead.

Adolescence is indeed the period of life during which emerges, with a decisive acuteness, the question of sense and direction of existence: what/who/where am I in this world. The child no longer centers its experiences in the present, with the family, but is conscient from now on, of its past and future (adulthood) and the world out there, with its social representation.

Teenagers recognise themselves as teenagers: they are neither children, nor adults and they refuse vehemently both the infantilisation and the adultification of their age.

Adolescence is by definition the period of transition: the passage of primary to grammar school, the transformation of the body by puberty... The teenager arrives in a world which is not his and he (she) has to become capable of building "himself" from the raw material of childhood.

A society that doesn't give its youngsters sufficient space for this vital transformation, would become sterile or burst under pressure, as this also reflects the society's own (in-) capability to evolve.

To accompany the development in youngsters so that their creative potential is preserved, such is the first task of the parents and the educators.

To support them when they feel weak, contain them when they are overwhelmed by despair or violence, favor their transformation when they are blocked, such are the tasks of the professionals which intervene in the field of the mental health of the adolescence.

ADOCARE ran from December 2013 till December 2015.



This final report gathers the different steps and the results of the work carried out over the last two years. It aims at drawing the outlines of concerted actions that allow us to improve the contexts influencing the mental health of adolescents and youngsters in Europe. The perspective in which we wished to take place is wide and this on several levels.

First of all, we thought it was necessary to see the “target population” in a continuity from the age of adolescence till the succeeding time of young adulthood, which is a period of acquisition of various dimensions of adulthood that reflect the complexity of the current world. Furthermore, we wanted to situate the problems of mental health and the specific actions in this field in a wider vision of the place our societies give to the development processes of the teenagers and the young people.

All the fields of social life, but of course more particularly those of education, social action, youth protection and justice are thus (potentially) concerned; but beyond, also all the big tendencies in our societies, marked by the acceleration of the rhythm of the technological evolutions, by the effects of the increasing ascendancy of the financial capitalism on the systemic regulations, in particular political, and by the irreversible transformation - on the scale of the human generations - of the human ecosystem by the human activities, entailing major risks of man breaking with nature.

Finally, we thought that it was essential to try to involve the teenagers and the young people themselves, as well as their families and the organisations which represent them, in the processes of reflection initiated by our mission.

All the different dimensions were of course not entirely but only partially treated due to the methodology of our work and the gaps in this report are definitely indicative of the areas in which we shall have to concentrate our efforts in the future.

It is also the reason why we hope that the reading of this report will spark reactions, critics and suggestions of which we shall try to make the best use.

We thank you for it in advance, and wish you a fruitful reading.

Dr Marc Derély

President of Action for Teens

Dr. Jean-Paul Matot

Project Director

(*) ADOCARE : service contract with the European Commission to implement a preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems – service contract SANCO/2013/C1/005 S12.668919.

Introduction

1. The prevalence of mental health problems among adolescents

Recent figures on mental suffering and well-being of adolescents are alarming. Worldwide, 15 to 20% of adolescents in Europe suffer from at least one psychological or behavioural problem. Problems that frequently occur among teens are eating disorders, substance abuse, early school leaving and absenteeism, self-harming behaviour, and external forms of violence (fighting, pestering, aggressive games, and violent games). A worrisome finding is that the prevalence of many of these problems has increased in the last 10 years (WHO, 2005a). There is a real risk that mental health problems during adolescence evolve into chronic conditions, lasting further into adult life. About half of the mental health problems in adults are estimated to have their onset during adolescence (Kessler et al., 2007a; Patel, Flisher, Hetrick, & McGorry, 2007).

Mental suffering not only affects young adolescents and their surroundings, it also has profound implications for social development and global economy (Sawyer et al., 2012). A yearly loss of 3 to 4% of the European gross national product is linked to the effects of absence of mental health on global productivity (absenteeism, reduced performances at work, etc.) (World Health Organisation, 2003).

But there is also good news. According to a recently conducted cohort study (Patton et al., 2014), there is reason for a more optimistic perspective. If clinicians succeed in implementing interventions that shorten the duration of mental health episodes, then this could reduce the morbidity later in life.

2. Encountered problems regarding mental health care for adolescents

Today, young people and their environment too often fail to find adequate help when they experience mental health problems. There exists a reluctance to seek help as only 18 to 34% of young people with high levels of depression or anxiety symptoms seek professional help. Most barriers to seek for help are related to public, perceived and self-stigmatising attitudes to mental illness, concerns on confidentiality with respect to the potential source of help, a lack of accessibility (e.g., time, transport, cost) and young peoples' lack of knowledge about mental health services (Gulliver, Griffiths, & Christensen, 2010).

In addition, there is a lack of adapted mental health care facilities for adolescents and most traditional facilities do not take into account the specific needs of this age group (12 – 24y). In many countries, mental health care facilities are oriented towards either children or adults, overlooking the specific character of adolescent mental health problems. As stated by the WHO, adolescents have other care needs than adults or children as they are right in the middle of a maturation process (World Health Organisation, 2002). For example, adolescents need more



information and psycho-social support (Gulliver et al., 2010). Also, they generally stress the ethos of a care service more than its technical qualities (World Health Organisation, 2002).

Every adolescent should receive the opportunity to grow into healthy and responsible adults who are able to fully participate (socially and economically) in society. To achieve this, action is urgently needed. A decade ago, it was already formally stated that European Member states have to deliver adapted and good mental health care to adolescents who are in need of help. More specifically, one has to ensure “age-sensitive mental health services (i.e., primary and specialized health care services and social care services) operating as integrated networks” (World Health Organisation, 2005b).

When referring to adapted mental health care for adolescents, we mean care that focuses exclusively on adolescents and that is adapted to their specific needs and characteristics. Good mental health care not only refers to medical and psychological treatment, but also includes supporting adolescents to reintegrate into society as good as possible. This thus includes addressing adolescents’ needs, such as the need for education, the need to find good housing or a good job, the need to build trustful relationships with others, etc.

3. Mission of ADOCARE

The overall mission of ADOCARE is to create a European Union expert network to promote and sustain the creation of adapted and innovative care structures for adolescents with mental health problems and thus to improve mental health care for adolescents with mental health problems in 10 European member states: Belgium, Finland, France, Germany, Hungary, Italy, Lithuania, Spain, Sweden and the UK.

4. General objectives of ADOCARE

The primary goal of ADOCARE is to mobilise European countries to improve the mental health care that they provide for adolescents. On the one hand, we want to raise awareness on the current need of specialised care for young people. On the other hand, we want to help countries in expanding and improving their adolescent mental health care facilities. More specifically, ADOCARE aims to:

- Install an innovative cross-sector collaborating network of researchers, psychiatrists, psychologists, policy makers, caregivers, and care users to centralise existing experience and expertise in the field of adolescent mental health care in the 10 member states.
- Promote the creation of adolescent mental health care services in the 10 member states.
- Raise awareness about the specific mental health problems and solutions for adolescents.
- Identify and assess the availability of mental health care facilities and good practices for adolescents in the 10 member states.



- Formulate guidelines and recommendations that are useful, inspiring, and supporting for governments and mental health care units in order to improve adolescent mental health care.

4.1. Two work packages of ADOCARE

Practically, the project of ADOCARE is split into 2 work packages.

Work package 1 consists of everything that is related to research and has the following objectives:

- Collect information on the state of mental health and mental health problems among adolescents in the 10 member states.
- Collect relevant information and experience on existing care facilities and good practices for adolescents with mental health problems in the 10 member states.
- Collect information and experience on actions and legislations of authorities in order to improve the treatment of adolescents with mental health problems.
- Develop a typology of existing or possible forms of adapted care settings for adolescents with mental health problems.
- Analyse advantages and disadvantages, and transferability of adapted care settings to the 10 member states.
- Analyse relevant practical issues related to the provision of adapted care to adolescents with mental health problems.
- Write a scientific report summarising all outcomes of the research activities under work package 1 and of the series of events organised under work package 2.
- Develop guidelines and recommendations for the set up and sustainable operation of such adapted care settings and of expert networks in this field.

Work package 2 involves everything that is related to communication, awareness-raising, capacity building and dissemination, and has the following objectives:

- Bring together experts with multidisciplinary backgrounds (such as medical, psychological, social, educational, etc.) from the 10 participating member states with the objective of promoting integrated support services for adolescents with mental health problems as well as parent and youth organisations.
- Organise awareness-raising and capacity-building activities in the 10 member states.
- Organise a first expert symposium on adapted care for adolescents with mental health problems.
- Organise workshops with the different stakeholders.



- Organise a second expert symposium on adapted care for adolescents with mental health problems, to present the guidelines, guiding principles, and recommendations for the set up and continuation of adapted care settings for adolescents with mental health problems.
- Organise the internal and external communication of the project.
- At key stages of the project produce the necessary visibility to key audiences and target groups referring visibly to the EU support of the project.
- Disseminate information about the preparatory action, the activities under it and their progress via a project website.

4.2. Involvement of different stakeholder groups

As mental health of adolescents is an important part of building a healthy and productive society, everyone benefits of making mental health an inherent part of public health. To tackle the several challenges bound to offering good mental health care for adolescents, it is important to create a common vision and to have shared goals among all stakeholders. Therefore, an inclusive and participatory approach is used involving four different stakeholder groups: (1) policy makers, (2) research scientists, (3) professionals, and (4) end-users. Throughout the project a European network of expert stakeholders was brought together. They were involved in both the research and awareness building and capacity raising activities of the ADOCARE project.

4.3. Content of the current report

The report consists of the following chapters:

- Chapter 1: Network
- Chapter 2: Method
- Chapter 3: Results of the five surveys
- Chapter 4: Results of the first high level conference
- Chapter 5: Results of the four workshops
- Chapter 6: Reflection following the capacity building and awareness raising activities
- Chapter 7: Answering the research questions
- Chapter 8: Recommendations

Chapter 1

Network

The first aim of ADOCARE was to install an innovative, collaborative, cross-sector network of experts in the field of adapted care for adolescents with mental health problems: professors, doctors, psychiatrists, psychologists, therapists, researchers, policymakers, caregivers, care users, educators, parents and youth, etc., some of them also representing other EU organisations.

To be representative at the EU level, the 10 participating countries (Belgium, Finland, France, Germany, Hungary, Italy, Lithuania, Spain, Sweden, and the UK) were selected on the basis of their geographic location so as to represent the five EU regions: British Isles, Eastern Europe, Mediterranean Europe, the Nordic region and Western Europe.

The development of this network was an ongoing process throughout the 2 year project. In the current section we describe:

- The initial network of ADOCARE
- The actions that were taken to enlarge the network
- The final network
- The involvement of the network throughout the ADOCARE project

1. The initial network of ADOCARE

The ADOCARE Network was created with the initial Action for Teens Network and 44 new stakeholders who merged together with the Action for Teens members.

In December 2013, ADOCARE started with 72 participants.

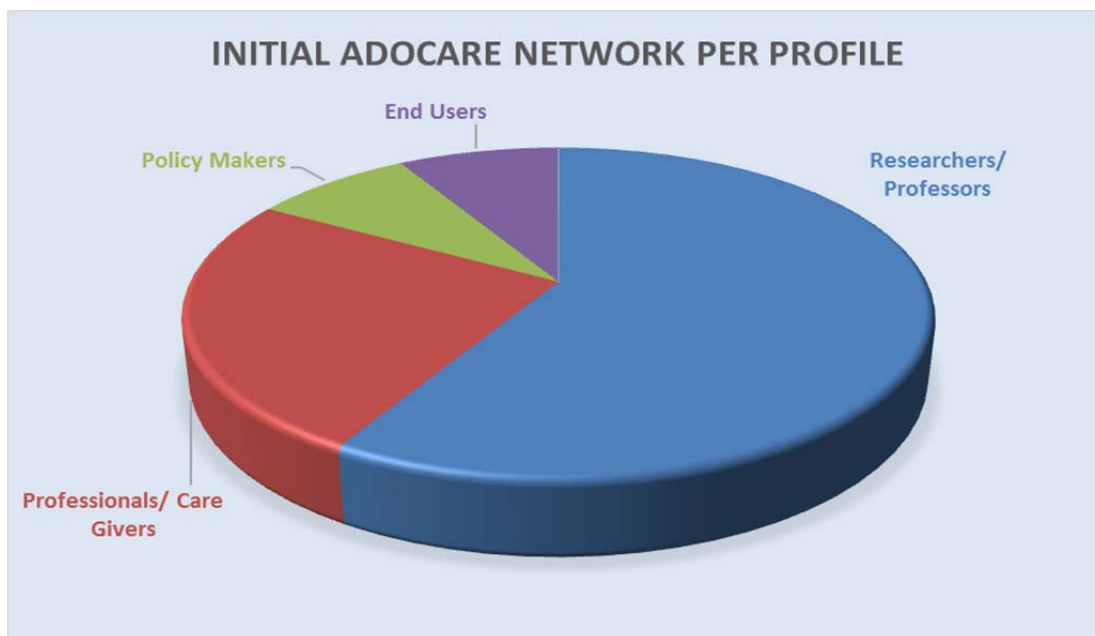
In addition to this, another 32 experts were unable to respond positively to the invitation to join the network due to other professional obligations. Despite the fact that these stakeholders did not formally join ADOCARE, their contact details were kept on ADOCARE records as relevant stakeholders for future reference.

The 10 participating countries were represented in this initial network as well as other countries such as the Czech Republic, Estonia, Ireland, Portugal, Slovenia and Switzerland. Although these latter countries were not contractually involved in the ADOCARE project, the participants from those countries proved to be very proactive in the project. Their know-how and input was included.

Regarding the profile of the participants, most of them were researchers (e.g., professors, doctors and researchers active at the academic level), followed by the professionals in the field (i.e.,

psychiatrists, psychologists, therapists, nurses, etc.). Policy makers and end-users (i.e., the youngsters and their entourage) were the smaller groups (see figure 1).

Figure 1: Distribution of stakeholders within the initial ADOCARE network.



2. Actions taken to enlarge network

One of the main goals of the ADOCARE Project was to enlarge the network. According to the multidisciplinary approach of the project, the emphasis was placed on diversifying the profiles of the participants to represent all the main stakeholders.

To reach this objective various strategies were used to identify new participants engaged in the field of adolescent mental health care.

2.1. Research and identification of relevant key-stakeholders

Throughout the project, one of the main activities was to research relevant stakeholders to join the network. Therefore, online research on relevant stakeholders as well as on relevant publications was continuously conducted by the ADOCARE Team. Once identified, they were invited to join ADOCARE.

2.2. Referrals by European networks/structures/organisations

The National Focal Points, the Public Health Attachés, European/International Organisations (such as the WHO, ESN, EBC, EPA, ESHA, ADHD Europe, AEPEA, CPME, Gamian, Eufami, EUN, Mental



Health Foundation) and the other ADOCARE participants also gave input in the search for relevant stakeholders. This created often a snowball effect that helped identifying new stakeholders.

2.3. Networking at ADOCARE and other events

At the ADOCARE events (the 2 conferences, the 4 workshops and the awareness raising and capacity building activities), networking opportunities were always ensured to meet with the participants and to identify new relevant stakeholders. During the breaks and especially during the networking dinners that were organised, participants had the opportunity to get in touch with the ADOCARE team and to get to know the project in more detail.

Those networking opportunities helped to create synergies with the new participants. At the same time, these contacts gave a multiplier effect disseminating the information on the project, and as a result thereof, new stakeholders got in touch with the ADOCARE team.

Networking opportunities were also used during the events organised by other organisations to which ADOCARE was invited.

2.4. Questionnaires

The dissemination of the questionnaires was a great opportunity not only to fulfil the primary objective of gathering data on mental health services but also to identify potential ADOCARE participants. This was carried out by pro-actively searching for the right candidates to reply those questionnaires and by contacting the people suggested by the respondents in the questionnaires themselves.

As for the proactive approach, finding the right respondents was a challenging task, which led to a thorough investigation that in the end resulted in the identification of numerous very valuable stakeholders.

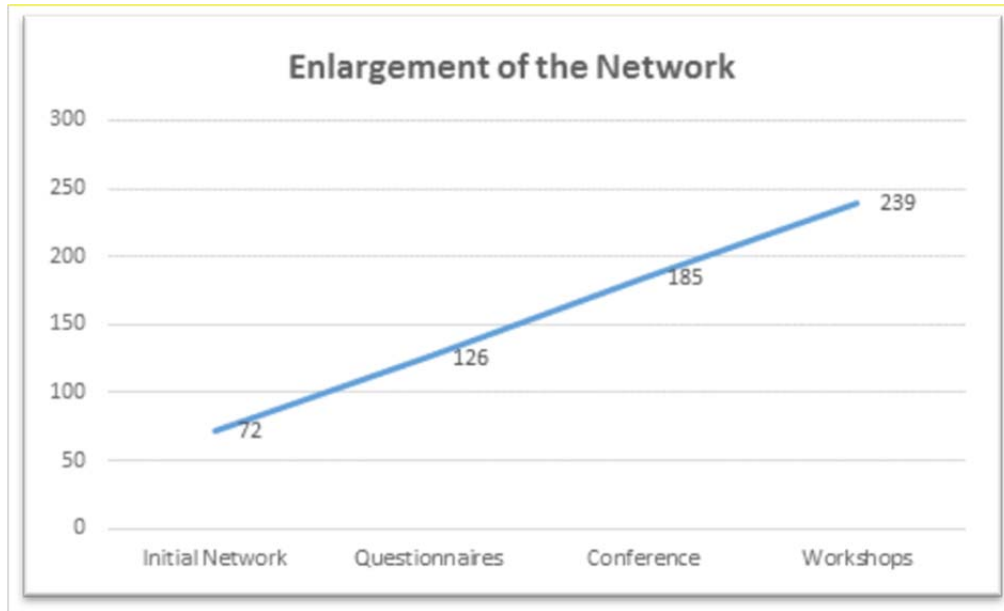
Regarding the referral approach, in the 5 types of questionnaires addressed to policy makers, experts, professionals, end-users and their entourage, a slot allowed them to suggest good practices or relevant stakeholders that in their opinion should be taken into consideration by ADOCARE. This information was used to find new respondents where needed and to invite these new contacts to join the network.

There were 4 key phases in which the network was enlarged: at the start of ADOCARE with the initial network, with the dissemination of the questionnaires, at the conference and at the 4 workshops.

Figure 2 shows the number of participants that joined the network in these 4 phases.

As the figure shows, ADOCARE reached **239 participants by October 2015** which means an **increase of 230%**.

Figure 2: Overview of the enlargement of the network throughout the 4 phases of the project.



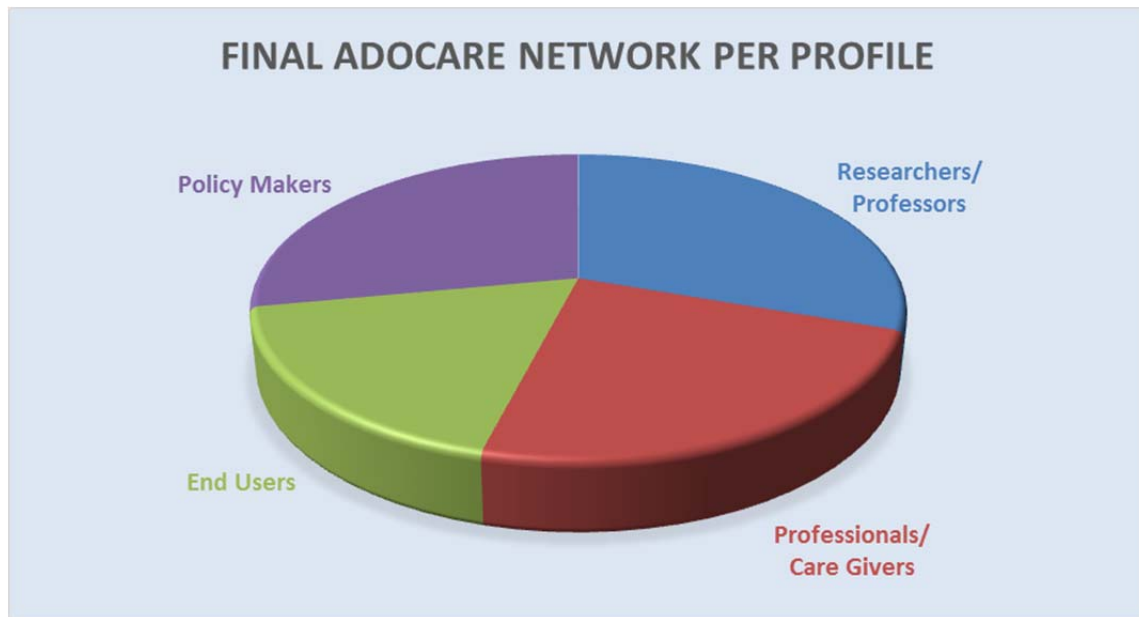
3. Description of the final network

Regarding the characteristics and profile of the new participants, an emphasis was put on developing the network geographically throughout the participating countries, but participants from other countries (such as Greece and Slovakia) also showed interest and joined the project.

A second emphasis concerned the profiles of the participants themselves. In line with the multidisciplinary approach of the project, a broad range of people with a valuable experience in the field of adolescent mental health were selected. Were thus added: youngsters, family members, governmental representatives, social educators, directors of mental institutions and care settings, etc. while increasing the number of participants with profiles that were already present in the ADOCARE network, such as researchers, professors, psychologists, psychiatrists, care givers, policy makers, etc. Figure 3 provides an overview of the distribution of the different stakeholder groups within the final ADOCARE network.

In addition to the participants that took a proactive role in ADOCARE, the network also counts more than 80 other people who were identified as potential stakeholders. These stakeholders' contact details were also kept in the ADOCARE database as they remain useful contacts for the future continuation/dissemination of the project's activities.

Figure 3: Distribution of stakeholders within the final ADOCARE network



4. Involvement of the network throughout the ADOCARE project

The ADOCARE participants were consulted and invited to participate in various activities and give input in the project. The ways in which they participated were:

- Sharing relevant literature, documentation and data with ADOCARE
- Answering the questionnaires, disseminating them within their networks and helping ADOCARE in identifying the right respondents
- Participating in the different ADOCARE events (2 conferences, 4 workshops and the other capacity building and awareness raising activities) as well as forwarding the invitations and sharing the information with their contacts
- Helping to identify interesting initiatives/best practices of care within their countries
- Helping to identify other relevant stakeholders
- Helping to identify occasions, upcoming events on psychiatry and adolescents (conferences, work sessions...) organised in the EU countries to disseminate the ADOCARE work
- Further developing the network and the collaboration at EU level

Chapter 2

Method

Apart from installing an innovative network of experts, ADOCARE aims to:

- Conduct research to arrive at useful guidelines and recommendation for EU member states in order to improve their care for adolescents with mental health problems.
- Raise awareness about the specific mental health problems and solutions for adolescents.

In the current chapter we describe the method that was used to reach these two goals.

1. Research

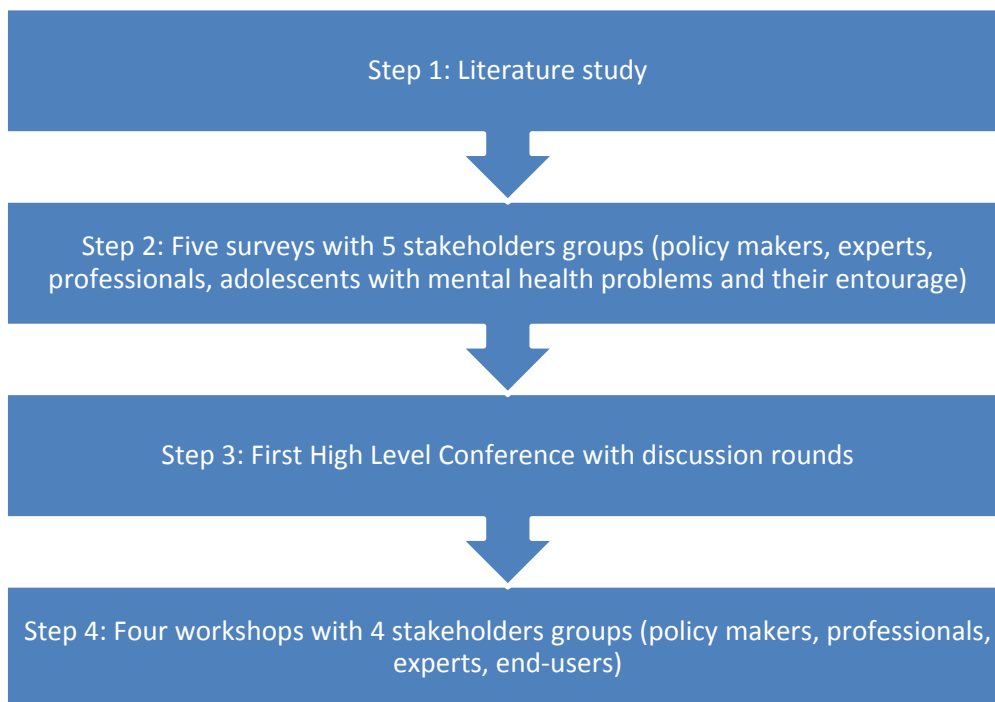
The general aim of the research part of ADOCARE is to collect the latest and most relevant information, ideas and insights on adolescent mental health care. More specifically, the ADOCARE research tries to formulate an answer on the following research questions:

- What is the overall state of adolescent mental health in Europe?
- What data on adolescent mental health exist in the ADOCARE member states?
- How do mental health problems develop?
- What are vulnerable groups in Europe?
- What problems with new technologies are encountered in adolescents?
- What other problems are encountered in adolescents today?
- How is adolescent mental health care organised in Europe?
- What is the availability of adolescent mental health care services in Europe?
- How to improve the availability of adolescent mental health care services?
- What is the quality of adolescent mental health care in the ADOCARE member states?
- How to improve the quality of adolescent mental health care?
- How to improve the knowledge, skills and competences of professionals?
- What should youth friendly services and staff look like?
- How to evaluate the quality of adolescent mental health care services?
- What can schools do to improve adolescent mental health?
- What is meant by integrated mental health care?
- To what extent is integrated mental health care implemented in Europe?
- What are mental health policies, plans and legislation?
- To what extent do policies on adolescent mental health exist worldwide and in EU member states?

- Which relevant policies and legal frameworks related to adolescent mental health care exist in the ADOCARE member states?
- What are challenges regarding adolescent mental health policy in the ADOCARE countries?
- How to develop and implement adolescent mental health policies and plans?
- Why is epidemiological research of adolescent mental health relevant?
- How can epidemiological research be improved across Europe?
- What about prevention and promotion in European countries?
- What can countries do to improve prevention and promotion?

To answer these research questions, information was collected using a multifaceted approach combining literature reviews, survey consultations, panel discussions, and workshops with different stakeholder groups (i.e., policy makers, professionals, experts, and end-users). Figure 4 provides an overview of the different steps of the research process. In the following sections the different research activities are described one by one.

Figure 4: Schematic overview of the research process





1.1. Step 1: Literature study

Throughout the whole project relevant reports and articles on adolescent mental health and adolescent mental health care were reviewed. More specifically, we reviewed the following documents:

- Information and evidence obtained by the WHO, the OECD, and other relevant international organisations
- Data and knowledge resulting from EU-supported activities
- Relevant literature on adolescent mental health that was provided by our stakeholder network
- International peer-reviewed articles

The literature review was used to develop the necessary research instruments and formats for the other consecutive research activities and to formulate answers on the research questions (see chapter 6).

1.2. Step 2: Five surveys with different stakeholder groups

Five surveys were conducted questioning five different stakeholder groups in the 10 participating EU countries: policy makers, experts, professionals, adolescents suffering from mental health problems, and youth in general and their surroundings (see annex 1 to 5 for the constructed questionnaires).

The identification of the different stakeholders willing to participate in the survey was done through the existing network of Action for Teens and the expanding ADOCARE network. The Mental Health attachés network was also consulted for the identification of the policy makers.

The questionnaires were sent out by e-mail (online link, word and pdf version) and followed up by e-mail or telephone giving additional information and explanations on the procedure.

Regular and intense follow up on the answers and reminders by e-mail and telephone were necessary as well as further identification of stakeholders to complete the data collection where needed. It was for example, very difficult to find relevant policy makers willing to participate in some countries.

Due to the patient/doctors privacy, the distribution of the questionnaire for end-users was mostly done via the network of ADOCARE and through European patient organisations such as Eufami, ADHD Europe, Gamian, etc.

Adapted versions of the questionnaires for the policy makers as well as for the experts were sent to the CPME (Standing Committee of European Doctors) and an extra questionnaire was



developed for the entourage of the adolescent (responses were gathered from teachers, siblings, parents...)

To make it more easy for the stakeholders to answer to the questionnaires, different translations were made at their request: the questionnaire for the policy makers was translated into French, the questionnaire for the professionals was translated into French and Spanish, and the questionnaires for the end-users were translated into Dutch, French, German, Hungarian, Italian and Spanish.

Table 1 provides an overview of the final number of stakeholders that filled in the surveys in each of the 10 countries (see annex 6 for the full list of stakeholders who filled in the questionnaires). Using the questionnaires, ADOCARE aimed to consult experts at all levels in order to collect their knowledge and insights on the provision of adolescent mental health care. The results of the surveys are presented in chapter 3. More specifically, the results of the survey with policy makers, professionals, and experts are summarised in section 1 of chapter 3 describing the country profiles. The results of the survey with the end-users and their entourage are described in section 2 of chapter 3.

Table 2: Number of stakeholders who filled in the surveys

Country	Policy makers	Professionals	Experts	End-users	Entourage
Belgium	2	7	4	3	14
Finland	2	1	2	2	1
France	0	2	6	0	0
Germany	1	1	2	0	0
Hungary	2	0	1	1	0
Italy	3	2	0	0	0
Lithuania	1	0	2	0	0
Spain	1	4	2	6	0
Sweden	1	1	0	0	2
UK	1	2	5	5	3
Total	14	20	24	18	39

In the following paragraphs we shortly describe the main focus of each of the five surveys.

Survey with policy makers

The survey for policy makers was completed by 14 policy makers of the 10 member states and focussed on the following questions:

- Which relevant policies and legal frameworks related to the provision of care for adolescents with mental health problems exist in your country?



- What are relevant key experts and main care providers regarding adolescents with mental health problems in your country?
- Which initiatives related to the provision of care to adolescents with mental health problems exist in your country?
- Which integrated care settings for adolescents with mental health problems exist in your country?
- Is training in adolescent mental health included in the curricula of relevant higher education qualifications?

The questionnaire was strongly based on the questionnaire that was developed and applied in the context of CAMHEE WP 4 (Braddick, Carral, Jenkins, & Jané-Llopis, 2009) (see annex 1 for the survey that we developed to question the policy makers). It was not our intention to redo the research work of CAMHEE all over again and thus to collect the same findings. Instead, we intended to focus on new developments that emerged in the field of mental health since the end of the CAMHEE project. Hence, countries that had already participated in the CAMHEE project were asked to make mention of what had changed in their country since 2009. Countries who were not involved in CAMHEE were asked to fill in the whole questionnaire.

Survey with experts

The survey for experts was completed by 24 experts of the 10 member states. With experts we refer to researchers, academics, but also psychiatrists directing a mental health care service themselves. With the survey (see annex 2 for the survey that we developed to question the experts), the following questions were answered:

- Which practices for adolescents with mental health problems exist in your country?
- Are there so-called integrated mental health care services in your country?
- What is your opinion about the quantity and quality of these services in your country?
- Is there any evaluation of mental health care services and initiatives in your country?
- What is your opinion about policy initiatives concerning mental health care for adolescents?
- Is training in adolescent mental health issues included in the curricula of relevant higher education qualifications in your country?

Survey with professionals

The survey for professionals was completed by 20 professionals working in a mental health care service for adolescents in the 10 participating member states. Via the questionnaire (see annex 3 for the survey that we developed to question the professionals), we answered the following questions:



- What does your mental health care service offer to adolescents and how is your mental health care service organised?
- What are the strengths and weaknesses in the care for adolescents that your mental health care service offers?

Survey with adolescents with mental health problems

To collect information from end-users, two different surveys were developed. A first survey aimed to question adolescents with mental health problems who received treatment in the past 6 months. This survey was completed by 18 adolescents and assessed to what extent their needs were met by the existing mental health care services (see annex 4 for the survey that we developed to question adolescents with mental health problems).

Survey with young people in general and the entourage of the end-users

A second survey targeted young people in general and the entourage of the end-users, the parent and patient organisations (see annex 5). It assessed their opinion and experiences regarding mental health services for adolescents. The survey was completed by 39 participants.

1.3. Step 3: First High Level Conference

The first high-level (FHLC) was organised on the 16th of October 2014 at the European Parliament in Brussels to present the objectives of the network, present and discuss aspects related to the issue of providing adapted care for adolescents with mental health problems, present the first outcomes of the research, approve a plan for the follow-up workshops and to organise a discussion round to receive inspiration for possible awareness raising and capacity building activities in the 10 participating Member States (see annex 7 for the conference program).

A heterogenic group of 98 stakeholders (see annex 8 for the participants list) was invited to join and actively participate in two plenary discussion sessions. The participants were experts, professionals, policy makers, and representatives of parent and patient organisations. All attendees were encouraged to share their thoughts, opinions, insights, and reflections on several important issues related to adolescent mental health care in Europe aiming to fine-tune the first research findings obtained via the literature review and the surveys with different stakeholder groups. Travel and accommodation, as well as networking events were organised for them.

Based on our preliminary findings, we formulated seven key statements on the broad scenery of adolescents' mental health care to be discussed during the FHLC:

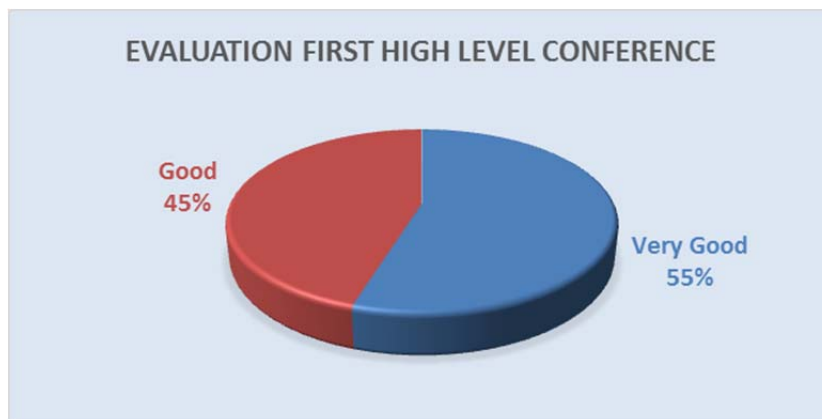
- Statement 1: Prevalence rates are important for the development of effective policies and action plans, tailored to the needs of the population.

- Statement 2: One generic data system across sectors and for patients of all age groups is necessary to assure administrative data of high quality.
- Statement 3: Governments should install the right political climate, youth oriented policies, and adequate legal frameworks in order to improve AMHC.
- Statement 4: High quality mental health care for adolescents is not possible without competent, well-trained professionals, very familiar with the world of adolescents.
- Statement 5: Integrated AMCH is recovery oriented and pursues full citizenship. Care should be provided by a multidisciplinary team of professionals within a broader network of services.
- Statement 6: Offering good AMHC means that the provided care and care environment is empowering and stimulating for a good working alliance.
- Statement 7: High quality AMHC services are specifically dedicated to this age group and easily accessible (in time, geographically, financially).

Via two plenary discussion rounds and a small notebook, attendees were invited to state their ideas on each statement. Chapter 4 provides an overview of the remarks and reactions that were collected. The results acted as a steppingstone for the next phase of the ADOCARE project.

At the end of the conference participants were asked to fill in an evaluation form. 31 stakeholders filled in the form. As shown in figure 5, the conference was rated to be good to very good:

Figure 5: Evaluation of the first high level conference.



As greatest achievements were mentioned:

- Feeling unity of purpose
- The broad spectrum of participants/network for further collaboration
- Connecting easily professionals, stakeholders, policy makers and sharing ideas and proposals; join professionals to think and discuss together
- Bringing together cross-national perspectives
- The good examples of best practices that were presented (Finland, UK, Belgium)



- A better understanding of the similarities /differences in adolescent mental health in the EU.
- Reassuring to see there is a strong agreement in major aspects
- Listening to bottom-up perspectives

1.4. Step 4: Four workshops with four different stakeholder groups

Four two-day workshops were prepared and organised in four EU countries as a follow up on the first high level conference for four different groups of stakeholders:

- 19-21/01/2015: Belgium, Brussels – workshop for policy makers (see programme in annex 9)
- 05-07/02/2015: London, UK – workshop for professionals (see programme in annex 11)
- 03-05/03/2015: Stockholm, Sweden – workshop for experts (see programme in annex 13)
- 16-18/03/2015: Rome, Italy – workshop for end-users (see programme in annex 15)

Participants, speakers, best practices and initiatives were identified and invited for each workshop. Their travel and accommodation was organised for them. After each workshop a networking dinner was organised. The programme and attendance list of each workshop can be consulted in annexes 10, 12, 14, and 16.

The first day of each workshop was devoted entirely to the generation of the guidelines and recommendations for establishing integrated mental health care for adolescents across Europe. The method used during the workshops with policy makers, professionals, and experts was very similar. For the workshop with adolescents and representatives of parent and youth organisations another approach was used. In the sections below the applied method is described more in detail.

Method workshop with policy makers, professionals, and experts

Based on the information that was collected during the previous steps of the research process (i.e., literature study, survey, discussion groups during the first high level conference) a first draft of the guidelines was developed. We selected key themes to be included in the guideline and for each theme a general aim and some initial recommendations were formulated.

During the workshops, participants received the opportunity to contribute actively to the further refinement of the selected themes and recommendations. Each workshop started with a short presentation of the selected topics and the preliminary recommendations (the presentations that accompanied each workshop can be found on the ADOCARE website).

Via small group and plenary discussion rounds, participants were invited to reflect on the proposed aims and recommendations, to formulate additional recommendations and to make recommendations more practicable and concrete.



Importantly, not all topics were discussed during each workshop. We focused during each workshop on those topics that were most relevant for the participating target group. In preparation to the workshop, participants received a preliminary research note summarising the output of the two plenary discussion rounds organised during the first high level conference.

Method workshop with adolescents and representatives of parent and youth organisations

On the 17th of March 2015 a final workshop was organised with adolescent patients who had experienced psychological problems in the past, their relatives, and representatives of parent and patient organisations. It was our goal to listen to the voice of young people in order to find an answer to the following questions:

- What are the visions and concerns of young people on adolescent mental health care?
- What would be a youth-friendly support for adolescents with mental health problems?
- What characteristics should professionals have?
- What can governments do to improve mental health in young people?

Inspired by the UNHCR tool for operation (2012), we used a different method in order to make the workshop more youth friendly. More specifically, the workshop consisted of three different exercises:

- In exercise 1, seven statements in relation to adolescent mental health care were read out for the whole group. Participants were invited to indicate whether they agreed or disagreed with this statement by holding either a red card (disagree), a green card (agree) or a white card (neutral). Accordingly, participants received the opportunity to give feedback on their opinion.
- For exercise 2, the participants were split in four small groups. Each group received a flip chart and a marker and was invited to brainstorm on the question: “What are good places and strategies to help young people who need help?” They could make use of the flip chart to write down or draw their main ideas. Afterwards, each group was asked to summarise in plenary the ideas that came across during the brainstorm.
- For the final exercise participants were again divided in four smaller groups. They were asked to imagine that they were all policy makers of a country sitting together to share thoughts and to come up with some good ideas on how to improve the mental health of the young citizens in their country.

During the three exercises, adult participants were asked to give the floor as much as possible to the young people. They received the task to support the youngsters as good as possible in expressing their ideas.

Evaluation of the four workshops

Evaluation of the workshop with policy makers

Eight evaluation forms were filled in; with the majority of the participants rating the workshop to be good or very good (figure 6).

As greatest achievements were mentioned:

- New ideas and variability of ways to provide care
- Learning about examples of good practices in Belgium and other countries
- Allowing to share experience

Figure 6: Evaluation of the workshop with policy makers



Evaluation of the workshop with professionals

Fifteen evaluation forms were filled in with the majority of the participants rating the workshop to be overall good to very good.

Figure 7: Evaluation of the workshop with professionals.



As greatest achievements were mentioned:

- Debate about integration of care
- Bringing together thoughts and making the project more concrete on what exactly we are trying to achieve
- Managing to incorporate varied ideas in order to work for the better good of teen mental health, that starts with issues arising in childhood; congratulations on all the hard work to make this possible
- Networking and active discussion
- Exchange of experience, ideas inspiration for further activities,
- The hope of changing something in the organisation of adolescents health care

Evaluation of the workshop with experts

8 evaluation forms were filled in; with the majority of the participants rating the workshop to be good or very good.

Figure 8: Evaluation of the workshop with experts.



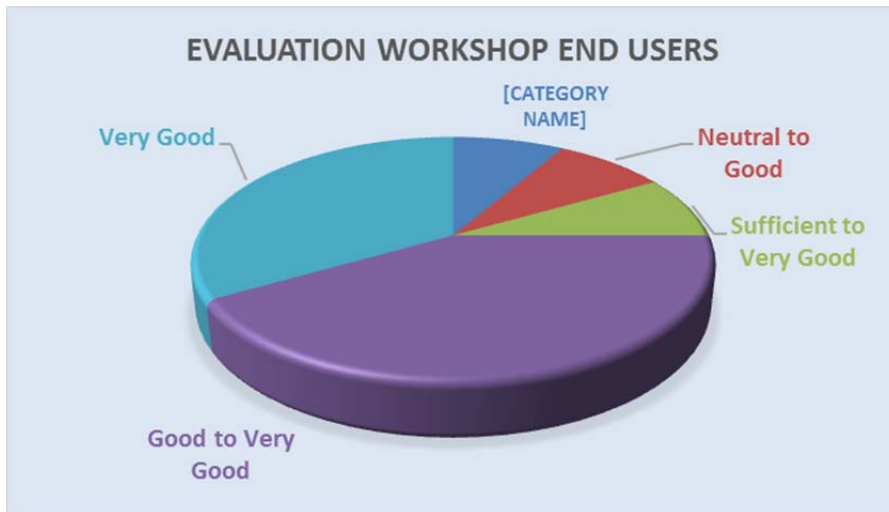
As greatest achievements were mentioned:

- Fruitful discussions of the results of the statements of the first high level conference
- Wonderful exchange of points of view – great deal on clinical perspective from professionals
- To raise questions and discussion about the link between the research and clinical practice

Evaluation of the workshop with end-users

13 evaluation forms were filled in; with the majority of the participants rating the workshop to be good or very good.

Figure 9: Evaluation of the workshop with end-users



As greatest achievements were mentioned:

- Giving a voice to young people with mental health problems; making them feel that they are being listened to, that their experiences help to shape future policies and creating a network in which youngsters are strongly represented
- The openness of all of the young people, and the sense of being valued. There is a good potential to make life-changing strategies
- The strong participation and the involvement of young people and their capacity to advocate for their rights
- That people from different countries had the opportunity to meet, share ideas and discuss what their visions are on mental health
- A lot of new ideas came out on how to improve care services and we got to speak and say what we want and need

2. Capacity building and awareness raising activities

2.1. Events

The second day of the four workshops was entirely dedicated to awareness raising and capacity building activities. The purpose was to bring together experts with multidisciplinary backgrounds (such as medical, psychological, social, and educational) as well as parent and youth organisations from different EU member states with the objective of promoting integrated support services for adolescents with mental health problems. Different capacity building and awareness raising activities were identified.

For each workshop a specific topic was chosen in function of the group of stakeholders that was invited and was related to the overall objective of ADOCARE: « *the identification, development*



and promotion of models of adapted care for adolescents with mental health problems...". The presentations were a starting point for discussions and exchange of field experiences, leading to possible ways to facilitate the development of new initiatives in the different participating member states.

The topic addressed at the **policy makers' workshop** was the *administrative, financial, legislative aspects of the creation of care facilities, their impact (positive/negative) on the realisation of projects.*

The purpose was to look how (changes in) regulation (administrative, financial, legislative...) can help facilitate the creation/operation of care structures. The following initiatives were presented and were the base of the general debate on the topic:

- Presentation by Ms Gaëlle Paupe, "Association des Maisons des Adolescents", on the different administrative structures of houses of adolescents in France and their impact on the operation of those houses.
- Presentation by Dr Ann d'Alcantara of the "Centre Thérapeutique pour Adolescents" in Brussels who addressed the impact of regulations on daily clinical experience in adolescence through the CThA history.
- Presentation by Chris Van Lysebetten, director of "Habbekrats" a Belgian youth care structure, visited the previous day, which offers low threshold support for youngsters between 10 and 21 years.
- Presentation and visit of the "Lycée thérapeutique" at the clinic Fond'Roy in Uccle (Brussels). This therapeutic lyceum is a day hospital for adolescents. It combines therapeutic support with a school system and is a place of life, care and learning.
- Presentation of the Belgian "new mental health policy for children and adolescents" by representatives of the Belgian Federal government, FPS Public Health (psycho-social health care unit).

The topic addressed at the **workshop for professionals** was *the training of professionals* (more in specific regarding multi- and transdisciplinary care and the importance of integrated care that also focuses on the re-integration of the youngster in society).

- Presentation by Prof. Pierre-André Michaud (EUteach - European training in effective adolescent care and health) on the training of professionals on adolescent friendly services and adolescent friendly care.
- Presentation by Mr Miles Rinaldi (representative of ImRoc) on supporting individual recovery through organisational change. ImRoc aims to answer 2 key questions:
 - 1) How to change the attitudes and behaviour of staff and teams so as to make them more supportive of recovery for people using these services?
 - 2) How to change organisations such that these changes in staff behaviour are supported and maintained? (Changing the 'culture')



- Presentation by Dr Alexandre Beine of “AREA +”, an innovative care structure for adolescents in Brussels that welcomes up to 52 youngsters between 12-20 and whose objective is to take care of all kind of crises and problems.

AREA+ is a structure that is composed at the same time of a residential hospital for adolescents, a day hospital/therapeutic lyceum, a policlinic and a welcome desk with permanence.

At the **workshop for experts** the topic *evaluation* was addressed: *what are the objectives of existing initiatives, their structure and how can those objectives be formalised and then evaluated – what can be the positive/negative effects of evaluation procedures and the use of the results thereof – what conditions have to be met so that the evaluation effectively helps to improve the functioning of the care setting...*

- Presentation by Prof. Danuta Wasserman from the Karolinska Institute of the results of the SEYLE (Saving and Empowering Young Lives in Europe) project, their implementation and impact on the organisation of prevention.

The topic addressed at the **workshop for end-users** was: *information and access to information for end-users and their entourage, the accessibility of adapted care (what initiatives can be developed by patient/parent-organisations, by professionals and authorities - The use of internet/new technologies)*

- Presentation of *GIFT* by Ms Yvonne Anderson (+ youngsters). *GIFT* stands for *Great Involvement Future Thinking* and is the name of a partnership commissioned by NHS England to support children and young people’s participation in the CYP IAPT mental health service transformation programme. *GIFT* supports young people to be involved in many different ways, national and local – e.g. to sit on interview panels for new staff, to talk to managers about what needs to change, to write articles highlighting good practice.
- Presentation of the *Presage Project* by Ms Vanessa Bisson which aims to prevent suicide attempts with an algorithm based feedback smartphone application.
- Presentation of *Tejo*. *Tejo* offers first-line therapeutic counselling to young persons with mental health problems. The therapist of *Tejo* all work on a voluntary basis.

Apart from those four workshops, **several other activities** were organised or identified to raise awareness, to increase capacity building, to have an ongoing dissemination of information, to get the support of key stakeholders, to expand the network, and to promote exchange between key stakeholders of different member states (see annex 17 for the list of capacity building and awareness raising activities).



2.2. Communication, visibility, promotion and dissemination

Together with the communication specialist BVG Communication, an ADOCARE **visual identity** (look and feel, logo, layouts, etc.) was developed around the keywords “ado” and “care”. A choice was made not to visually dramatize the situation of mental health in youth but to create an image of hope and of looking at the future.

Following different brainstorming meetings the ADOCARE logo and “look and feel” was created for the project. As “ADO” is not a typographic element but considered as a drawing, a different and specific typography was created to make the difference (because ADOCARE makes the difference).

An ADOCARE website was developed for the project (www.adocare.eu). The structure of the ADOCARE website was developed based on the structure of the websites of other EC projects. The website contains the main information about the project, its objectives, events, news, publications, and is regularly updated. It also contains the list of organizations that take part in the project, the questionnaires that were used in the framework of the research and the invitations, programs and presentations of the different ADOCARE events.

The website was also used to reach the end-users. The questionnaires for adolescents and their families were uploaded and could be answered online.

Several other **communication tools** (leaflets disseminated via the internet or in paper form, posters, PowerPoints, templates, roll-ups, conference and workshop material, business cards, mailings, etc.) were developed for the different events such as conference maps, videos with testimonies of youngsters, to raise awareness on the subject of mental health in youth and adapted care, to explain the reasons for this project, to build capacity, to seek support, to develop an enlarged network of expert stakeholders or to dissemination information and results through different channels (network of participants, other existing networks, website, events, etc.).

With file maker pro the ADOCARE team developed a specific database to store, select and analyse the different ADOCARE contacts.

Chapter 3

Results of the five Surveys

In the current chapter we describe the present situation regarding mental health care for adolescents in the 10 participating member states. These country profiles are mainly based on the results retrieved from the surveys with policy makers, experts, and professionals. Where necessary and when possible, supplemental data coming from the literature study are added. For each country we try to give a description of the following issues:

- Some general figures: number of inhabitants, number of adolescents, whether or not there is a youth policy, the age of criminal responsibility
- Prevalence of mental health problems and research
- Policy and legislation regarding mental health for adolescents
- Availability and quality of mental health care services for adolescents
- Human, financial, and material resources
- Training of professionals on adolescent mental health issues

For some countries, it was not possible to provide a description of these issues as the necessary information was not available.

1. Country profiles

1.1. Belgium

General figures

- According to the figures of Unicef, in 2012, 11.2% of the total population in Belgium was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Belgium appeared to be moderately affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 12 (Youthpolicy.org).
- Belgium has a national youth policy (Youthpolicy.org).

Prevalence and research

- According to the survey with policy makers, administrative data sources and national statistics on the prevalence rates of mental health problems and mental well-being in adolescents are available, but not analysed. The main reason for this is the lack of financing and the complex division of jurisdiction in Belgium. Hence, the Belgian prevalence rates of mental health problems in adolescents are based on extrapolations from WHO-data. According to these data, 5.5% of the 15 to 24 year olds has an anxiety disorder, 15% has a sleep disorder, and 4.8% a depressive disorder (Braddick, Carral, Jenkins, & Jané-Llopis, 2009, p. 29).
- Administrative data sources on mental health problems in adolescents exist. Unfortunately the data do not comprise all types of organisations providing adolescent mental health care.

Policy and legislation regarding mental health for adolescents

- In 2013, an act was launched to promote the collaboration between different organisations providing care to children and youngsters at local level. Since then, several networks of organisations providing child and adolescent care have been formed. Organisations within the network try to work together to establish better care, to avoid overlap in care, to create one common vision on care, and to create continuity in care without losing expertise. Also, the act entails an agreement between the existing governments responsible for child and youth care to create a common ground for developing a good mental health policy. An important obstacle that hinders the implementation of the act is the lack of financial resources.
- A new mental health plan for children and adolescents is being developed. Implementation will probably start in 2016. In the new plan, the following 5 core missions are pursued:
 - Stimulate early detection, screening, and orientation
 - Improve diagnosis
 - Improve treatment
 - Strengthen inclusion in all areas of life
 - Exchange and pool expertise
- Moreover, the new mental health plan consists of the following 4 strategies:
 - Strengthen leadership and governance for mental health in children and adolescents
 - Provide comprehensive, integrated and responsive mental health and social care for children, adolescents, and their context in community-based settings
 - Implement strategies for preventing mental health problems and promoting mental health
 - Strengthen information, registration and communication systems and research for mental health
- Some general standards and rules for organisations that provide mental health care exist. Yet, no specific rules for services providing adolescent mental health care exist. Some rules are applicable for the whole country while other rules are only applicable in certain communities



(Flemish, French or German speaking community) (e.g., guidelines for the organisation of ambulant mental health care services).

- Legislation exists on the rights of youngsters in care. For example, young people have the right to refuse care as from 12 years on.
- The effectiveness of policy initiatives on adolescent's mental health care is not formally evaluated.

Availability and quality of mental health care services for adolescents

- According to the contacted experts, the availability of the four main types of mental health care services (i.e., home-based services, day care services, outpatient ambulatory services, and residential services in hospital or non-hospital settings), whether or not exclusively for adolescents, is poor.
- Despite the poor availability of these services, the quality of care offered by the existing services is rated to be good. Day care facilities are rated to be of very good quality, residential non-hospital services are of average quality.
- Experts noted that in Belgium the group of young people aged between 18 and 25 years old and adolescents suffering from chronic somatic diseases or having mental health disabilities are lacking attention.

Human, financial and material resources

- Belgium has an ombudsman to protect the rights of adolescents for each community.
- Adolescent psychologist, adolescent psychiatric nurse, and adolescent psychiatrist are not recognised as separate professions in Belgium.
- At a national level, 20 milliard EUR is spent on health care, with 6% of this budget being dedicated to mental health care in general.
- The funds dedicated specifically to children and adolescents' mental health are not clearly identifiable in the most recent national budget. However, it is estimated that the amount of financial resources spent on adolescents' mental health did not change much in the past five years.
- Within the Belgian government there is an overall tendency to invest in evidence-based and community-oriented services for adolescents.

Training of professionals in adolescent mental health issues

- According to the questioned experts and policy makers, adolescent mental health issues are generally not incorporated in the higher education of relevant mental health professionals. When adolescent mental health issues are included in the curriculum, training is rather limited.

Good practices

Solidarcité – a programme to stimulate the inclusion of young people into society

Solidarcité is an organisation active in Brussels and Liège offering support to young people between 16 and 25 years old from different backgrounds. The organisation aims to foster young people's personal development and their integration into society. They support adolescents to become active citizens that are critical, take responsibility, and are caring. This objective is achieved by organising several activities for the benefit of the society (e.g., cleaning nature to protect the environment, small restorations of public buildings, assistance to the poor, street parties in the neighbourhood, fundraising, etc.) and by providing individualised social support to adolescents to stimulate their inclusion into society.

More information can be found on the website: www.solidarcite.be

Therapists for youngsters (TEJO) – ambulant therapeutic counselling for young people

TEJO is a non-profit primary care organisation that provides ambulant therapeutic counselling to young people with mental health problems. A maximum of ten treatment sessions is given; adolescents with more complex problems are referred when specialised care is required. The organisation is run by a group of highly motivated youth therapists who all work on a voluntary basis. Volunteers receive training on a regular basis to make sure that they are well-acquainted of the living environment of adolescents. Importantly, TEJO is highly accessible for young people: the opening hours are convenient, adolescents are treated in an anonymously way, and the treatment is free of charge.

The main goals of TEJO during treatment are to:

- Stimulate normal development
- Strengthen feelings of competence
- Enable young people to get their problems under control
- Stimulate resilience
- Ensure that young people feel safe
- Support young people to deal with their emotions in a better way
- Support young people to reflect on their own possibilities in a realistic way

During the counselling the following approach is used:

- An emancipatory approach: young people are considered to be experts who know best what they want to achieve.
- A solution-focused approach focusing in particular on the qualities and positive strengths of the youngsters.
- Mediation therapy is offered to the entourage of the child (parents, siblings, school) in case they want to be involved.

More information can be found on the website: <http://www.tejo.be>



La Maison de l'Adolescent (Lamado) – a drop in service for adolescents

The centre is a drop-in service for adolescents between 11 and 25 years old which they can visit to express their concerns or to ask questions and support. The goal of Lamado is to bring the expertise of different services and partners together in one place in order to offer an efficient link for the adolescent and his or her family.

Lamado provides:

- Psychological care (on appointment)
- Interviews with various professionals specialized in adolescent issues
- Support groups for adolescents and parents that are led by professionals
- Therapeutic workshops (cultural care, creative expression workshop, writing workshop)
- Documentation centre: the youngster, parents and professionals can access documentation and information on issues that affect teens (books, magazines, DVDs)
- Internet access

More information can be found on the website: www.lamado.be

AREA+ – an integrated psychiatric care structure exclusively for adolescents

AREA+, a Belgian pilot project, is a House for Teens that opened its doors on July 1, 2015. AREA+ is a multiple psychiatric care structure providing different services for 52 adolescents aged between 12 and 20 years. It aims to respond to any type of crisis or problem: psychological distress, eating disorders, depression, family breakdown, school drop-out, etc.

Its operation is based on a multidisciplinary, therapeutic, social, legal and educational approach, it combines therapeutic care, education, sports, art workshops, etc.

The structure consists of:

- A residential hospital for adolescents
- A polyclinic
- Day care hospital
- Hospital school for outpatients and stabilised inpatients to maintain or return to school
- Acute care unit (voluntary admittance)
- Forensic unit
- Therapeutic boarding school (outside school activities)
- Partnership with sports club (sports with care team as well as training with non-hospitalised young people)
- A permanent welcome desk

More information can be found on the website:

www.laramee.be/index.php/hospitalisations/area



Centre Therapeutic pour les Adolescents (CThA) – a residential care service exclusively for adolescents

The CThA is an open residential care service providing institutional therapy to adolescents between 14 and 21 years old with either neurotic or psychotic disorders. Adolescents can stay in the service for 1 to 9 months. This in accordance with the psychoanalytical therapy that is offered as the time range resembles a 'symbolic pregnancy'.

The CThA is a pilot project that offers an alternative to the "classic" psychiatric hospitalisation. The youngsters stay in the center during the week on the model of a classic boarding school and return to their living environment on weekends, with the exception of one weekend per month.

The objective of the CThA is to work on the particular problems of adolescence and on the specificities of clinical situations at this age. Young people are supported in their personal development and in their relationship with the family. They are assisted in the establishment and management of new social ties.

The basics of the CThA are:

- A progressive decrease of antidepressants
- Attention to community life
- Confrontation to limits
- Involving families and/or the entourage

The treatment approach contains the following elements:

- Attitude
- Bonding
- School drop out
- Promote social interaction
- Attention for the body
- Experience-based learning
- Anger, rage, and hate management
- Risk and fear management

More information can be found on the website: www.saintluc.be/services/medicaux/psy-infanto-juvenile/ctha.php

Social welfare centre Limburg – ambulatory guidance of young adults in the home setting

The social welfare centre Limburg offers ambulatory guidance and support in the home context to adolescents from 18 to 25 years old with various problems and care needs (financial problems, relational problems, housing problem, traumatic experience, living in poverty, etc.). The guidance starts with an assessment of the needs on several life domains (mental health, relational, financial, social, living skills, etc.) and accordingly consists of various treatment methods. The main objective of the guidance is to support the adolescent in picking up his own life again as soon as possible. During weekly home visits, the social worker collaborates with the adolescent to help him addressing several areas, e.g. administration, organisation of the household, relationships, budget counselling, (mental) health and hygiene, structure (work and leisure), and support in parenting. When assisting young people with severe mental health problems (depression, suicide thoughts, etc.), a collaboration with mental health care services is set up. During the guidance, there is a focus on creating a social network (volunteers, family members, professionals, etc.).

The advantages of this project are:

- Working outreaching
- A focus on integrated care
- The adolescent is the owner of his counselling process which stimulates self-care
- The adolescent is supported in picking up normal life as soon as possible

More information can be found on: www.cawlimburg.be

Habbekrats – a youth welfare organisation promoting mental wellbeing in underprivileged adolescents

Habbekrats is a youth welfare organisation that focuses on underprivileged children and adolescents aged between 12 and 25 years old. Several activities are organised in order to offer these young people useful leisure, help, and educational training in a free and accessible way. The activities aim to make these young adults more empowered and are centred on the following five themes: (1) meeting friends, (2) experiencing culture, (3) enjoying food and recreation, (4) discovering new things by training, and (5) enjoying sports and play. All activities are packed as adventurous events, so adolescents push their boundaries and enhance their strengths in a joyful manner. By making these adolescents more empowered, they may find their way in life, despite their disadvantaged background.

Currently, Belgium counts 11 Habbekrats meeting houses. Every house is decorated in a colourful and cosy way, so the youngsters have the opportunity to spend their leisure time in a warm nest.

Finally, the organisation works with a very dedicated and highly motivated team of

professional youth workers who are perceived by the youngsters as their big brother or sister. The youth workers also work outreaching; they go out on the street and actively approach vulnerable youngsters and invite them to join activities and to come visit one of the houses.

More information can be found on the website: www.habbekrats.be

1.2. Finland

General figures

- In Finland, the total number of inhabitants is 5.3 million, with 300,000 inhabitants being between the age of 13 and 17 years old.
- According to the figures of Unicef, in 2012, 11.5% of the total population in Finland was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Finland is moderately affected by the great recession (Fanjul, 2014).
- The age at which young people are responsible for possible criminal behaviour is 15 (Youthpolicy.org).
- Finland has a national youth policy (Youthpolicy.org).

Prevalence and research

- Administrative data on prevalence rates of mental disorders in adolescents are available. Every two years the Adolescent Mental Health Cohort study is administered in Finland of cohorts of 15 to 17 year old school pupils assessing their health related habits, social situation, and school well-being. The results show that the prevalence of mental disorders among 15 to 17 years old is not increasing. In addition, Finland participates in the ESPAD study – the European school survey project on alcohol and other drugs – assessing substance use among 15 and 16 years old students.
- Due to the fact that the health and welfare systems are quite decentralised in Finland, there is a lack of national statistics.
- Finland is involved in an international study, in which thousands of adolescents participate. This study provides information of the general population.
- A survey conducted by the Adolescent Psychiatric Society showed that in adolescent psychiatric care services the following psychosocial interventions are used most often: psychodynamic psychotherapy (83%), family therapy (54%), cognitive psychotherapy (50%), art therapy and music therapy (42%), and occupational therapy (21%).
- According to the National Insurance Institution statistics, 1.6% of the adolescents aged between 11 and 15 years used psychopharmacological medication in 2007. Boys were prescribed more often ADHD medication than girls, whereas girls used more often antidepressants. In girls, the incidence of medication usage peaks over 13 years of age.



Prescriptions were usually made at a specialist level of care. 4.2% of the 16 to 20 years old and 8.4% of the adolescents aged 21 to 26 years old used psychiatric medication.

Antidepressants were used by 4.5% of the 18 year old women and 1.8% of the 18 year old men. The percentage of 22 year old men and women using antidepressants was 8 % and 4.3% respectively.

Policy and legislation regarding mental health for adolescents

- Until recently, the health and welfare system in Finland was quite decentralised. Health care and social services were financed via the municipalities and there are over 300 municipalities in Finland. Currently, however, the National Development Plan for Social Welfare and Health Care (i.e., Kaste Programme) is running (from 2012 till 2015) to reform social and health policy: the health care services and social services will be brought together within 5 regional entities instead of within 300 municipalities. This reform is expected to have a great impact on the financing of services, the coordination and the synchronisation of services.
- A generic law (Health care law, 2011) enforces maximum waiting times in child and adolescent psychiatry: elective referrals have to be evaluated within 3 weeks; patients should be assessed within 6 weeks; and treatment should be initiated within 3 months after the need is detected. Since this law, waiting lists have been shortened and the accessibility of mental health care has improved.
- Since 2004, there are explicit criteria concerning the access to specialised care services. Criteria are formulated for all specialties – thus not only for mental health care. Priority rating tools are used by all medical specialties to ensure that the threshold to specialised level care is similar across the country. The access to specialised care is supervised by a national office. This initiative helped reducing the unequal variation in accessibility of specialised care services between regions.
- According to the Mental Health Act (1990) and the Mental Health Decree (2000) minors have to be treated separately from adults in inpatient mental health services.
- In 2007 the National Plan for Mental Health and Substance Abuse Prevention (i.e., Mieli plan) was launched. The plan runs from 2009 till 2015 and outlines common national objectives for mental health and substance abuse prevention, involving all age groups (including adolescents) with a focus on primary and community care. One of the aims of the plan is to integrate mental health and substance abuse services. Often substance abuse problems are being treated by welfare services. This has been problematic since substance abuse problems among adolescents go often hand in hand with other mental health problems and hence mental health services should also be involved. For adults, the integration of welfare and mental health services evolves well. However, the integration of adolescent welfare and adolescent mental health services proceeds with more difficulties.
- In 2011, it was ruled that at school three health care checks should be organised for youngsters at the age of 7, 10, and 14 in order to allow a good psychosocial orientation at



these ages. They are organised by school health services and conducted by school doctors or school nurses. All school children are personally invited for these check-ups, but participation is on a voluntary basis. Parents are also involved in these check-ups in order to assess the family's well-being. They are asked to fill in some questionnaires and are then invited for a conversation. It is not always easy to reach the parents, especially those of the most vulnerable adolescents. When a problem is detected, follow-up care is organised when needed. The check-ups are well accepted by the general population. The data are not accumulated for statistical purposes or to assess the general needs of adolescents. They are only used at an individual level.

- The Finnish Adolescent Psychiatric Association published guidelines and recommendations for the outpatient care of adolescents, focusing on accessibility, and the different types of assessment and treatment.
- In Finland, there is a strong legislation on data security. This has created some troublesome situations, in which sharing of information is desperately needed but inhibited.
- The Child Welfare Law (2007) stipulates that child psychiatric services and social services have to cooperate.
- Young offenders between 15 and 21 years old who committed a crime need to be evaluated to determine whether they have social, educational, general health or mental health needs that require an intervention.
- The Youth Guarantee (2013) states that every young person under the age of 25 and every recently graduated person under the age of 30 is offered a place to work, a work try-out, a study place, a place at a workshop or a rehabilitation placement within three months after being registered as unemployed.
- Recently, the Act on Student's Welfare (2014) was launched aiming to increase welfare and promote prevention within school institutions. The emphasis lies on multidisciplinary work.
- In Finland, 13 quality criteria were developed to assess psychiatric services for adolescents aged between 13 and 22 years old. Each criterion is evaluated on a scale ranging from 0 to 5. The following 13 criteria should be tried to be met:
 - Adolescent psychiatric services should exist for adolescents aged between 13 and 22
 - Primary and secondary services are coordinated and there is a quality assurance plan
 - Maximum 5% of the adolescents are treated in adolescent psychiatric care
 - There are 13 mental health professionals per 10,000 adolescents
 - There are 2.5 adolescent psychiatrists per 10,000 adolescents
 - Adolescent psychiatric services are provided by multi-professional teams
 - Low threshold services are available and there are maximum waiting times
 - Assessment always includes meeting with a psychiatrist and involves family work
 - Medication is started by a psychiatrist only
 - Appropriate psychosocial interventions are used
 - Appropriate rehabilitation is provided
 - User satisfaction is taken into account

- Therapy outcome is monitored
- In 2010 an evaluation showed that adolescent psychiatric services score average on the 13 criteria (i.e., an overall score of 3.5 on 5).
- Currently, different sectors are responsible for adolescent health care (medical and psychiatric care), social care, employment services, education, and youth care. Cooperation between services active in different sectors is limited. It is generally expected that the reform will facilitate cooperation between adolescent psychiatric and welfare work.
- Mental health policies are supervised by the National Institute for Health and Welfare. This institute supervises that maximum waiting times are not exceeded, keeps track that the number of services provided by inpatient and outpatient care units is in relation to the financial resources of the hospital districts, and supervises how the Mieli and Kaste programmes are going.

Availability and quality of mental health care services for adolescents

- In Finland, different levels of adolescent care are organised as follows. Within the municipalities mental health teams and school and student health services for young people (i.e., primary care) are available. Secondary care (i.e., adolescent psychiatric outpatient and inpatient services) is organised by the hospital districts. In the country there are 21 hospital districts, with each district having its own specific psychiatric services for adolescents between 13 and 17 years old. The exact age group that is treated by each service slightly varies across regions. In some regions young patients aged 18 till 22 are treated in adolescent specific services, whereas in other regions they are treated in adult services. Furthermore, there are two services for rare issues such as adolescent forensic psychiatry and gender identity problems among adolescents that are organised at national level. The care that is provided by these different types of services is free for adolescents. In addition, private care services (e.g., private practices of adolescent psychiatrists and private psychotherapists) are also available and are partially reimbursed by the national health insurance (NHI) and the hospital districts.
- Thus, psychiatric services exclusively for adolescents exist. In 2012, specific wards for adolescents aged 13 till 17 counted 2,037 inpatients. The number of beds is determined by the hospital districts. The average stay in a psychiatric hospital is 32 days.
- From 2006 to 2012 adolescent psychiatric outpatient visits at a national level increased from approximately 150,000 to 220,000. The number of adolescents admitted to inpatient care increased from 2001 to 2012 from 1,400 to 2,200.
- Inpatient beds for adolescents on general psychiatric wards do not exist in Finland, as by law minors have to be treated separate from adults.
- The availability of adolescent mental health care services is rated to be either good or very good. Only home-based services are rated to be less available.



- Overall, the quality of services specialised in adolescent mental health issues is rated to be either good or very good.
- There is currently no systematic evaluation assessing to what extent patients get better thanks to the provided care. Recently, university clinics agreed to use a quality of life questionnaire to evaluate the outcome of the given treatment. For that purpose, an evaluation instrument is being developed at the moment.

Human, financial and material resources

- In Finland, there is an ombudsman for adolescents' rights.
- The profession of adolescent psychiatrist is recognised as a separate specialty. There are currently 168 adolescent psychiatrists active in Finland.
- Neither the profession of adolescent psychologist nor the profession of adolescent psychiatric nurse are being recognised as a separate specialty.
- At a national level, 17.5 billion EUR is spent on health care (9% of the GDP), with 4.28% of this budget (i.e., 749 million EUR) being dedicated to mental health care.
- It is estimated that 10% of the budget spent on mental health care is dedicated specifically to adolescent psychiatry (i.e., approximately 74 million EUR). Funding of primary and secondary care occurs via different channels: budget for basic services is provided by the municipalities, whereas budget for specialised care is provided by the hospital districts. The budget spent on adolescent and adult mental health work at the primary level is not separated. Hence, the exact budget dedicated to children and adolescent mental health care is not clearly identifiable in the most recent national budget.
- The last 5 years, there occurred a big shift in resource allocation. The funds that once went to the inpatient adolescent units are mainly being relocated to outpatient initiatives.
- Services are financed mainly by the state, the municipalities, the Finnish Social Insurance Institution, private insurances, and non-profit organisations serving households and employers.

Training of professionals on adolescent mental health issues

- In Finland, adolescent psychiatry is a separate medical specialty, requiring a six year educational training.
- Medical doctors with a specialisation in child psychiatry, psychiatry, family practice or paediatrics can follow a retraining to become adolescent psychiatrist.
- All medical doctors have completed some courses on adolescent mental health.
- Other health workers like social workers, psychiatric nurses, psychologists, and teachers can follow courses on adolescent mental health issues or attend postgraduate courses, but this is not compulsory. They can also graduate without studying adolescent mental health at all.

1.3. France

For France, policy makers were unable to complete the online survey. Hence, some information is missing.

General figures

- According to the figures of Unicef, in 2012, 12.1% of the total population in France was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, France is moderately affected by the great recession (Fanjul, 2014).
- The age at which young people are responsible for possible criminal behaviour is in France 13 (Youthpolicy.org).
- France has a national youth policy (Youthpolicy.org).

Prevalence and research

- Based on our literature review and based on the surveys with policy makers and experts we were unable to ascertain whether recent data on the prevalence of adolescent mental health problems are available in France.

Policy and legislation regarding mental health for adolescents

- According to the experts, the primary objective of the French government is to reduce costs as much as possible. Due to this overall saving strategy, a lot of mental health care organisations have to reconsider efficient programmes and successful initiatives.
- Nonetheless, recent policy changes created the opportunity to establish houses for adolescents throughout the whole country.

Availability and quality of mental health care services for adolescents

- In France, the availability of home-based services providing adolescent mental health care is very poor and the availability of residential services is poor. The availability of day care services and outpatient services is slightly better.
- Outpatient services providing adolescent mental health care are rated by experts to be of good quality. Home-based services, day care services, and residential services are rated to be of either average or good quality.
- In France, mobile teams are a growing type of outpatient services providing adolescent mental health care and are also rated to be of good quality.
- France also has several houses for adolescents across the whole country. The houses vary widely from one another, but all use a multi-professional approach. Although these houses of adolescents are valuable, they often lack resources that prevent ideal working standards.



Human, financial and material resources

- Experts in France indicate that the number of professionals is not evenly distributed across regions. In some regions, the number of professionals is disproportionate to the number of young people.

Training of professionals on adolescent mental health issues

- According to the experts, training in adolescent mental health issues is included in the curriculum of paediatricians, psychologists, psychiatrists, psychiatric nurses, social workers and the staff of juvenile detention centres.

Good practices

Espace Méditerranée de l'Adolescents (EMA)

Since 2012, EMA, a unique innovative psychiatric hospital in France, provides complete care for adolescents with mental health problems from the crisis to the follow-up care, including somatic care, psychiatric rehabilitation, cultural mediation and school support. The hospital ensures a thorough medical monitoring and brings together care, culture and education, encompassing art, cultural expression, sports and teaching.

In collaboration with the universities of Marseille and Aix-en-Provence as well as the CNRS, INSERM and INCA.

The EMA also aims to become a resource centre for research and training in the field of adolescence in crisis.

For more information: <http://fr.ap-hm.fr/ap-hm/enjeux/evolution-hopitaux-sud/ema-espace-mediterraneen-adolescent>

Centre Abadie – a psychiatric hospital for adolescents providing multidisciplinary care

The Centre Abadie is composed of 4 units:

- The unit for Nutritional Disorders: composed of 8 residential places and 5 day hospital places for teenagers from 14-24 years suffering from anorexia-bulimia and residing in Aquitaine.
- The Medico-Psychological Unit for Adolescents and Young Adults: composed of 15 full-time beds, designed for adolescents of 14-24 years who have made a suicide attempt or are giving signals of repeated risky behaviour.
- The Multipurpose Consultation Centre for Children and adolescents: open to 12-24 year olds. The consultation is provided by somatic child psychiatrists and psychiatrists (gynecologist, dermatologist, and endocrinologist), psychologists, social workers,



dieticians and nurses.

- The University Department of Child and Adolescent: comprising full-time 10 beds and five days beds, designed for 7-17 years old youngsters with particularly severe depressions, severe anxiety disorders and eating disorders.

These units can benefit, depending on the needs, of in situ intervention of other professionals: volunteer teachers, sport educators sports, etc.

More information can be found on the website: www.centreabadie.wordpress.com

Maison de Solenn

La Maison de Solenn offers multidisciplinary care in pediatrics and adolescent medicine in the field of eating disorders (anorexia and bulimia), cross-cultural issues (children of migrants, mixed couples ...) and international adoptions, psychology and psychiatry for adolescents (11 to 18 years) without geographic location limit.

During the consultations a quality relationship with the teenager is built so that care can be based on the best possible therapeutic alliance, guaranteeing the quality of a therapeutic process. By giving psychic and somatic care adapted to teens, we seek to understand the adolescent in its psychic, somatic, social and educational entirety.

The adolescents will first be met by a multidisciplinary team that will welcome them, listen to them, inform them and assess their needs. Subsequently, depending on each particular case, they will be referred either to an adolescent psychiatrist, a general practitioner a specialist physician (pediatrician, gynecologist, dietician, endocrinologist), or to a facility offering individual psychoanalytical or cognitive-behavioral therapy, group therapy, occupational therapy, relaxation or speech-therapy. The use of different mediators encourages creativity and the expression of suffering and conflicts. Other forms of help can also be provided, such as social assistance, educational support and legal aid.

La Maison de Solenn has a particular concern for families. Parents or legal guardians and those who accompany adolescents are particularly associated with the consultations during the first appointment. They can assess transcultural consultations and family therapy.

For more information: www.mda.aphp.fr

Houses for adolescents – multidisciplinary mental health care service supporting Adolescents, parents and professionals

In France, 104 houses for adolescents exist which are represented and supervised by the National Association of Houses for Adolescents. The houses are a place where teens



between 11 and 25 years, their family and even professionals can go with questions and concerns related to diverse domains of the adolescent's life (medical, sexual, psychological, educational, legal, social, etc.).

All houses pursue the following objectives:

- Provide (mental) health services for teenagers that are currently not provided by other services in the region.
- Anonymous, confidential and free appointments are guaranteed in the houses of adolescents.
- Provide information, advice and assistance in developing a life plan
- Bring together multidisciplinary professionals to facilitate access to health care services for teenagers who are not reached by the more traditional circuit.
- Welcome teenagers from 12 to 25 years old, their families and the professionals; either within the structure or via the partner network.
- Ensure the continuity and consistency of health care and paths.
- Act in the region as an information platform for all actors who are involved in adolescent mental health (parents, professionals, institutions) by creating a network between existing structures

The houses do not have a unified structure; instead different forms of houses exist. Also, each house has its own missions and targets depending on the provision of care in the region.

More information can be found on the website: www.anmda.fr/les-mds

1.4. Germany

General figures

- In Germany, in 2012, 9.8% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Germany appeared to be moderately affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 12 (Youthpolicy.org).
- In Germany a national youth policy is under construction (Youthpolicy.org).

Prevalence and research



- Both administrative data and national surveys on prevalence rates of mental disorders and positive mental health in adolescents are available. Examples are the Kiggs study (www.kiggs-studie.de) and the Bella study (www.bella-study.org).

Policy and legislation regarding mental health for adolescents

- In January 2014, the federal committee decided that 20% of physicians and psychotherapists who offer psychotherapy should only treat children and adolescents.
- In July 2009, an agreement was developed on specific actions to improve the socio-psychiatric care for children and adolescents.
- In 2012, the federal law on child protection has been updated focusing on issues such as child protection, early intervention, and issues about sharing information.
- Mental health policies are not supervised. Also, there are no formal instruments to evaluate policies for adolescent mental health care.

Availability and quality of mental health care services for adolescents

- In Germany, mental health care services exclusively for adolescents exist. Although the quality of the care provided by these services is rated to be either good or very good, the number of services is not in line with the actual demand for care.
- Within child psychiatric wards, there are 8,381 inpatient beds available to which minor adolescents are allowed. This corresponds to 0.63 beds per 1,000 minors.
- Adolescents aged above 18 years old are generally taken care of in adult psychiatric hospitals.

Human, financial and material resources

- In Germany there is no ombudsman for adolescents' rights.
- Adolescent psychologist, adolescent psychiatric nurse, and adolescent psychiatrist are recognised as separate health professions in Germany.
- Germany counts 3,334 established child and adolescent psychotherapists which corresponds to 4,005 minors per specialist; and 818 established child and adolescent psychiatrists, which corresponds to 16,322 minors per specialist.
- At a national level, 300.4 billion EUR is spent on health care, with 11.3% of this budget being dedicated to mental health care. The funds dedicated to children and adolescents' mental health are not clearly identifiable in the most recent national budget. Nevertheless, funds spent to adolescent mental health care services seem to have increased.

Training of professionals on adolescent mental health issues



- Training in adolescent mental health issues is integrated in the curricula of relevant higher education qualifications, except for teachers.

Good practices

iFightDepression – an internet-based guided self-management tool for depression

The iFightDepression tool is an internet-based, guided self-management tool for adults and adolescents with mild to moderate depression, which is currently implemented in Germany and Europe. The tool was originally developed and optimised according to scientific standards and following a systematic review process. It is based on existing self-management programmes that appeared effective and good-practices concerning online interventions targeting depression. Furthermore, the tool was developed with the help of patient end-user groups, general practitioners (GPs), and mental health professionals. A central element of the tool is that people using the tool are guided by a trained GP or mental health professional as research demonstrates that guided programmes are more effective than programmes without supervision.

The iFightDepression tool is based on cognitive-behavioural therapy which has been proven to be effective in the treatment of depression and other psychiatric disorders. The tool consists of several online modules that patients can work through at their own pace. One module can be worked on over several sessions. The texts provided in the different modules are written in a colloquial and youth-friendly way. For young people, an adapted version of the programme is also available, containing age specific modules on social anxiety and social relationships.

In addition to the iFightDepression tool, there is a website providing comprehensive information about depression and its consequences addressing three different target groups. First, the website targets people suffering from depression by providing them information on the causes and symptoms of depression, helpful strategies to promote positive mental health (e.g., self-management resources) and where to find professional help. Second, there is a section on how to support a family member, friend or person in need of assistance. Third, there is a section for community and health care professionals who can act as gatekeepers or advocates in recognising and responding to depression, in disseminating best-practice recommendations for individuals with depression and in facilitating their access to care.

Importantly, the website and the tool are available in different languages: English, French, Spanish, Portuguese, Italian, Hungarian, Bulgarian, and Estonian.

More information can be found on the website: www.ifightdepression.com.



The department of child and adolescent psychiatry and psychotherapy at the Leipzig university hospital – bridging the gap between the hospital and the real world

The department of the university hospital provides integrated support to children and adolescent patients. There is a school at the hospital that teaches patients in small groups and ensures that they don't fall behind at school during their residence at the hospital. Furthermore, there are social workers who make the connection between the life at the hospital and other social fields and institutions (family, school, training position/work place). In most cases, various forms of therapy are offered next to psychotherapy (e.g., occupational therapy, music therapy, sport therapy) following a systematic approach, including family members.

More information can be found on the website: <http://psychiatrie.uniklinikum-leipzig.de/>

Gesundes Kinzigtal integrated care – a project stimulating integrated care

In 2005, an integrated health care project was started in the Kinzigtal region in Southwest Germany, trying to overcome the traditionally fragmented German health care system within this region. The project is managed by Gesundes Kinzigtal GmbH (Ltd.) (GK), a regional integrated care management company founded by a network of physicians in the region and a German health care management company. The first goal of the project is to improve the cooperation of health care providers within and between different health care sectors. This is done by (1) improving and intensifying the cooperation between general practitioners (family physicians), specialists, and representatives of other health professions such as physio- or psychotherapists, and (2) by optimising the coordination of ambulatory (outpatient) care and hospital (inpatient) care. The second goal is to overcome the economic inefficiencies of the traditionally fragmented health system, resulting from a poor coordination of service interfaces between general and specialised care as well as between inpatient and outpatient care.

Some characteristics of the approach are (Hildebrandt, 2014; Hildebrandt, Schulte, & Stunder, 2012; Schulte & Pimperl, 2013):

- The company cooperates with almost a hundred care providers, including general practitioners, specialists, hospitals, psychotherapists, nursing homes, ambulatory home health agencies, and physiotherapists. Additionally, GK has agreements with pharmacies, health and sports clubs, gyms, companies with workplace health promotion programmes, adult education centres, self-help groups, and local governments.
- Whenever a registered patient has been identified as being at risk of a certain disease (for example, during the comprehensive check-up that routinely follows registration), the physician and the patient develop an individual treatment plan on which both of them agree. GK teaches physicians how to improve their case management and provides additional services for patients, such as education programmes.

- GK attempts to support patients' active participation by providing self-help and self-management activities for patients and by training doctors in shared decision making.
- The coordination of care is facilitated via jointly developed care pathways, synchronising formulary management, and common electronic health records used across the sectors. Care providers that are part of the network have access to the patients' electronic health record if the patient (who is the owner of his own record file) has granted that access.
- The evaluation of the GK's work is run by independent research institutions. Recently, researchers found that the project resulted in a decline in the over-, under- and mis-use of healthcare in many indications in the Kinzigtal region. At the same time an increase in healthcare quality was observed.

More information on the project can be found on the website: <http://www.gesundes-kinzigtal.de/en/>

1.5. Hungary

General figures

- In Hungary, in 2012, 11.2% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Hungary appeared to be highly affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 12 (Youthpolicy.org).
- A national youth policy is available (Youthpolicy.org).

Prevalence and research

- Administrative data sources on prevalence rates of mental health disorders in adolescents exist but are not used as no governmentally supported research is available to process the data. Hence, no recent figures on the prevalence of mental disorders and on mental well-being in adolescents are available.

Policy and legislation regarding mental health for adolescents

- The authorised politicians specialised in the field of mental health are currently not in the possibility to create effective strategies or to release financial resources for adolescent mental health care.



- Within the Hungarian government, currently no one is responsible for the domain child and adolescent mental health. Also, the need of child and adolescent psychiatric care in comparison with adult psychiatric care is not known.
- In Hungary the main focus in the field of adolescent mental health care lies on prevention. As a consequence, there is a shortage in the medical health system for this age group.
- There is no specific legislation concerning adolescent mental health care in Hungary. Though, there is a law (December 2013) that states that an adult psychiatric institute is not allowed to treat patients under 18 years old.
- According to the experts, these facts show that adolescent mental health care is up until now no priority for the Hungarian government. Recently, a state secretary for youth and family affairs was appointed which strengthens the hope for new opportunities for Hungarian adolescents.
- Overall, mental health policies are not supervised in Hungary.

Availability and quality of mental health care services for adolescents

- In Hungary, there are hardly any services providing mental health care for adolescents. Experts rate the availability of these services as being very poor. The few services that are available treat both children and adolescents. Mental health services exclusively for adolescents are non-existent.
- Home-based services are virtually absent.
- The available mental health care services – day care services, outpatient ambulatory services and residential services in hospitals – are rated to offer good or very good quality care.

Human, financial and material resources

- The number of child and adolescent psychiatrists and child and adolescent psychotherapists is critically low in Hungary. There are only 86 recognised child and adolescent psychiatrists in Hungary.
- Child wards are fighting severe shortage of professionals in child and youth psychiatric wards. Hence, most of these services are unable to treat adolescents between 14 and 18 years old with severe emotional and/or behavioural problems.
- Hungary does have an ombudsman for adolescents' rights.
- At a national level, 7 milliard EUR is spent on health care, with 5.1% of this budget being dedicated to mental health care. Funds dedicated to adolescent mental health care are not clearly identifiable. Though, there is the overall impression that resources allocated to adolescent mental health largely increased in the past years. This is especially the case for community-oriented services for adolescents. The budget for adolescent residential institutions increased only slightly.

Training of professionals on adolescent mental health issues

- Courses on adolescent mental health issues are provided in the higher education curriculum of pediatricians, general psychiatrists and child and adolescent psychiatrists.

1.6. Italy

General figures

- In Italy, in 2012, 9.5% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Italy appeared to be highly affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 14 (Youthpolicy.org).
- A national youth policy is not available (Youthpolicy.org).

Prevalence and research

- In Italy, there is a general data system for registering data on children, adolescents and adults.
- Administrative data collection occurs consistently in inpatient care services but only partially in outpatient care services. In outpatient services it is rather difficult to differentiate mental health interventions from other interventions.
- Administrative data sources and national surveys on prevalence rates of adolescent mental health problems are available but not easily accessible. There is also doubt about the quality of the data on ADHD, autism and pervasive developmental disorders.

Table 3: Existing prevalence rates of mental health problems and other significant statistics among adolescents in Italy

Disorder	Prevalence	Age target group	Data source	Date of data collection
Anxiety disorder	2.36%	10-14 years	CBCL and DAWBA	2003
	1.93%	14-19 years		2008
Depression	1.92%	10-14 years	CBCL and DAWBA	2003
	2.36%	15-19 years		2008
ADHD	3.28%	10-14 years	CBCL and DAWBA	2003
	2.53%	15-19 years		2008
Conduct disorder	1.14 %	10-14 years	CBCL and DAWBA	2003
	1.5%	15-19 years		2008
Suicide attempt	3.6 per 100,000	14-17 years	National statistics	2010
	6.2 per 100,000	18-24 years		

Suicide	0.8 per 100,000	14-17 years	National statistics	2010
	2.7 per 100,000	18-24 years		
Early school leaving	17.6 %	18-24 years	National statistics	2012
Youth unemployment	43%	15-24 years	National statistics	2014
Juvenile offender	0.77%	14-17 years	National statistics	2012

- A data base of pharmacological prescriptions exists and can be consulted. Moreover, this dataset can be used to deduce national statistics on medication use. It is estimated that 1.1 on 1,000 children and adolescents aged between 0 and 17 uses antidepressants, 0.7 on 1,000 uses antipsychotics, and 0.3 on 1,000 uses stimulants.

Policy and legislation regarding mental health for adolescents

- In Italy policy and legislation on adolescent mental health exists on a national and regional level. We focus here on the national situation only.
- Between 1998 and 2000 the mental health department launched a national act on mental health focusing on the primary and secondary prevention of mental health disorders. Within the act there was a special focus on the early detection of child and adolescent mental health disorders. The huge diversity in between regions regarding the availability of adolescent mental health services interfered with the implementation of this act.
- In 2008, after an analysis of the current situation concerning adolescent mental health, guidelines were developed for adolescent mental health services. A new act stated that mental health services should focus more on autism spectrum disorders, the transition from child to adolescent and adolescent to adult services, and the continuity of care between inpatient and outpatient services. Unfortunately, no financial resources were released to implement this act.
- In 2013, a new national action plan on mental health was launched as some important needs in the mental health system were identified. First, there appeared to be a huge variability in child and adolescent services across regions and a nationwide lack of specific structures. Second, the need was stressed for multi-professional care promoting rehabilitation, as this is believed to be an essential aspect of child and adolescent mental health care. Third, the involvement of the families of children and adolescents was highlighted. In the new national action plan the following 8 specific objectives are formulated:
 - Build a complete and integrated network of services providing child and adolescent mental health care
 - Build a network of day care and residential services providing child and adolescent mental health care
 - Define pathways of transition to adult services



- Define integrated pathways of care for the families of people with mental health needs
- Realise early and appropriate interventions for severe mental health problems and psychiatric emergencies in adolescence
- Realise early and appropriate interventions for autism, complex disabilities and relevant neurologic and neuropsychiatric diseases
- Improve mental health interventions for young crime offenders
- Work out a proposal for a specific and appropriate data set and monitoring system
- The national action plan is implemented by the regional governments – therefore variations in implementation are possible.
- More information about the national health policy in Italy can be found on: www.salute.gov.it; www.iss.it; and www.sinpia.eu.
- In Italy, mental health service policies are evaluated using several outcome indicators.

Availability and quality of mental health care services for adolescents

- In general, there are no beds specifically dedicated to adolescents in psychiatric wards for adults. In very exceptional circumstances – when more appropriate solutions are not available – beds in adult wards are used for adolescents.
- In 2006, 15% of adolescents between 12 and 17 years old, who needed inpatient care because of a psychiatric diagnosis, were admitted to adult psychiatric wards. In 2006, adolescents represented approximately 0.67% of all admissions in adult psychiatric wards.
- Child neuropsychiatric wards treating patients aged 0 to 18 years with neurologic and/or psychiatric disease have only a limited number of beds nationwide. In 2013, there were 324 beds, which is equivalent to 3.23 beds for 100,000 inhabitants. A part of these beds (2.4 for 100,000 inhabitants) is used for adolescents between 12 and 17 years with mental health problems.
- The average stay in a psychiatric hospital is about 10 days.
- Pharmacological treatment is prescribed in accordance to existing evidence-based recommendations.
- Outpatient services are available in most regions, but inpatient beds are very limited and accessible in only 13 of the 20 regions. The availability of residential care and day care services is extremely limited in Italy. The existing services differ greatly with respect to mission, organisation, and human resources.

Human, financial and material resources

- In Italy, different regions have an ombudsman for adolescents' rights.



- Adolescent psychologist and adolescent psychiatric nurse are not recognised as a separate health profession.
- Child neuropsychiatrist is recognised as a separate profession and includes training in child and adolescent psychiatry. The total number of recognised child and adolescent neuropsychiatrists in Italy is about 3,000. It is estimated that only a few of them are specialised exclusively in adolescent psychiatry.
- At a national level, 110 billion EUR is spent to health care, with approximately 3.5% of this budget being dedicated to mental health care. The majority of funds dedicated to adolescent mental health are not clearly identifiable in the most recent national budget. Funds for adolescent mental health are scattered over different areas (education, social care, health care, justice) and those resources that are spent to adolescent mental health are further divided across prevention, child and adolescent neuropsychiatry, paediatric health, rehabilitation, etc.
- It is estimated that in the past 5 years, the allocation of resources to adolescent mental health changed little or none in the Veneto region, and increased largely in the Lazio and South Tirol regions. In Italy, especially funding of residential adolescent care institutions increased.

Training of professionals on adolescent mental health issues

- Training in adolescent mental health issues are incorporated in the educational curriculum of psychiatric nurses, paediatricians, psychologists, general psychiatrists, and child neuropsychiatrists.

1.7. Lithuania

General figures

- In Lithuania, in 2012, 11.3% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Lithuania appeared to be highly affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 14 (Youthpolicy.org).
- A national youth policy is available (Youthpolicy.org).

Prevalence and research

- Administrative data sources and national statistics on (amongst others) prevalence rates of mental health problems in adolescents exist and can be consulted via the following websites: <http://www.stat.gov.lt/en/home> and <http://sic.hi.lt/html/en/lhic.htm>.



Policy and legislation regarding mental health for adolescents

- Lithuania worked out a national programme to implement the mental health strategy (2008-2010 and 2011-2013), but has only a few policy programmes that target adolescents. This is mainly due to the inefficient cooperation between the government, the ministries and the municipalities.
- Nevertheless, in 2010 a procedure has been worked out to regulate the provision of psychiatric care for children and adolescents.
- In 2014, a programme started to teach parents the necessary parenting skills and to support them with advice.
- Currently, services providing mental health care for adolescents are scattered over different sectors (medical sector, educational sector, mental health sector). Between the different sectors there are several gaps and overlaps in services providing mental health care for young people.
- Policies on adolescent mental health are not formally evaluated.

Availability and quality of mental health care services for adolescents

- After the Soviet time there were in Lithuania several services specifically for adolescents. However, their approach was very repressive and extremely medical. Nowadays, these services are closed because of a lack of support by authorities.
- No separate services for adolescents are available, with the exception of very few day care programmes for adolescents.
- Today, inpatient and outpatient services exist for children and adolescents between 0 and 18 years old, but they are not exclusively for them.
- The availability of outpatient ambulatory services and residential services is quite good. Day care and home-based services, however, are poorly or even very poorly available. Also, there is an overall lack of specialised professionals.
- The quality of services is low, because the biomedical paradigm is still the dominating model that is most often applied in (adolescent) psychiatry. Especially residential services for the less fortunate adolescents, meet poor standards and fail to guarantee good recovery. This is mainly due to the fact that the Lithuanian health insurance system is reluctant to cover psychosocial interventions. Also, traditional services relying on outdated principles such as social exclusion, institutionalisation, excessive medication use, and a paternalistic approach still exist in Lithuania.
- There are primary mental health care centres in which child and adult psychiatrists work as a team.



Human, financial and material resources

- In Lithuania there is an ombudsman protecting the rights of adolescents.
- Adolescent psychiatrist is recognised as a separate profession. Nevertheless, there are only 87 adolescent psychiatrists in the whole of Lithuania.
- Neither the profession of adolescent psychologist nor the profession of adolescent psychiatric nurse are recognised as separate professions.
- On a national level 2.15 billion EUR is spent on health care. It is unknown what percentage of this budget is dedicated to mental health care in general. The funds dedicated to adolescent mental health care are also not clearly identifiable in the most recent national budget.

Training of professionals on adolescent mental health issues

- It is unclear whether issues on adolescent mental health are incorporated in the curriculum of higher educational institutes.

Good practices

Big brother big sister programme – a youth mentoring programme

The “Big Brothers Big Sisters” program of the child support centre “Paramos Vaikams Centras” is a youth mentoring and education support programme helping young people between 7 and 17 years old who need support and a positive role model. The programme focuses in particular on children and adolescents who suffer from violence, are living in foster homes, feel lonely, spend too much time without adult supervisions, lack social skills, or have development difficulties or difficulties to adapt to the school setting. Young people are mainly directed to the program by their teachers, psychologists, or social workers. Within the programme, a trained adolescent volunteer (18+) (the mentor) interacts on a one on one basis with a youngster (the mentee). They meet once a week during which the volunteering mentor helps the young mentee to deal with uncomplicated psychological problems. Importantly, the relationship between the volunteer and the child is supervised and facilitated by specialists (psychologists, social workers, and etc.). Moreover, the volunteering mentors receive face to face group trainings which focus on:

- The psychological needs and characteristics of young people between 7 and 17 years old
- Communication skills: verbal and non-verbal communication, communication barriers
- Conflict and conflict resolution
- Psychological crises (detection and support)
- Prevention and intervention of violence and abuse

Today the programme is successfully implemented in many Lithuanian cities and schools, covering a huge gap in the absence of psychological and therapeutic services for adolescents and families in Lithuania.

More information can be found on the website: <http://www.pvc.lt/en/about-us>

1.8. Spain

General figures

- In Spain, in 2012, 9.2% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Spain is highly affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 14 (Youthpolicy.org).
- It is not clear whether a national youth policy is available (Youthpolicy.org).

Prevalence and research

- Administrative data sources and national statistics on the prevalence of mental health problems in adolescents appear to exist but are not accessible.
- Some prevalence data for Catalonia are available (Braddick et al., 2009, p. 183).

Policy and legislation regarding mental health for adolescents

- Since 2009, several new policies and initiatives regarding adolescent mental health exist in the Basque region of Spain:
 - An initiative on alcohol abuse in adolescents with an estimated target group of 7,000 adolescents.
 - An initiative on drug abuse in adolescents with an estimated target group of 1,000 adolescents.
 - A programme to improve continuity of care after hospitalisation.
 - The creation of day hospitals for adolescents.
 - A programme to reduce the number of suicide attempts in adolescents with an estimated target group of 700 at risk adolescents.
- The implementation of these programmes is hampered by several difficulties, such as limited financial resources and difficulty in the collaboration between the involved sectors.
- In Spain, there is no specific legislation for mental health services in treating adolescents.
- Spain is highly affected by the economic crisis and it is still under discussion what investments the government will make in order to improve mental health care. The following two options exist: (1) create new mental health care services or (2) reinforce existing programmes in existing centres.
- It is not known whether the effectiveness of policies on adolescent mental health care is being formally evaluated.

Availability and quality of mental health care services for adolescents

- Different care programmes and specialised mental health care services exist at the community level, providing care to children, adolescents and adults. In these services, only patients with severe mental health problems are treated. However, the number of services is very small – there is only 1 service per 100,000 inhabitants.
- Throughout Spain, day care services offering specialised and interdisciplinary care for adolescents are reported to be quite available. Despite the limited resources (i.e., the small number of professionals and services, restricted consultation time for each patient) and due to the availability of well-trained professionals, the quality of these services is reported to be good.



- However, home-based services, outpatient ambulatory services and residential services in hospitals are rated to be poorly available and of moderate quality.

Human, financial and material resources

- Spain has no ombudsman to protect the rights of adolescents.
- Adolescent psychologist, adolescent psychiatric nurse, and adolescent psychiatrist are not recognised as a separate health profession.
- Overall, the number of health professionals is low – 200,000 professionals within the whole country.
- The funds dedicated to children and adolescent mental health care are not clearly identifiable in the most recent national budget. Although resources allocated to adolescent mental health care seem to have increased a little in the past 5 years, they still are insufficient to allow good implementation of policy initiatives.

Training of professionals on adolescent mental health issues

- Adolescent mental health issues are incorporated in the higher education of psychologists, psychiatrists, psychiatric nurses, paediatricians and the staff of juvenile detention centres.

Good practices

Support programme for adolescent mental health in juvenile justice

The child care team of the Health Foundation San Pere Claver in Catalonia strongly collaborates with the department of juvenile justice to support young people aged 14 and over who committed a criminal offense. The support programme entails a multidisciplinary approach integrating the following complementary interventions:

- Diagnostic orientation and psychotherapeutic interventions to strengthen the mental health of the adolescent.
- Guidance and support in the educational setting of the adolescent to facilitate learning and development opportunities, to limit risk behaviours, and to meet basic needs.
- Guidance and support to the family to strengthen or build appropriate parental roles and prevent or modulate the establishment of vicious negative feedback.

More information can be found on the (Spanish) website: <http://www.spcsalut.org/salut-mental.php>

1.9. Sweden

General figures

- In Sweden, in 2012, 11.4% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, Sweden is least affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 15 (Youthpolicy.org).
- A national youth policy is available (Youthpolicy.org).

Prevalence and research

- In Sweden, data are collected from children and adolescents. The same children are asked the same questions at different ages (7th grade till 9th grade) to see how their answers and behaviour (e.g., alcohol use, drug use) change over time.
- National statistics on the prevalence of mental health problems in adolescents are available (see table 3).
- In Sweden, some centres exist that are responsible for data gathering.
- Also, data is gathered by SOTKA NET (<http://uusi.sotkanet.fi/portal/page/portal/etusivu>). With respect to mental health, they collect the following information: use of psychiatric hospital services; outpatient care visits for mental health reasons, health behaviour and psychic symptoms; sick-leave for mental health reasons; use of special refunds on medicines; reimbursements of antidepressants; mortality (mental health indicators); involuntary care and psychiatric rehabilitation homes.

Table 4: Prevalence rates of mental health problems among adolescents in Sweden

Disorder	Prevalence	Age target group	Data source	Date of data collection
Bipolar disorder	0.06%	16-24 year	Patient Register	2012
Schizophrenia	0.26%	16-24 year	Patient Register	2012
Suicide attempt	1.00%	16-24 year	Patient Register	2012
Suicide	0.07%	16-24 year	Patient Register	2012

Policy and legislation regarding mental health for adolescents



- Since 2011, a policy initiative for child and adolescent mental health care services called “Psynk” exists. More information about Psynk can be found on the website: <http://www.psynk.se/in-english>.

The programme aims to create coordinated effective service systems for the promotion, the prevention and the treatment of mental health problems and other related challenges in children and youth aged between 0 and 25 years old and their families. Therefore, an agreement is made between the national government and the regional and local governments. Local authorities are tasked to identify, test and disseminate innovations and “best practice” models in adolescent mental health care. Local services that try to improve their functioning receive the necessary tools, training, and technical assistance. The reimbursement of services is performance-based and only occurs when the following targets are being met:

- When an agreement is made between (1) regional authorities who take charge for health care and (2) local authorities who take charge for education, social care and welfare on the collaboration and the division of responsibilities.
 - When information about existing services is provided to the general public via a website.
 - When a coordinated care plan is composed in case someone is treated by more than one service.
- No mention is made of any specific legislation for adolescent mental health care services.
 - Mental health policies are supervised by the Agency for Health and Service Analysis.

Availability and quality of mental health care services for adolescents

- We were unable to collect information on the availability and the quality of mental health care services for adolescents in Sweden.

Human, financial and material resources

- In Sweden, there is an ombudsman protecting the rights of adolescents.
- Adolescent psychologist, adolescent psychiatric nurse and adolescent psychiatrists are not recognised as a separate health professional.
- On a national level 36.69 billion EUR is spent on health care with 7.9% of this budget being dedicated to mental health care. Funds dedicated to children and adolescent mental health are not clearly identifiable in the most recent national budget.
- In general, resource allocation to adolescent mental health services (evidence-based, community-oriented and inpatient residential services) is perceived to have increased a bit in the last 5 years.

Training of professionals on adolescent mental health issues



- Training in adolescent mental health issues is incorporated in the higher educational curriculum of psychiatric nurses, psychologists, and general psychiatrists.

Good practices

Saving and Empowering Young Lives in Europe (SEYLE) – a European health promoting school programme for adolescents

Within the SEYLE project three culturally adapted intervention strategies aimed to promote mental health and to prevent risk-taking, violent and suicidal behaviour among European adolescents were developed and evaluated within a randomized control trial (Carli et al., 2013; Wasserman et al., 2012; Wasserman et al., 2010; Wasserman et al., 2015).

The first intervention strategy is a **Youth Aware of Mental health programme (YAM)** which is a manualised universal intervention targeting all students. The programme aims to raise mental health awareness about risk and protective factors associated with suicide, including knowledge about depression and anxiety, and to enhance the skills needed to deal with aversive life events, stress, conflict and crises. In the context of this intervention a didactic and pedagogical booklet about mental health was developed for students focussing on the following themes: (1) awareness of mental health; (2) self-help advice; (3) stress and crisis; (4) depression and suicidal thoughts; (5) helping a troubled friend; and (6) getting advice: who to contact. In addition to this booklet, a structured programme of lectures and interactive role play sessions, and six educational posters (conform the six themes of the booklet) were developed.

The second strategy is a **manualised gatekeeper programme to train teachers and other school staff** to recognise suicidal behaviour in pupils and enhance their communication skills to motivate and help pupils at risk of suicide to seek professional help. In the context of this intervention a standardized one-day training programme has been developed consisting of a set of slides, teaching notes, a booklet for teachers, and business cards that are meant to be handed out to students in need for help.

The third strategy is a **screening programme for professionals** aiming to empower them in identifying students at risk and in referring at-risk pupils to the local health care system. A baseline questionnaire and a structured interview are developed that mental health professionals can use for screening. The baseline questionnaire is intended to be administered of all students and measures variables related to mental health, lifestyle, and risk behaviours. The structured interview has to be administered of those students scoring high on the questionnaire and aims to identify and exclude false positive cases that need no referral to health care.

Results of a randomised control trial show that the YAM programme is associated with a significant reduction of incident suicide attempts and severe suicidal ideation. For the other two programmes unfortunately no significant effects were found (Wasserman et al., 2015).

All SEYLE materials (evaluation instruments & prevention kits) exist in different languages (e.g., English, German, Gaelic (Irish), Estonian, French, Hungarian, Hebrew, Italian, Romanian,

Slovenian and Spanish) and are culturally adapted (Carli et al., 2013; Wasserman et al., 2012; Wasserman et al., 2010; Wasserman et al., 2015).

More information can be found on the website: www.seyle.eu

1.10. United Kingdom

General figures

- In the UK, in 2012, 11.6% of the total population was aged between 10 and 19 years old (Fanjul, 2014).
- Economically, the UK is moderately affected by the great recession (Fanjul, 2014).
- The age at which young people become responsible for possible criminal behaviour is 10 (Youthpolicy.org).
- A national youth policy is available (Youthpolicy.org).

Prevalence and research

- Some national statistics on the prevalence of mental health problems in adolescents are available (see table 4).
- Some professional centres are responsible for data gathering:
 - The Health and Social Care Information Centre is the national provider of information, data and IT systems for health and social care (www.hscic.gov.uk/).
 - Information related to public health is collected by the Public Health Outcomes Framework (www.phoutcomes.info/).

Table 5: Prevalence rates of mental health problems among adolescents in the UK (Braddick, 2009, p. 196)

Disorder	Prevalence rates	Age range	Date of collection
Anxiety	3.3	5-16	2004
Depression	0.9	5-16	2004
ADHD	2.5	5-16	2004
Learning disorder	4-8		2004
Conduct disorder	5.8	5-16	2004
Eating disorder	0.3	5-16	2004
Autism	0.9	5-16	2004
Schizophrenia	Extremely low rates		2004
Childhood or adolescent suicide	8 per 100,000 in boys 3 per 100,000 in girls	15-19	2000-2006



Policy and legislation regarding mental health for adolescents

- In 2011, a regional initiative called “Children and Young People’s Improving Access to Psychological Therapies” (i.e., CYP IAPT) was launched in England aiming to transform child and adolescent mental health care services and to improve access to evidence-based psychological therapies. Psychological therapy is available now for 54% of the young people aged between 0 and 19 years old. Through the programme, therapy will hopefully become available for all youth. In particular, this initiative intends to build an intensive collaboration and partnership between children, young people, families, and therapists. More information on the programme can be found on the following link: <http://www.cypiapt.org/>.
- In 2011, the project “no health without mental health” was launched aiming to develop new services for young people to prevent mental health problems and to establish early intervention services.
- In 2012, the Health and Social Care Act was launched. As a consequence the number of health care and social care commissions in most parts of England was reduced.
- In 2014, the website Minded has been developed – a free online education to help adults to identify and understand children and young people with a mental health condition. The website has been funded by the national department of health and is hosted by the Royal College of Paediatrics and Child Health and other organisations such as the British Association of Counselling and Psychotherapy. The website can be consulted on the following link: <http://www.rcpch.ac.uk/minded>.
- In January 2014, England launched the action plan “Closing the Gap: Priorities for essential change in mental health” aiming to improve the transition from child and adolescent mental health services to adult services, targeting in particular adolescents aged between 16 and 25 year olds. More information can be found on the following link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf.
- Also, the provision of care in specialised inpatient mental health services for children and young people in England will be improved as follows:
 - The number of beds for young patients in child and adolescent mental health care services will be increased across the country according to the needs.
 - 10 to 20 new case managers will be recruited across the country to ensure that young people receive appropriate levels of care
 - The way people move in and out of specialised care will be improved by introducing standard criteria for admission and discharge based on best practice.

Availability and quality of mental health care services for adolescents

- In the UK, mental health care services exclusively for adolescents exist and are provided by statutory mental health services and voluntary sector organisations.



- The number of NHS-funded beds in mental health services for children and adolescents has increased from 844 in 1999 to 1,128 in 2006, rising further to 1,264 in January 2014. Nevertheless, there is still an undersupply in some areas.
- In spite of increased mental health needs, mental health care services have become more fragmented, short-lived and under-funded. The cost saving that took place after the Health and Social Care Act in 2012 put a huge pressure on the services. The commissioning arrangements by the government adversely affected the relations between services and created fractured care pathways. Many non-governmental organisations have gone out of business.
- Since 2011, the accessibility of mental health care facilities for adolescents has declined, due to changes in policy. Accessibility is perceived to be best in London and the South East part of the country.
- Funding for day care services and residential services in hospitals has been cut and hence they are now poorly available. As a consequence, in some regions of the country young people need to have severe mental health problems before they receive any treatment. Also, adolescents who are admitted to a residential service in a hospital are sometimes referred to an adult mental health unit.
- Quality of care that is provided by mental health care services is reported to vary within and between services. The last few years, since the development of standards for expected care, mental health services provide more attention to quality outcomes and hence quality of care has improved. Nevertheless, quality of care is rated to be average, mainly because of reduced staffing and precarious professional morale caused by staffing overload.
- Recently, the NHS published a report on the current provision of care in specialised inpatient mental health services for children and young people. According to this report, it is impossible to conclude whether the current number of beds is sufficient to meet the need. There is an undersupply of beds in some areas and there is also evidence of patients being inappropriately admitted to specialised units. This was caused by a variety of reasons including gaps in outpatient services and other local health and social services, and weaknesses in commissioning and case management. For example, intensive outreach teams have the potential to halve the average length of inpatient stay, yet in many areas no such teams are available.

Human, financial and material resources

- In the UK there is no ombudsman protecting the rights of adolescents.
- Adolescent psychologist, adolescent psychiatric nurse and adolescent psychiatrists are not recognised as a separate health professional. A particular problem in the UK is that many experienced practitioners are retiring early or are leaving England.
- On a national level, 135.83 billion EUR is spent on health care with 11% of this budget being dedicated to mental health care in general. The funds dedicated to child and adolescent



mental health are clearly identifiable in the most recent national budget: 958 million EUR is dedicated specifically to children and adolescent mental health.

- After the Health and Social Care Act in 2012, cost savings took place, putting a huge pressure on the services. Mental health budgets for the criminal justice system and homeless young people also have been cut.

Training of professionals on adolescent mental health issues

- Very few primary care doctors and nurses receive training on adolescent mental health issues. Also, few psychologists and psychiatrists are trained in specific adolescent mental health issues.

Good practices

The Well Centre – a youth health centre for adolescents

The Well Centre is a youth health centre where adolescents aged between 13 and 20 years old can drop-in to see a youth worker, nurse, counsellor or doctor. There is a policy of free drop-in requiring no appointment, and any health concern or worry can be discussed in a safe and confidential space. The service works closely with local organisations to ensure an integrated and effective approach meeting the different health care needs of young people.

Services that are provided to young people are:

- GP consultations
- Mental health interventions with a mental health nurse
- Counselling
- Youth work advice and support
- Specialist workshops and lessons on several topics

The centre uses different media. For example, a “4:01 Show” exists which is a YouTube support group for teenagers. Youngsters can chat with celebrities and YouTubers about topics such as relationships, sex, body confidence, bullying, drugs, drinking. Youngsters can also share their thoughts via Twitter and Facebook.

There is a youth panel consisting of a collection of local teenagers who meet regularly and provide valuable advice with respect to the physical design of the centre, the services they feel are most important to offer, and the best way to reach out and engage potential users.

More information can be found on the website: www.thewellcentre.org



The Zone – outreaching support for adolescents

The Zone is a voluntary centre providing various services to young people aged between 13 and 25 years. The centre includes:

- A drop-in service staffed by youth support volunteers providing free and confidential advice and support to young people on sexual health, relationships, housing, homelessness, mental health issues, and many other issues.
- A free confidential service for young people and their parents/carers experiencing conflicts or difficulties at home.
- An early intervention service for people aged between 18 and 35 years who experience symptoms of early psychosis.
- Activity days and courses that are free to all young people who are 13-25 years old.
- One-to-one support to young people who may have difficulties with their finances or who need to develop financial skills.

The overall mission of the centre is to support, enable and empower young people to make decisions for themselves about the things that are important to them, and help them to reach their full potential.

Most young people access the centre by coming along to the drop-in service for a talk with one of the specially trained volunteers who are able to refer the adolescent to one of the services of the Zone or to other organisations in the region.

More information can be found on the website: www.thezoneplymouth.co.uk

MAC UK's street gang initiative – outreaching support provided on the street

The MAC UK's street gang initiative focuses on young people who feel excluded, are at risk of offending or are offending, and who fail to find their way to the right support. By implementing the Integrate model the traditional mental health service delivery is adapted in order to reach this excluded group of young people. The model takes mental health professionals out of the clinic and onto the streets to work with excluded young people where they are and when they need it.

The Integrate Model works intensively for 2 to 4 years with up to 50 young people per year. By giving them the opportunity to create and own a project they find interesting (e.g., setting up a boxing club, DJ-ing, building a website) young people successfully learn to engage. The MAC-UK team works collaboratively with the young people on their chosen project, helping them to develop leadership and employment skills and build trusting relationships with MAC-UK staff. The work is research-driven and is underpinned by psychological theories (community psychology theory, attachment theory, and lifespan developmental theory).



Integrate also trains existing services (e.g., housing providers, the police) using a youth-led approach to enhance professionals' understanding of young people's mental health needs.

The mission of MAC UK is:

- To take mental health services out of the clinic and into the community with young people for young people.
- For mental health to be at the heart of all interventions and services for excluded young people.
- To effectively campaign for recognition that serious youth violence is a mental health issue as much as a justice one.
- To reduce serious youth violence and re-offending.
- To get young people engaged in training, education and/or employment.
- To help young people connect with existing services.

See website for more information: www.mac-uk.org

The Haven Integrated Health Centre – a school based health care service

The Haven Centre is a school-based health care service located at the domain of a school in Cornwall. It is managed by students and provides different services related to health and well-being such as:

- Drop-in sessions at break and lunch time to ask for advice on any health or emotional well-being worry (e.g., help with career options/choices, access information about health services, free condoms and pregnancy tests, bereavement support, smoking cessation, etc.)
- Group work
- Seminars

The Haven stands out because:

- It is awarded as a young person friendly service
- It is managed by students
- There is a close collaboration with the school
- There is a drop-in service
- It combines general health and mental health support
- It is highly accessible, no stigma

For more information: www.budehaven.cornwall.sch.uk/the-haven-ihc/



Implementing Recovery through Organisational Change (ImROC) – a training program to change the attitudes and behaviour of professionals

The ImROC programme is a new approach to help people with mental health problems to recover: to find ways to live meaningful lives, with or without the on-going symptoms of their condition. This overall goal is reached by changing the attitudes and behaviours of professional staff and teams working in health services so as to make them more supportive of recovery. For this, changing the “culture” of an organisation is important. Via on-site consultancy visits and/or workshops ImROC helps organisations to refocus their services around the principles of recovery. Afterwards, participating organisations are grouped in learning set networks where sites can share knowledge and learn from one another on how to solve some of the practical problems of implementation. A simple method is used based on agreed goal-setting, implementation and review (i.e., Plan-Do-Study-Act cycles) which appeared to be an effective method for organisational change/innovation (Iles & Sutherland, 2001).

The content of the program is built around the following ten key challenges:

- Changing the nature of day-to-day interactions and the quality of experience
- Delivering comprehensive user-led education and training programmes
- Establishing a “Recovery Education Centre” to drive the programmes forward
- Ensuring organisational commitment, creating the “culture”
- Increasing personalisation and choice
- Changing the way we approach risk assessment and management
- Redefining user involvement
- Transforming the workforce
- Supporting staff in their recovery journey
- Increasing opportunities for building a life beyond illness

See website for more information: www.imroc.org

The Children and Young People’s Improving Access to Psychological Therapies programme

The CYP IAPT is a service transformation programme delivered by NHS England aiming to improve existing child and adolescent mental health services (CAMHS) working in the community. The programme works to transform services provided by the NHS and partners from local authorities and third sectors that together form local area CAMHS partnerships.

CAMHS partnerships that join CYP IAPT become part of a learning collaborative. Each learning collaborative includes a higher educational institution (university or other teaching providers) which provides training to existing CAMHS staff and service managers in:

- Evidence-based psychological interventions



- Collaborative working and participation by children, young people and their family in service delivery and design
- How to carry out routine outcome monitoring

More information can be found on the website: www.cypiapt.org

Great Involvement Future Thinking (GIFT)

GIFT stands for Great Involvement Future Thinking and is the name of a partnership commissioned by NHS England to support children and young people's participation in the CYP IAPT mental health service transformation programme (see previous box). GIFT supports young people to be involved in many different ways at a national and local level:

- Work in partnership with the government
- Attend national policy shaping groups
- Plan national events
- Participate in the shaping of local services via participation groups
- Raise awareness in schools and develop resource packages for schools on young people's mental health

More information on: www.cypiapt.org/participation.php



Young Minds

Young Minds is a UK charity organisation committed to improve emotional well-being and mental health of children and young people by informing and actively engaging with children, young people, parents, policy makers, and professionals. More specifically, the organisation engages in the following activities:

- Share the voice of children and young people with mental health problems with professionals and policy makers at a national and local level to improve mental health services and outcomes for all children and young people.
- Run a website about mental health medication giving young people accessible, down-to-earth information on this matter.
- Support parents and carers in understanding their child's behaviour and enabling them to find the right professional help via a free parents' helpline.
- Train and support professionals who work with children and young people to give them the necessary knowledge and confidence to promote better mental health and to recognise and provide help to children who are struggling.
- Make mental health information more accessible by writing easy-to-read publications about children and young people's mental health. The website also provides online information for different target groups.
- Change the attitudes and policies of local, regional, and national services via campaigning and awareness raising activities.

More information can be found on the website: www.youngminds.org.uk

MindEd – e-learning to support young healthy minds

MindEd is a free, completely open access, online educational resource on children and young people's mental health for all adults who care for or regularly come into contact with children, young people and families (e.g., parents, teachers, counsellors, police officers, etc.) helping them to support the development of young healthy minds.

The website contains short online learning sessions (20 to 30 minutes) helping adults to identify mental health issues and showing them what actions they can take in the best interest of the child or adolescent. Sessions exist on over 300 topics.

In addition, the website contains a number of specialist learning frameworks for clinicians, counsellors, psychotherapists and other professionals who (start to) work with children, young people and young adults.

More information about MindEd can be found on the website: www.minded.org.uk

1.11. Conclusions country profiles

Table 5 provides a summarising overview of the main findings regarding adolescent mental health as described in the country profiles. Based on the overview some overall conclusions can be formulated:

First, although most countries have administrative data and national statistics on adolescent mental health, in only half of the countries (Finland, Germany, Italy, Sweden, and the UK) these data are analysed and thus can be used to get a clear image on the mental well-being and the needs of adolescents. Reasons for not processing these data are diverse: they are scattered across different data systems, representatives have no knowledge of the existence of these data, there are no financial resources to process the data or there is no research institute assigned to process the data. Moreover, the quality of the administrative data is often unreliable as they do not comprise all types of mental health care services treating adolescents or all regions of the country.

Second, most countries do have policy programmes that target adolescents. However, only six out of ten countries (Belgium, Finland, Italy, Spain, Sweden, and the UK) appear to have a mental health plan specifically for adolescents. In three of these countries (Finland, Italy, Sweden), policies on mental health are evaluated and supervised. Moreover, only three countries (Finland, Italy, and the UK) have specific legislation that applies to mental health services treating adolescents. Furthermore, most countries know how many percent of the health care budget is spent to mental health in general: across countries it varies from 3.5 to 11%. However, of all ADOCARE member states only in the UK funds dedicated to adolescent mental health are clearly identifiable. Thus, except for the UK, most countries have no idea how much money they reserve for adolescent mental health. In the UK, 11% of health care funding is spent on mental health, with less than 1% being spent on children and adolescent mental health. We suspect that – as is the case in the UK – only a small fraction of the budget spent on mental health is allocated to children and adolescents.

Third, except for Hungary and Lithuania, most countries do have mental health care services exclusively for adolescents. However, the quality and especially the availability of these services are generally not outstanding. Overall, the quality of mental health care services that treat adolescents is rated to be of good or very good quality in Belgium, Finland, France, Germany, and Italy. In the other countries, the quality is rated to be either in between, poor or unclear. The availability of mental health care services is in most countries rated to be either poor, very poor or unclear. Only in Finland, the availability of services is rated be good.

Finally, in five out of ten countries (Finland, Germany, Hungary, Italy, and Lithuania), the profession of adolescent psychiatrist is recognised a separate profession. Also, in six out of ten countries (France, Germany, Hungary, Italy, Spain and Sweden) courses on adolescent mental health are integrated in the education curricula of relevant health professionals (e.g., general practitioners, social workers, psychiatric nurse, psychologist, and paediatricians). In the other



countries, health professionals can graduate without knowing anything about adolescent mental health at all.

Table 6: Summarising table of the country profiles

	Belgium	Finland	France	Germany	Hungary	Italy	Lithuania	Spain	Sweden	UK
Does the country have administrative data and national statistics on the prevalence of mental health problems in adolescents?	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Are the available data being analysed?	No	Yes	Unclear	Yes	No	Yes	Unclear	No	Yes	Yes
Does the country have a mental health plan for adolescents?	Yes	Yes	Unclear	No	No	Yes	No	Yes	Yes	Yes
Does the country have specific legislation for mental health services treating adolescents?	No	Yes	Unclear	No	No	Yes	No	No	No	Yes
Does the country have mental health care services exclusively for adolescents?	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Unclear	Yes
What is the overall availability of mental health care services where adolescents can be treated?	Poor	Good	Poor	Poor	Very poor	Unclear	Poor	Poor	Unclear	Unclear
What is the overall quality of mental health care services where adolescents can be treated?	Good	Very good	Good	Very good	Good	Unclear	Poor	In between	Unclear	In between
How is the availability of outpatient care	Poor	Good	In between	Poor	Very poor	Unclear	Poor	Poor	Unclear	Unclear
How is the quality of outpatient care services?	Good	Very good	Very good	Very good	Good	Unclear	Poor	In between	Unclear	In between
How is the availability of day care services?	Poor	Good	In between	Poor	Very poor	Unclear	Very poor	In between	Unclear	Poor
How is the quality of day care services?	Very good	Very good	Good	Very good	Good	Unclear	Poor	Good	Unclear	In between
How is the availability of home-based services?	Poor	Good	Very poor	Poor	Very poor	Unclear	Very poor	Poor	Unclear	Unclear
How is the quality of home-based services?	Good	Very good	Good	Very good	Unclear	Unclear	Poor	In between	Unclear	In between
How is the availability of residential services?	Poor	Good	Poor	Poor	Very poor	Very poor	Poor	Poor	Unclear	Poor
How is the quality of residential services?	In between	Very good	Good	Very good	Good	Unclear	Poor	In between	Unclear	In between
Is funding spent by the government on adolescent mental health clearly identifiable?	No	No	Unclear	No	No	No	No	No	No	Yes
Is the profession of adolescent psychiatrist recognised as a separate profession?	No	Yes	Unclear	Yes	Yes	Yes	Yes	No	No	No
Are courses on adolescent mental health integrated in the general education of relevant (mental) health workers?	No	No	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	No

2. Results of the surveys for end-users

The current section provides an overview of the results that were obtained through the two surveys for and filled in by the end-users:

- The survey for adolescents with mental health problems
- The survey for young people in general and their entourage

2.1. Experience of adolescents with mental health problems

Respondents

Unfortunately, only 18 adolescents with mental health problems from 6 different countries filled in the survey: 3 Belgian, 2 Finish, 1 Hungarian, 1 Irish, 6 Spanish, and 5 UK adolescents. Their age ranged from 14 to 29 years with a mean age of 18 (SD = 3.9 years).

Diagnosis

On average, each participating adolescent reported to have 2.7 psychological problems. Table 3 describes a list of psychological problems and the number of adolescents who did report to have that problem. Depressive and anxiety disorders were reported most frequently, followed by eating problems and self-harm.

Table 7: Mental health problems experienced by adolescents

	Frequency
Depressive disorder	11
Anxiety disorder	9
Eating disorder	5
Self-harm	5
ADHD	4
Psychosis/schizophrenia	2
Bipolar disorder	1
PTSD	1
Autism	1
Behavioural problem	1
Addiction (alcohol or drugs)	1

Received support

In past 6 months, the majority of the adolescents received day care support for their problems (table 4). Two adolescents reported to have received none of the types of care listed in the questionnaire (category other); instead they received support in a youth house.

Table 8: Support received by adolescents

	Frequency
Home-based care	3
Day care	9
Outpatient ambulatory care	4
Residential care	0
Other	2

Ten adolescents indicated that they received support in a mental health care service treating exclusively adolescents (age between 12 and 24 years). Four respondents saw it as a shortcoming when an adolescent is treated in a mental health care service treating also other age groups (children and adults), 4 respondents didn't see this as a shortcoming, and 5 respondents had no opinion about this.

Statements on the tasks and responsibilities of adolescent mental health care services

In the survey, participants were presented with a list of statements describing possible tasks and responsibilities for mental health care services. First, participants were asked to rate on a 5 point Likert scale to what degree these tasks/responsibilities were fulfilled by the service that treated them (0 = not at all, 1 = rather not, 2 = in between, 3 = a lot, and 4 = definitely). Second, participants were asked to rate on a 5 point Likert scale how important they believe it is for a service to implement these tasks/responsibilities (0 = not important at all, 1 = rather not important, 2 = neutral, 3 = rather important, and 4 = very important).

Tables 5 and 6 report for every statement the mean response that was given on each of the two questions (fulfilled and important). The results in table 5 show that none of the tasks/responsibilities were implemented "a lot" or "definitely". According to the results listed in table 6, adolescents find almost all listed tasks and responsibilities important (mean scores lie between "rather important" and "very important"). Only two tasks were rated to be less important: helping adolescents to find good housing and a good job.

Table 9: The extent to which tasks and responsibilities are fulfilled by AMHC services

When I received care in the MHC service ...	Mean
I was asked for my ideas	2.1
I was given choices about treatment	1.9
I was satisfied that my care was well organised	2.5
I was asked to talk about my goals	2.6
I was sure that my doctor thought about my values, beliefs and traditions	2.4
I was helped to make a treatment plan that I could carry out	2
I was encouraged to attend programmes	2.1
I was referred to a specialised treatment that matches my own needs	2
the service supported me to live my life	2.4
the service provided the necessary information and/or support to my family	2
the service offered me opportunities that were meaningful to me	2.3
the service took into account my educational needs	1.9
the service supported me in finding good housing	0.7
the service supported me in finding a good job	0.9
the service supported me in building trustful relationships with others	2.2
the service supported me in taking care of my self	2.4
the service supported me in spending free time in a meaningful way	2

Table 10: The extent to which tasks and responsibilities are important to fulfil by AMHC services

A good MHC service ...	Mean
asks for my ideas	3.6
stimulates me to think about my own treatment	3.7
asks me about my goals	3.6
takes into account my values, beliefs and traditions	3.3
refers me to a specialised treatment that matches my own needs	3.6
helps me to (re)integrate into society as good as possible	3.6
supports my family	3.3
offers opportunities (e.g., activities, skills training) that are meaningful to me	3.4
addresses my educational needs	3.3
helps me to find good housing	2.8
helps me to find a good job	2.7
helps me to build trustful relationships with others	3.6
helps me to take care of my self	3.9
helps me to spend free time in a meaningful way	3.4

Critical remark

The number of participants who filled in the questionnaire was very low. Hence, the present data should be interpreted with caution.

2.2. Experience of young people and their environment

Respondents

In total, 39 participants from 7 different countries (see table 7) filled in the questionnaire. Their age ranged from 16 till 59 years, with a mean age of 40 (SD = 13).

Table 11: Nationality of the end-users who filled in the general survey

Country	Frequency
Belgium	14
Malta	9
Greece	9
England	3
Sweden	2
Luxemburg	1
Finland	1

About half of the respondents (21/39) experienced a mental health problem themselves and almost all of them (36/39) had an adolescent with mental health problems in their close environment. That adolescent was in most cases a friend (14/39), a son or daughter (16/39) or a sibling (8/39).

Statements on adolescent mental health care

Within the survey, participants were presented with a list of statements on adolescent mental health care and a list of statements on attitudes toward mental health problems. Participants were asked to rate on a 5 point Likert scale to what extent they agreed with each statement (0 = strongly disagree, 1 = disagree, 2 = neutral, 3 = agree, 4 = strongly agree).

Table 11 presents the mean response that was given by the participating end-users on the list of statements relating to adolescent mental health care. Table 9 presents the mean response on the list of statements measuring the participant's attitudes toward mental health problems.

The results in table 11 are rather negative: people experience difficulty to find adequate help, report a lack of information on where to find help, and are unaware of good initiatives. Also, there is quite a lot of agreement with the statement that adolescent mental health care services are scarce.

Unsurprisingly, the results in table 12 show that the participating end-users have positive attitudes toward mental health problems and are willing to help people with such problems.

Table 12: The end-users' mean response on the list of statements related to adolescent mental health care

List of statements on AMHC	Mean
It is easy to find adequate help for adolescents with mental health problems.	0.9
I know where to find adequate help for adolescents with mental health problems.	2.3
I am aware of good initiatives for adolescents with mental health problems.	1.8
There is sufficient information on where to find help for adolescents with mental health problems.	1.3
Mental health care services for adolescents are scarce.	2.8
Mental health care services for adolescents are available but not easily accessible.	2.6
Mental health care services exclusively for adolescents are non-existent.	2

Table 13: The end-users' mean response on the list of statements measuring their attitude toward mental health problems

List of statements on attitudes toward mental health problems	Mean
People with mental health problems could snap out if they want to.	1
Mental health problems are a sign of personal weakness.	0.7
Mental health problems are not a real medical illness.	0.7
People with mental health problems are dangerous.	1.3
It's best to avoid people with mental health problems, so you don't become mentally ill yourself.	0.7
People with mental health problems are unpredictable.	2.2
If I would have a mental health problem, I wouldn't tell anyone.	1.2
I wouldn't employ someone if I knew he/she once had a mental health problem.	0.9
I wouldn't vote for a politician if I knew he/she once had a mental health problem.	1
When I notice that someone in my near environment struggles with mental health problems, I would ask this person about his/her problems.	2.6
When I notice that someone in my near environment struggles with mental health problems, I would encourage this person to get professional help.	3.2
When I notice that someone in my near environment struggles with mental health problems, I would help this person to get professional help.	3.1

Additional comments

The questionnaire ended with an open question inviting participants to provide additional comments regarding mental health care for adolescents. We received the following comments:

- Adolescent mental health is strongly related to parents' behaviour, expectations, and attitudes. Hence, parent should be included in the provided care.
- Sexual abuse and broken relationships are important detrimental factors.
- Schools should focus more on health behaviour and recognising mental health problems.
- In Greece, only few cities have mental health experts.



- Universities in the UK have a social mentor to support adolescents in their first year at college. They encourage adolescents to engage in social activities and are helpful to strengthen their confidence.
- In Belgium, inpatient mental health care is more available than outpatient mental health care. Consequently, far too many children and adolescents are needlessly being put into hospital for a month or longer. This is expensive and inefficient.
- In Belgium, there are too little places providing adolescent mental health care.
- In Belgium, there are professionals who have an official qualification for treating ADHD, but who are actually obsolete and not open to new ideas.
- It is very hard to find an appropriate institution, especially in the beginning.
- There are long waiting lists and no appropriate services where adolescents can be referred to.
- Public institutions are scarce. Hence, families can either chose to wait for a long period of time or they can decide to go to a more expensive private centre.
- Within society there is a huge stigma on asking for help and on the hospitalisation of a loved one.
- Free consultancy should be available in schools.
- There are only limited services targeting exclusively adolescents.
- Often adolescents are not taken seriously when they seek help. For example, professionals minimize their problems by saying that depression is normal in young people.

Critical remark

On the current survey the same critical remark applies: the number of participants who filled in the questionnaire is rather low. Hence, the data should be interpreted with caution.

Chapter 4

First High Level Conference

The current chapter provides a summary of the two plenary discussion rounds that were organised during the First High Level Conference (FHLC). During the conference all participants were invited to give their opinion on eight different statements. A detailed description of the method and statements that were used during the discussion rounds can be found in chapter 2 (p. 33).

The full list of stakeholders who participated at the discussion sessions is presented in annex 8.

The section below, reports on the remarks and reactions that were given on the eight statements. All comments are listed point wise and are grouped by subject. The chapter is divided in the following subjects:

- 1 Prevalence rates
- 2 Generic data system
- 3 Governments
- 4 Well-trained professionals
- 5 Integrated MHC
- 6 Empowerment
- 7 Specific and accessible MHC
- 8 Other remarks

1. Prevalence rates

Statement 1: Prevalence rates are important for the development of effective policies and action plans, tailored to the needs of the population.

- Data collection is very time -and cost consuming. Whilst resources are scarce, it is important to think wisely where to invest. It's perhaps not necessary for all countries to invest in epidemiological research. Especially since prevalence rates of major disorders (e.g., eating disorders, psychosis, bipolar disorder, autism spectrum disorder...) seem to be fairly similar across western countries.
- Delinquency rates and substance use rates do vary across countries, so it would be more valuable for countries to invest in collecting data on the prevalence of these problems.
- Prevalence data aren't always that representative. The prevalence of mental health disorders is very high in refugees, homeless people, and Roma. However, they mostly fall out of the statistics.
- Experts tend to register and evaluate, but in the end the findings are seldom translated into action.

- Epidemiological data are very important but it needs to be translated into practice so that professionals can actually use it to adapt their care facilities and care delivery.
- Although an extensive amount of prevalence and incidence rates are available, they do not seem to have an impact on mental health policies. Epidemiological data are seldom taken into account by governments when designing new policies, implementing new laws or reorganising mental health care.
- Collecting epidemiological data is important – it is a first step in order to improve adolescent mental health care. Europe needs to know what is happening. Since prevalence rates are not static but evolve over time, data should be collected on a regular basis.
- It's important to provide more attention to the way epidemiological data are communicated to policy makers. Data must be presented in an evocative and correct way in order to convince politicians.
- To convince governments not only prevalence rates are important, stories and testimonies may have an important influence as well. Politicians can be touched by visiting mental health care services for adolescents and by getting in contact with the target group.
- Relevant epidemiological data should also be communicated to the general public. The whole society should know what adolescents are going through.
- When collecting prevalence and incidence rates, it is important that countries use a common procedure and similar indicators. Now, databases vary a lot: different sources (e.g., data coming from hospital or service registrations, population data, etc.) and different definitions of mental health problems (e.g., problems as defined by the DSM or the ICD, problems as assessed by a clinician, problems as reported by the patient itself, etc.) are used.

2. Generic data system

Statement 2: One generic data system across sectors and for patients of all age groups is necessary to assure administrative data of high quality.

- Data registration brings a lot of administrative workload for professionals. Accordingly, the real work – treating young people – can often not be done anymore.
- Since Europe is overall striving towards a better Europe, it is perhaps a good moment to work out a European generic data registration system in which the same set of indicators are used. This would yield more reliable data and would allow comparison between countries.
- There is no need to reinvent a complete new registration system. It's important to work cost-efficiently and to focus on existing registration systems that proved to be successful. For example, the registration systems of Denmark and Sweden can act as a model.
- One generic registration system that is used across countries simply won't work. There will be too many obstacles: the data won't be equal in quality and there will be several cross-sectorial issues. Therefore, elaborating one generic registration system shouldn't be a priority.



- Just having good statistics won't help adolescents who are in need of help. It is more important to establish services that are effective and easily accessible by the ones who need them.
- It's important to select indicative performance indicators in order to evaluate the effectiveness of the care that is provided. Only then, services can improve the care that they provide.
- When collecting and storing data of patients and their family, it is important to work out a proper regulation on what data will be registered, for what purpose these data will be used, how these data will be collected, and who will receive access to these data.
- It's not only important to register data of adolescents that are in treatment, but we should also have knowledge of those adolescents who are in need of help, but who aren't reached by any mental health care service. Also, data of adolescents who come to a service for an intake interview, but eventually do not receive any treatment as they do not fully belong to the target group of the service, should be recorded. Only then the needs of the whole target group can be mapped and a country is able to decide what kind of mental health care services are most needed.
- By using a generic data registration system across settings, data from different sectors (social, health, court of justice, schools) can be brought together. This way a more complete and correct image of the adolescent can be obtained which would help professionals to outline a more appropriate treatment plan.
- By using a generic data registration system for all age groups, there would be more continuity in the data of child and adolescent care on the one hand and the data of adult care on the other hand.
- Collecting epidemiological data and launching a generic data registration system are a titanic job. It should not be the purpose of ADOCARE. The true purpose of ADOCARE should be to provide models of good services and to provide indicators to evaluate the quality of care.

3. Governments

Statement 3: Governments should install the right political climate, youth oriented policies, and adequate legal frameworks in order to improve AMHC.

- Governments need to spend more funding on adolescent mental health than they do today. This is urgently needed in order to prevent mental health problems and to improve mental health care.
- Without mental health services for adolescents, the burden of disease would be much higher. Being able to treat adolescents prevents mental health problems in adulthood. Consequently, fewer financial funding is needed for adult mental health care.
- Most countries are in the middle of a crisis right now. Budgets for mental health prevention are the first to be cancelled. Hence, several countries are not in the position to create the



right political climate. As a consequence, adolescents receive only help when their problems become more serious and then it is often far more difficult to provide help.

- Within a country, governments should foresee a budget for evaluation. Without evaluation services do not know whether they are working in the right direction and are unable to demonstrate that what they are doing is effective. Accordingly, when services are unable to proof their effectiveness, it is hard to obtain further funding.
- Evaluation is also important for governments themselves. They should know whether the initiatives that they fund are effective. Policies should be more evidence-based.
- Performing a good evaluation is not that easy. It's important to use the right outcome indicators.
- Media can be used to overcome governments. Whatever comes in the media comes on the political agenda.
- When developing services and designing quality audits, young people should be consulted. A good example in which young patients and their parents are involved in the improvement of access to psychological therapy is the CYP IATP project in the UK (www.myapt.org.uk).
- Governments should keep in mind that mental health care is a human right – everybody should have the right to receive treatment. Hence, policies should not only focus on those adolescents who already have access to care, but should also provide special attention to youths who are not in treatment. Countries should set up a legal framework to facilitate the access to care, to improve help-seeking behaviour, to bring adolescents with mental health problems into care (even if they don't want to), and to break the stigma that exists on mental illness. In addition, legislation is needed on other critical issues such as at what age adolescents can claim help without the permission of their parents and whether or not to inform parents if an adolescent is in danger (i.e., respect the adolescent's privacy).
- When governments fund projects, funding is often stopped after a few years even when projects appear successful. Governments simply forget about it.
- Successful care systems can mostly not be implemented in less financially stable countries such as the Baltic countries, Romania, Spain, etc.
- Mental health problems are linked to many factors: other mental health problems, relational problems, low self-esteem, bad school performance, poverty, neglect, abuse, etc. The whole society (not only professionals) should take responsibility. It takes a whole village to raise a child.

4. Well-trained professionals

Statement 4: High quality mental health care for adolescents is not possible without competent, well-trained professionals, very familiar with the world of adolescents.

- Psychiatrists should receive training in providing psychotherapy, as many mental health problems in adolescents cannot be treated by medication only.
- When professionals really want to be competent, they need to follow some extra courses.
- Professionals working with adolescents need training in evidence-based psychosocial interventions.
- The training that is provided should be comprehensive focusing on psychotherapy, pharmacotherapy, family therapy (with parents), group therapy, etc.
- Professionals should also receive training on the characteristics that are typical for adolescents and on the continuous evolution of adolescents in this quickly evolving society. Hence, it can be useful to involve young people in the training programme of professionals as is done in the CYP IATP project in the UK.
- High quality and well-trained staff will result in more effectiveness and in the long run in more cost effectiveness.
- Not only psychiatrists and clinical psychologists working with adolescents should receive training, but it is also important to train other professionals who come in contact with adolescents such as general practitioners, teachers, pediatricians, social workers, youth workers etc. They play a central role in the early detection of mental health problems and can refer adolescents to more specialised care in time.
- Mental health disorders often manifest themselves for the first time in the school environment. Hence, schools play an important role in identifying problems. Therefore, school staff (e.g., teachers and nurses) should receive training on mental health as well.
- Although there is a need for more in-depth education on issues related to adolescence, there is no need to create the sub discipline of adolescent psychiatrist. It could even hinder the continuity of care and lead to discontinuation in care from child and adolescent to adult care.
- Not only competence in technical skills, but also administrative skills should be emphasised, as clinicians are not educated to run a mental health care service properly.
- In some countries it is not possible for professionals to follow a specialisation in child and adolescent psychiatry. There, professionals are forced to go to another country in order to get an appropriate training.
- Professionals working in general mental health services should receive training on specific disabilities and mental health problems such as ADHD, autism, eating disorder.
- A common EU model for training professionals, especially psychiatrists and clinical psychologists active in the area of adolescent mental health care, should be set up.
- Professionals should not only be well-trained, also maturity and experience are important.
- Next to training, intervision and supervision are important, so professionals can exchange ideas and experience.



- What adolescents really need is a good connection and alliance with their caregiver. Hence, professionals should be able to engage with young people and build a trustful relationship with them.

5. Integrated MHC

Statement 5: Integrated MHC is recovery oriented and pursues full citizenship. Care should be provided by a multidisciplinary team of professionals within a broader network of services.

- ADOCARE should look up whether there is evidence for the effectiveness of an integrated care approach.
- Providing integrated care relies on professionals with a different background working together: psychologists, psychiatrists, sexual health workers, social workers, youth workers, nurses, assistants in general care, assistants in mental health care, etc.
- Offering integrated care occurs most efficiently and effectively when professionals with a different background (i.e., psychologists, psychiatrists, sexual health worker, social workers, youth workers, nurses, etc.) work together under one roof. This way, all the needs of adolescents can be addressed at once.
- In reality, working together under one roof is difficult to organise.
- Providing multidisciplinary care is quit demanding. It requires good scheduling, special requirements regarding the location, a clear task description for everyone who is involved, transparency regarding everyone's responsibility, and good administration by everyone who is involved.
- Adolescents can have many problems: medical problems, psychological problems, and social problems (e.g., problems with parents, relational problems). Integrated care should include different approaches to meet these different needs.
- "Pursuing full citizenship" is not the right terminology. Adolescents with mental health problems are full citizens also. Furthermore, adolescents don't want to pursue full citizenship. They are more concerned with being a person, with their identity, with searching for meaning and independency, with spiritually, and with their relation to others (parents, brothers or sisters, friends, boy or girl friend, etc.).
- Integrated care also means working preventively (i.e., screening and identifying problems at an early stage). This makes integrated care more cost effective than mental health care in general.
- Participation of youngsters within treatment is important (i.e., what do they think of the treatment that they are being offered?). They must feel respected, their voice should be heard.
- Also the voice of parents should be heard in order to make treatment successful. Often there are conflicting rights and interests between parents and their adolescent child.

- Integrated care should pursue recovery over generations and prevent that later on adolescents with mental health problems carry over their problems on their children.
- Schools are the place where all problems of the society come together and where there is a need to search for solutions. In adolescents, mental health problems are directly linked to early school leaving. However, schools will never be able to solve all problems by themselves. Therefore, a platform should be created where teachers and other school staff can convey their problems.
- Partnership with family, peers and teachers is very important. This way, the adolescent not only receives support in the clinical setting, but also in the school and home setting.
- It's important that the social, the health, and the school sectors cooperate.
- Integrated care also means offering hope, increasing empowerment and teaching self-help strategies for adolescents and their parents, so they learn how to deal with future problems.
- Although it is important to work in an evidence-based and standardised way, there should be room for diversity in therapy.
- The concept of integrated care can also be interpreted from a macro perspective. For example, in Finland a huge reform of health care is taking place. The number of health care districts is being reduced, an integration of primary and specialised care is pursued; and social and health care are brought within the same policy area and are being funded by the same budget. It's not clear yet how this reform will turn out.
- Integrated care can also be interpreted as an integration of primary, secondary and specialised care. Placing different levels of care under the same roof.

6. Empowerment

Statement 6: Offering good AMHC means that the provided care and the care environment is empowering and stimulating for a good working alliance.

- In the UK the Quality Network of Inpatient Care (QNIC) developed a list of standards that a mental health service should try to pursue.
- Except for intervening in the clinical, home and school environment, it is also important trying to reach adolescents in other, more relaxing settings. Especially when trying to prevent mental health problems, it is important to work by outreaching.
- For young people it is of great importance that they have a place where they can talk with someone.
- Participation is important for adolescents when offering good mental health care. They need to be the protagonist of the care that is provided to them. They should feel respected and listened to. This also counts for the family.
- It is not easy to induce participation and shared decision making. It requires a lot of competency of the professional.



- The relationship between the adolescent and the professional should be characterised by mutual respect, empathy, engagement, and trust.
- Participation of adolescents is also important when shaping or reorganising adolescent mental health care services or systems. Adolescents know best what their needs are. Also, they often know why certain systems or services do not work.
- It can be helpful when young adults who have overcome mental health problems during adolescence themselves volunteer or work as a staff member in mental health services for adolescents. They can act as good role models.

7. Specific and accessible MHC

Statement 7: High quality AMHC services are specifically dedicated to this age group and easily accessible (in time, geographically, financially).

- For several countries it is financially difficult to create specialised high quality mental health care services exclusively for adolescents.
- It is important to invest in mobile health promotion (i.e., working outreaching), for example by offering high quality after school activities within the adolescent's natural environment. Activities could focus in particular on vulnerable adolescents, learning them to build individual relationships. These projects have a positive influence on the self-confidence of adolescents. Moreover, outreaching teams are more cost efficient than mental health care services.
- Often general practitioners, pediatricians, and schools deal with adolescent mental health problems. They should receive additional training in detecting mental health problems and in making good referrals. Early detection is a prerequisite in order to facilitate access to care and to initiate treatment in time.
- Online help (i.e., internet-based treatment tools, mobile apps for mental health support, chat rooms and web-forums ran by professionals) is very much needed to reach young people who are unwilling to search for help in mental health services.
- Adolescents should learn how they can manage their problems themselves in order to prevent future relapse.
- It's not only important to have accessible care, but also to have (ethical) acceptable care.
- Programmes to prevent mental health problems can be included in the school curriculum of adolescents. Schools can teach adolescents about possible triggers of mental health problems and help them in developing coping strategies and resilience.
- There are also other, perhaps better, settings in which adolescents can be reached (e.g., youth or sport organisations). School is characterised by rules, it is a place where adolescents need to perform.



- High quality mental health care for adolescents within a country is assured, when different types of mental health care facilities are available: outpatient services, in beds wards, semi-residential and residential structures.
- For mental health care services it's less important to work with diagnostic labels. If services aim to prevent mental health problems, all adolescents who are experiencing problems should be welcomed in and treated by a mental health service, regardless of the diagnostic label.
- Separate care services for different age groups are important. Adolescents should not be treated together with children, otherwise they will become infantile.

8. Other remarks

In addition to the statements, two additional topics were discussed during the conference:

- The importance of using an evidence-based approach
- The age boundaries of adolescence

8.1. Evidence-based approach

- It's important to implement interventions that have proven to be effective. It's not because it feels right that it is right. For example, CBT in school to prevent mental health problems is used frequently, but appears to be harmful according to a recent UK study.
- On the other hand if everything has to be "scientific", there is no room for mystery or magic. This is not what attracts adolescents.
- Next to evidence-based approaches, a lot of other good practices exist.
- There should be room for trial and error.

8.2. Where does adolescence starts and ends?

- In the literature there is no consensus on the strict age boundaries of adolescents. Also, across regions and cultures the age at which someone is considered to be a grown-up varies widely. For example, the age at which someone can vote, at which someone is responsible for one's own actions, at which someone can drink alcohol, etc. greatly differs across countries.
- Adolescence can last until the age of 20 or 25. There are big individual differences as well. In some youngsters development occurs rapidly, in others it goes much slower. Therefore, it is difficult to put an age on it. In general, adolescence is marked by development and incomplete maturity.
- For young people themselves, the age boundaries that are used for defining adolescence is no main issue.

Chapter 5

Four workshops

Within the ADOCARE research four workshops were organised with four different stakeholder groups (i.e., policy makers, professionals, experts, and end-users). The workshops were a first step in generating guidelines and recommendations for establishing integrated mental health care for adolescents across Europe. The method used during the workshops is described in chapter 2 of this report (p. 34) and the full list of participants can be found in annexes 13 to 16.

The following paragraphs provide per topic a structured overview of the remarks that were raised during the four workshops. All verbal information offered by the participants during the workshops was written down. Next, this information was supplemented with the written comments participants offered on the note pages or by e-mail. Lastly, the data was reordered and partly rewritten to improve clarity.

1. Output workshop with policy makers

During the workshop with policy makers (see annex 10 for the full list of participants, the following nine policy-related themes were discussed:

- Topic 1: Administrative data collection
- Topic 2: Assessment of needs and treatment gap
- Topic 3: Policy on adolescent mental health
- Topic 4: Legislation on adolescent mental health
- Topic 5: Financial funding
- Topic 6: Integration and defragmentation
- Topic 7: Prevention and promotion
- Topic 8: Balanced care
- Topic 9: Evaluation

1.1. Topic 1: Administrative data collection

- The European Union should develop one broad database for administrative data collection. Not all aspects of such database will be usable in every country but governments can decide to use parts of this database. In addition, governments should be discouraged to develop parallel databases as this will decrease the possibility to exchange information. Yet, it will be a huge task to construct a generic data base that is usable in different sectors (social, mental health, etc.) and across countries.



- A first step in the process of developing a common EU system is to agree on a shared set of indicators. Next, some good instruments to gather data should be grouped or developed.
- Information on somatic disorders, school results, employment, vaccinations, etc. would be useful for professionals.
- When registering data, people should always be clearly informed about how, why and what data are registered.
- It is important to (re)formulate legislation that allows data gathering across services and sectors. This must be done at a European level and will mostly concern issues related to confidentiality. Within the EU, there are currently work groups discussing how data – also within the context of administrative data collection – can be protected.
- It is important to consider the construction of a 'layered database' consisting of different subdivisions and different levels of accessibility. With such a system, it can be arranged that professionals have only access to the data that they need.
- In many EU countries, good data registration systems exist. Yet, the systems are often not easy to link to each other due to different jargon, software, etc.
- In addition to the problem of linking different systems across sectors, there are other issues that complicate data registration. Professionals often do not hold a positive attitude towards using and learning to use data systems. This is often based on the fact that they do not perceive any advantages for clinical practice. Most professionals or directors of services also do not know how to use such systems. In addition, they already have a high workload and do not have the time to properly fill in complex data registration systems. It has to be underlined that a well-developed data registration system can reduce the workload of mental health professionals.
- It is important to guard that data registration systems are not misused to receive more funding. When diagnosis is necessary to receive funding, over-diagnosing can become a reality. For example, in some schools more psycho-emotional problems are registered in order to receive more funding.
- In Europe some professional centres that are responsible for data gathering and communication already exist:
 - In the UK, the Health and Social Care Information Centre is the national provider of information, data and IT systems within health and social care (www.hscic.gov.uk/).
 - In the UK, information related to public health is collected by the Public Health Outcomes Framework (www.phoutcomes.info/).
 - In Sweden, data is gathered by SOTKA NET (<http://uusi.sotkanet.fi/portal/page/portal/etusivu>). Regarding mental health, they collect information on the use of psychiatric hospital services; outpatient care visits for mental health reasons; health behaviour and psychic symptoms; sickness allowance for mental health reasons; the use of special refunds on medicines; recipients of reimbursements for antidepressants; mortality; involuntary care; and psychiatric rehabilitation homes.

1.2. Topic 2: Assessment of needs and treatment gap

- Well-being, the needs, and treatment gaps can be assessed for both physical and mental health at once. For example, in Finnish schools health care check-ups are organised for youngsters at the age of 7, 10, and 14. They are organised by school health services and conducted by school doctors or school nurses. All school children are personally invited for these check-ups, but participation is on a voluntary basis. Parents are also involved in order to assess the family's well-being and needs. Parents are asked to complete questionnaires and are invited for a talk. When a problem is detected, follow-up care is organised. These check-ups are well accepted by the general population. The data that are gathered could be accumulated for statistical purposes in order to assess the general needs of adolescents in the region and country.
- It is important to ask the same minimum set of questions across different ages (for example as in Sweden, at the 7th grade till the 9th grade). As such, it becomes possible to detect trends (e.g., alcohol use, drug use) and this can help to improve interventions.
- An important indicator to study the treatment gap is to look at the number of psychiatrics that are present in a country. In some countries, it is legally set how many adolescent psychiatrists and mental health professionals are recommended per 10.000 adolescents. Yet, such recommendation cannot be generalised to other countries as it varies depending on how health care is organised and on the position of the psychiatrist within the health care system.
- Some adolescents are not motivated to search for help or are hardly reached by professionals. For these adolescents, good instruments and interventions must be developed and it has to be studied why they are not reached.
- In some systems, people don't receive help because they do not want (or have) a diagnosis. Yet, it should be possible to receive treatment without having an official diagnosis.
- A good diagnosis is sometimes necessary in order to have a clear focus during treatment. In Finland, when a psychiatrist applies for a therapy, he needs to give a diagnosis and a full explanation arguing why that treatment is chosen. Yet, policy makers must keep in mind that there is no one-on-one relation between diagnoses and therapies. The type of therapy is chosen in agreement between the professional and the adolescent and does not rely completely on the diagnosis that was given.
- Instead of focusing solely on the diagnosis, it can be beneficial to look at the severity of problems (destructive, suicidal, etc.), functioning in society (GAF), functioning in school and family related problems, substance abuse, etc.



1.3. Topic 3: Policy on adolescent mental health

- Policy makers must take the lead to state that adolescents are a specific target group requiring specific attention and care. In addition, it is also important to attend to the family and the peers of adolescents. Policy makers must also use the correct language in order to normalise mental health problems. It is important to talk about mental health and well-being and not about disorders and diagnoses.
- In order to convince governments, it is important to offer them clear facts and results of the treatment that is offered by mental health care services. Nowadays, there is too often a dispute between mental health disciplines resulting in a less strong and coherent voice to the public.
- Governments can be persuaded by economic arguments as well. For example, investing in mental health has an impact on criminality. Moreover, many problems that exist in adulthood started during adolescence. Thus, investing in adolescent mental health is a form of prevention that is additionally cost-saving.
- In order to increase governmental interest, lobbying groups can be set up so that governments do not receive different messages from different stakeholders within the field of mental health.
- In the light of balanced and integrated care, it becomes increasingly important that different sectors (e.g., educational, justice, mental health) and services work together. Different governmental departments should collaborate (e.g., health, social, and educational department). Integrated care means that the structures on the macro-level work together and stimulate collaboration on the meso- and micro-level. Hence, it is crucial that one strategic plan is developed across different departments. Governments should work out a framework to facilitate collaboration between sectors and professionals. Such framework should clear out the responsibilities for each sector and should incorporate an overarching plan on how to achieve more collaboration and integration. An example of such a plan stimulating collaboration is the Finnish mental health act (1990).
- Within small regions, policy must ensure that all care organisations that provide youth care are brought together in one local board. The organisations within this board must work together to establish better care, to avoid overlap in care, to create one common vision on care, and to create continuity in care without losing expertise. An example of this is 'integrale jeugdhulp' in Belgium. Even politicians can be involved in such a board in order to ensure that strategic guidelines are being developed.
- Adolescents are in a stage of life that is subject to many changes and thus need a flexible treatment. This must be made possible by adapting policies and legislation so that services can offer more flexible help.

1.4. Topic 4: Legislation on adolescent mental health

- The children's rights should be implemented at different levels.
- Legislation should be developed on the right of youngsters to co-decide (and thus also to refuse care).
- The human rights approach should be stressed in all policy documents and interventions¹.
- Legislation concerning restraint procedures should state that restraining must be kept to a minimum.
- It is important work out legislation on maximum waiting times in primary and specialised mental health care. In Finland, such legislation exists. It forces primary care services to filter out adolescents with severe problems and to transfer them to specialised care more quickly. As a result, adolescents with mild problems are also treated more quickly in primary care. An adverse effect of such legislation is that adolescents get an intake within the prescribed waiting time but after that need to wait for a long time before a second therapy session takes place. It's important to address this problem.
- Adolescents should always have the right to contact a professional outside their parents' knowledge.
- Parents or other family members are crucial partners within the network of the adolescent. Therefore, a general rule must be that professionals inform and involve parents as much as possible although there should be room for exception. Within the treatment, one of the first aims should be to talk with the adolescent about informing and/or involving the parents.
- Parents have the right to receive information and may need additional support as well. Yet, for every specific case a good balance should be found between respecting the privacy of adolescents on the one hand and involving parents in the treatment of their child on the other hand.

¹ <http://www.unfpa.org/human-rights-based-approach>

1.5. Topic 5: Financial funding

- Policy plans should clearly show how much of the gross national product (BNP) is invested in mental health care in general and how much is spent on adolescent mental health care in particular. This is difficult to determine as many services and sectors (schools, justice, etc.) contribute to adolescent mental health. Yet, information on funding of for example specialised adolescent services is available and should be shared.
- In most EU member states, the amount of funding for adolescent mental health care should increase. The amount of budget spent on adolescent mental health care should equal the amount of budget spent on adult mental health care.
- An explicit part of the budget should be spent on prevention. Moreover, studies have shown that prevention programmes with a specific target (e.g., suicide prevention programmes) work best.
- Some countries make use of backpack funding systems to improve the quality of care. In this system, funding is given to a person instead of to an institution. Hence, the patient has his personal financial backpack and can 'shop' at different services.
- Volunteers such as families, friends, care users, etc. could be asked to take up a role in the support of adolescents with mental health problems. This will reduce costs and induce a sense of citizenship. But even voluntary support needs to be organised professionally and this is not free of costs.
- Different mental health problems need different levels of care. Likewise, different service types require different levels of funding.
- Countries need to experiment with new ways of funding. As countries' mental health systems are all different, generalisation will not be evident. Yet, an interchange of experiences and "do's and don'ts" should be stimulated.

1.6. Topic 6: Integration and defragmentation

- Governments should stimulate collaboration between existing services. In Belgium, a law exists aiming to reduce the number of hospital beds in the country (Article 107). The money that is saved by this initiative is invested in the development of community-based services and in stimulating the collaboration between services.
- Governments should ensure that collaboration between services is not done on a voluntary basis but is enshrined in legislation. Therefore, cooperation with other services should be part of any quality of care assessment.
- Governments can offer special funding to projects that solely focus on increasing collaboration instead of creating new types of treatment.
- Professionals should be reimbursed for collaboration activities such as going to schools or meeting other professionals involved in the treatment of an adolescent.

- A good working alliance between the patient and the professional has a positive impact on the therapy outcomes. However, building a strong working alliance requires time and trust. When adolescents are transferred regularly to different services and see other professionals each time, it won't be possible to build a good working alliance. Integrated care allows more continuity in the professionals that are involved.
- The cultural sector should be involved in care. Activities that allow children to express themselves through sport, music, theatre, etc. can play a role in mental health care. Therefore, art therapists, sport coaches, etc. should be stimulated to collaborate with professionals.
- Health care doctors and outreach-youth workers should be informed of youngsters dropping out of school or leaving the army. It is their task to follow the youngster and to find out whether psychological problems are present. This way, psychological problems can be identified at an early stage.
- Sometimes, adolescents are referred to specialised services too quickly. Professionals should realise that adolescents with mental health problems do not always need specialised care and that much can be done by primary care services.
- Continuity of care across services (coordination of care) is important but often professionals are not trained to think outside of their own organisation or to start collaboration.
- Children in foster care are generally more at risk to develop mental health problems. Therefore, they should have quick access to mental health services.
- To stimulate collaboration and self-referral, information on existing initiatives should be centralised. At www.mynhs.uk, services of the UK are listed.

1.7. Topic 7: Prevention and mental health promotion

- It is important that society is educated about the value of mental health and well-being. Once that is achieved, mental health problems must be normalised and prevented as much as possible.
- The combination of universal prevention and specific prevention works best in the short time. However, there is more evidence for prevention programmes targeting specific groups such as small children or young parents than for programmes targeting the whole population.
- Across the EU, different prevention and mental health promotion programmes exist (e.g., “Te Gek!?” campaign in Belgium, “Time to Change” in the UK, etc.). Before a country or region develops a new programme, they must study what other countries did and what worked. Moreover, it is important to look at what other sectors already implemented. For example, a lot of school programmes exist on bullying, resilience, coping and normalisation of mental health problems. These are often known by the mental health sector.
- Every school needs to have access to psychologists in order to work preventively.



- Mental health services must be accessible and rebranded positively so that adolescents will ask more quickly for help and thus prevention can start sooner.
- Help-seeking behaviour should be promoted as a personal strength.
- For some groups of adolescents (e.g., those not attending school), special outreaching prevention programmes should be implemented.

1.8. Topic 8: Balanced care

- Governments need to know what type of care services are present in their country, which steps in the balanced care model are implemented and which steps are lacking.
- Countries may need guidelines to implement balanced care, but it's difficult to formulate universal guidelines as the situation is different in every country. Therefore, the EU government should provide funding for study visits and exchange.
- In every country, both primary and specialised care should be offered. Primary care refers to prevention, mental health promotion, health checks (offered by the municipalities), walk-in type of services with trained professionals (mental health, sexual health...), etc. Specialised care refers to units that are specialised in certain mental health problems.
- To offer balanced care, many EU member states need to implement more community-based services. Therefore, it is important to invest in the training of general practitioners and other primary care professionals so they can offer such services. In addition, citizens should be convinced that community-based care is also effective. Today, some people immediately ask for specialised support as they are convinced that only specialised care is effective. However, for many patients specialised care is less effective than community-based care.
- Although more outreaching support is needed, the role of family members should not be overestimated. When family members provide care to a relative, they should be properly supported.
- Residential care should not be limited to hospitals. Every country needs different kinds of residential care services.
- Residential care should be offered only when necessary and with consent of the patient.
- There exist prioritising tools that help to distinguish whether residential or non-residential care is required (transparent criteria for specialist level adolescent psychiatric care). Screening and assessment tools may help professionals to make that decision. However, working strictly with legally set cut-off scores may have adverse effects.
- Adolescent psychiatry is not in all countries recognised as a separate profession. However, not everybody believes that there is a need to create a separate profession group for adolescents. There are advocates and opponents on this. Opponents argue that the period between childhood and adolescence is a continuum, and thus that there is no need for a separate sector or profession group. Professionals working with adolescents do need specific competencies on adolescent mental health.

- Every school should implement a whole school approach. A school should be a healthy environment that attaches great importance to health. This also means that schools should use a more positive teaching approach.
- In the school curricula of adolescents classes on mental health and well-being should be included. Such classes should focus on resilience building, respecting others, social skills, expressing feelings, etc. These classes should be given by a care teacher or a health educator. Also, experts or professionals should be regularly invited to give a class. Some EU member states already offer such programmes in schools. These programmes should be listed and evaluated so they act as a good example for other EU member states.
- Classes on mental health should be offered at different ages (but need to start very young).
- All teachers must be familiar with the teachers' record form (TRF). This is a tool for teachers to assess which students might be at risk for mental health problems.

1.9. Topic 9: Evaluation

- Adolescents, parents, professional caregivers, and researchers should be involved in the development of quality standards and quality audits.
- In some countries, quality standards and indicators have been developed by private commercial companies that offer audits and trainings. However, quality standards should be more closely linked to the mental health care framework and the needs of the system. Therefore, they are best developed in close collaboration with professionals, policy makers, experts, etc.
- Evaluation of services must be publically accessible as is done in the UK (My NHS).
- Professionals can be partly evaluated on how many additional trainings they followed on adolescent related topics (accreditation).
- A service or treatment should be evaluated from the perspective of the professional, the adolescent and the parent.
- Examples of good quality standards for services are:
 - Accessibility of the service
 - Length of the waiting list
 - Assessment and treatments
 - Education and training-level of the professionals
 - Whether a multidisciplinary approach is used
 - Diversity in treatment
 - Freedom to choose treatment
 - Targeted treatments
 - Taking into account the opinion of care users
 - Improvement of health
 - Improvement in quality of life

- Amount of collaboration with other services
- It would be useful that professionals enter the data on the given treatment in a national database. This way, the effect of treatments across regions, services, etc. can be easily studied. In the UK, this was done in a national programme called “I act” (improving access to services for psychological treatment).
- In the UK, all primary care practitioners are required to offer some form of psychological intervention to people with anxiety or depression prior to prescribing medication.
- In some countries (e.g., in the Netherlands) professionals were obligated by the government to evaluate the treatment that they gave (ROM, routine outcome monitoring). However, it had an adverse effect as it became a (bureaucratic) burden. Therefore, it may be more fruitful to use some relevant quality indicators in order to evaluate a service. Examples of such indicators are:
 - Organisation of the files
 - Entrance of reports
 - Team of specialists
 - Number of contacts
 - Structure of the hospital
 - The number of accredited doctors that are present
 - The number of publications
 - The number of psychologists
- For each indicator governments should prescribe the minimum requirement. Accordingly, each service should enumerate how these criteria are met and how they will further improve their services (a plan for quality improvement).
- It is very difficult for a non-psychiatrist to evaluate a psychiatric service. Therefore, every service needs a professional that is trained to evaluate the service. In addition, this professional-evaluator can be assisted by an outside observer who knows all legal criteria, is aware of the actual state of care within the country and is able to give advice to improve the service’s quality.
- Next to evaluating services, policies should be evaluated. When developing policies, it is crucial to clearly state what the aim of the policy is and how to evaluate whether the objectives are achieved.
- Since many aspects are not quantifiable, narrative-based outcomes can be interesting to evaluate services. For example, adolescents can be invited to talk about the things in therapy that went well and the things that went wrong.
- In the UK, New-Zealand, Australia, etc. national programmes are evaluate by four methods:
 - Via a quality care commission: they measure and inspect the safety and quality of a programme
 - Key performance indicators (KPI)
 - National and local data in relation to public health, epidemiology, etc.
 - Patient satisfaction surveys



- All data are publicly available to improve transparency.

2. Output workshop with professionals

During the workshop with professionals, the following eight topics were discussed:

- Topic 1: Integrated care
- Topic 2: Training and education
- Topic 3: Psychosocial interventions
- Topic 4: Youth friendly services and youth friendly staff
- Topic 5: Prevention
- Topic 6: Accessibility
- Topic 7: Participation and shared-decision making
- Topic 8: Evaluation

2.1. Topic 1: Integrated care

- Policy plans should contain strategies to improve the transition from child and adolescent mental health care services to adult mental health care services.
- Psychiatrists working in adolescent mental health care services and psychiatrists working in adult mental health care services should work together in joint teams in order to facilitate the transition of adolescent patients to adult services.
- In order to improve the coordination of different treatment steps and to assure that all team members –including those of other services – share a common care plan, regular multi-professional team meetings should be organised. All involved professionals are jointly responsible for working out and implementing this care plan. They should function as a coherent network. Such a network cannot work when interaction only occurs by mail or telephone. Thus, inter-professional contacts should be stimulated and reimbursed.
- Professionals should not only share a common treatment plan, it is also important that they share a recovery-oriented vision.
- Many outreaching or primary mental health services face problems with referral – they often cannot refer to the next level of care because this level does not exist or because waiting lists are too long.
- Improving integration between services will make care more accessible for groups who are now not reached by mental health care services (e.g., young homeless people, minorities, etc.). Their problems remain mostly invisible for services, researchers and policy makers. Policies need to take them into account and give them a voice.



- In many cases, nobody has the final responsibility for the care that is provided to adolescents. Hence, when the provided care appears to fail, when the promised care is not delivered or when referral to other services is not working, adolescents often do not have a contact person they can approach for complaints. Thus, a kind of local commission should be set up that supervises the quality of the care that is provided and that steers collaboration across services.
- The general practitioner is not an outsider but an integral partner of care. This notion should be promoted more. The inclusion of the general practitioner as a team member is important because it is essential to offer good primary care and to intervene at the lowest level possible. The publication 'Comprehensive mental health action plan 2013-2020' addresses this as well.
- When a general practitioner, school nurse or other professional refers an adolescent to a service, the referrer should be kept involved in the care process as much as possible. The referrer can provide continuity when treatment is interrupted or when any other problem occurs.

Working together with schools

- Increasing evidence shows that schools are an important setting for improving mental health. The last decades, progress is made as schools endorse their role in mental health improvement, but they should receive more support. Mental health practitioners should be stimulated to act more outside their clinical setting and need to be present in schools so that adolescents can see and meet them.
- Until now, many programmes focused on how teachers can help adolescents. Yet, it is also important that more specialised professionals are accessible via the school.
- School nurses have three important tasks: (1) detect mental health problems in students, (2) refer students to a mental health professional and make sure that this transfer occurs well, and (3) prepare students for this transfer. Some adolescents do not like to be referred to mental health professionals. To address this, some schools implemented the concept "co-encounters" where the school nurse and the mental health professional work together and are both present when the adolescent come for consultation.

2.2. Topic 2: Training and education

- Every care plan should contain a balanced use of medication, psychotherapy and social interventions based on the needs of the adolescent. Mental health professionals (e.g., psychiatrists, psychiatric nurses, psychologists, social workers) should receive training in order to provide such a balanced bio-psycho-social care plan. In the scientific journal Plos One, there is an article published on this: "Training of evidence-based protocols, evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations".

- The following core competencies of community mental health care professionals should be trained (The community health worker initiative of Boston, 2007):
 - Outreach methods and strategies
 - Client and community assessment
 - Effective communication
 - Culturally-based communication and care
 - Health education for behaviour change
 - Support, advocate and coordinate care for clients
 - Apply public health concepts and approaches
 - Community capacity building
 - Writing and technical communication skills
 - Special topics in community health
- However, the list above is constructed by professionals and should be complemented by what youngsters find important. The competencies that are important according to young people differ from those that are important according to professionals. Also, the list may differ in function of region, setting, target group, etc.
- The training of mental health professionals is not in every country of high quality. Moreover, training and education programmes are difficult to compare due to a lack of uniformity across countries. Hence, it is essential that across countries curricula are more comparable and rely on evidence-based protocols. The recommendations for training EU psychiatrists, formulated by the European Federation of Psychiatric Trainees (EFPT) should be the basis for all EU member states.
- It is essential to include child and adolescent topics in the curriculum of all people who are receiving training in mental health, irrespective of whether they are being trained to work in a child, an adolescent or an adult mental health care service.
- Practitioners should be trained to adopt a developmental approach. They should assess the developmental needs of the adolescent and formulate a treatment plan in accordance to these needs.
- Adolescents often keep their mental health problems for themselves or report only mild or somatic problems. Hence, professionals may underestimate the severity of the psychological problems experienced by adolescents or may attribute them to physical problems. Therefore, professionals should be trained to ask adolescents about possible mental health problems and to recognise signs of mild suffering that could become worse.
- Mental health problems are not among the top five problems on which school nurses focus. They most often attend to hearing problems or sexual topics. Nurses should be trained to focus more on mental health as they have an important role in detecting problems. Nurses need training in order to properly detect mental health problems and need granted time to follow-up adolescents when they suspect underlying mental health problems. In addition, general practitioners and school nurses must cooperate so that early detection of mental health problems can be improved.

- Psychiatrists, psychologists and other mental health professionals need on-going education and training. In some countries, this is already obliged for general practitioners and psychiatrists although they do not often have the possibility to choose topics related to adolescent mental health care.
- Medication can be beneficial for many adolescents. However, for some medication, the prescription is not in accordance with the medicine-based guidelines. Accordingly, in some countries there is an overuse of medication for the treatment of certain problems. Professionals should receive continuous training addressing the overuse of medication in certain circumstances and new evidence on the effectiveness of medication. In addition, more research on the use and the effects of medication on children is needed.
- In every team, it is important to focus on continuous feedback, training and communication to stimulate coherence in the team.

Sub-discipline of adolescent psychiatrists

- In Finland, the sub-discipline of adolescent psychiatrist exists and works according to many professionals well. Nevertheless, there are doubts concerning the effective transition of adolescents to adult services.
- Some parents or adolescents prefer to be treated by an adolescent psychiatrist.
- By creating the sub-discipline of adolescent psychiatrist, psychiatrists may lose the big picture.
- Instead of creating the sub-discipline of adolescent psychiatrist, it is possible to train all psychiatrists more intensively in adolescent issues.
- Professionals need work experience in child, adolescent and adult mental health care in order to improve mutual understanding and transition between child and adolescent mental health care services and adult mental health care services.

2.3. Topic 3: Psychosocial interventions

- Medication can be beneficial for many adolescents, but the prescription of some medication is not in accordance with the medicine-based guidelines. In order to offer good care, medication should always be offered in combination with psychotherapy and other interventions.
- It is essential that more psychosocial interventions are implemented as they are effective in supporting adolescents with mental health problems.
- Guidelines and evidence-based protocols should provide an overview of the bio-psycho-social interventions that are available for the treatment of different kinds of mental health problems. These protocols should describe the ideal combination of psychotherapy and medication for each problem. An interesting reference is “Mental Health Gap: guidelines to help and support”.



- Despite evidence-based protocols, only 1/3th of professionals use them. This is due to the fact that evidence-based interventions are sometimes difficult to apply in a clinical context. Professionals are often in conflict between offering a flexible and unique treatment for every adolescent on the one hand and providing standardised protocol-guided interventions on the other hand. There should be more room for flexibility and individuality when implementing and offering interventions.
- Not all interventions used by professionals should be tested via a randomised controlled trial as these trials are often not compatible with the clinical complexity. It remains important to take into account interventions that are not yet validated but are not invalidated by studies as well.
- Not everything can be standardised: each adolescent has his or her own identity and one size does not fit all. The Gatehouse project on changing school climates focused on standardising the process of intervention instead of standardising the intervention (www.gatehouseproject.com). This is not easy and professionals should be supported on how to offer individualised treatment that is evidence-based.
- During every treatment process, psycho-education is one of the interventions that should be offered first. Adolescents and their parents should be educated so they learn to understand their own problems.
- Stigmatising attitudes are prevalent in many societies. Psychosocial interventions should teach adolescents how to handle stigma.
- Music, creative arts, community art, spending time in nature, etc. are all important psychosocial interventions to improve mental health.
- During psychosocial interventions, e-health tools can be used for follow-up, diary keeping, additional support, information, etc.
- Topics that need to be addressed during a psychosocial assessment are: Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence. This can be easily remembered using the acronym “HEADS”².
- When developing and implementing interventions, the type and the modality of the intervention should be adapted to the socio-demographic characteristics of the adolescent: for example migration status, religion, gender, age, etc.
- Flexible and accessible beds for youngsters should be available.

² <https://www2.aap.org/pubserv/PSVpreview/pages/Files/HEADSS.pdf>



- Day care services are needed for youngsters who do not need to be hospitalised but cannot remain at home during the day.
- Many adolescents initially do not seek for professional help or refuse help in a clinical context. For them, voluntary peer supported organisations such as “girl-guiding” that link with adolescents are very important.
- An intervention to handle drop-out is to select a peer (a friend, teacher or parent) at the beginning of the therapy who can be contacted in case of drop-out. Accordingly, a meeting can be arranged with the adolescent and the peer.
- Regions should offer different kinds of services and interventions so that each adolescent is able to receive care that matches with their preferences and needs. For this, it is important to assess the needs of adolescents. In order to assess the needs of all adolescents, different methods (e.g., questionnaires, interviews) should be used.
- An additional topic that is important for adolescent psychiatry and primary mental health care is how to help pregnant teenagers. According to the statistics, these youngsters live in very difficult situations, but adequate support is still lacking.

Outreaching

- Professionals should work more through outreaching. Young people seldom go to clinical services on a voluntary basis. Professionals should go to places where young people hang out such as coffee bars, a popular swimming pool or places where homeless adolescents may temporarily reside.
- Outreaching methods should be used to find out what young people find important, what they miss, what can be done, etc. however, contacting adolescents remains difficult. An alternative is to ask professionals working in outreach teams about the needs and preferences of young people.
- When an adolescent drops-out of school, a school counsellor or youth worker should go out to contact the adolescent and to ask about the reason for the drop-out. In Finland, this practice is obliged. It should be applied by other European countries also.
- When outreaching, it is important to focus in particular on young people with multiple problems. They are often neglected by professionals as their problems are considered as far too complex. However, in many cases mental health problems are the underlying cause.

2.4. Topic 4: Youth friendly facilities and staff

Youth friendly facilities

- If services are not youth friendly, youngsters will be less likely to attend them.



- A study examining the most important quality criteria for health care services according to adolescents will soon be published. The results indicate that there are eight quality standards for adolescent health care services:
 - Adolescent literacy
 - Communicative support and linkages with other services
 - Package of services (in the facility, outreaching...)
 - Providers competences (technical competency and attitudinal competency)
 - Facility (posters, inviting, etc.)
 - Non-discrimination
 - Data-quality and improvement
 - Adolescent participation
- Another study, published in the Journal of Adolescent Health, showed that adolescent friendly services will lead ultimately to adolescent friendly care (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). The study offers eight slightly different indicators of youth friendly services:
 - Accessibility of health care: location, affordability
 - Staff attitude: respectful, supportive, honest, trust-worthy, friendly
 - Communication: clarity and provision of information, active listening, tone of communication
 - Medical competency: technical skills (procedures)
 - Guideline-driven care: confidentiality, autonomy, transition to adult health care services, comprehensive care
 - Age-appropriate environment: Flexibility of appointment times, separate physical space, teen-oriented health information, clean, waiting time, continuity of care, privacy
 - Involvement in health care
 - Health outcomes: pain management, quality of life
- Criteria to assess the friendliness of inpatient settings, are the revised You're Welcome (YW) quality criteria (Hargreaves, McDonagh, & Viner, 2013):
 - Accessibility
 - Publicity
 - Confidentiality and consent
 - Environment
 - Staff training, skills, attitudes and values
 - Joined-up working
 - Monitoring and evaluation, and involvement of young people
 - Health issues for adolescents
 - Sexual and reproductive Health
 - Child and adolescent mental health services (for CAMHS only)
- Also, a toolkit exists helping services to implement these criteria.



- There are different tools to measure the youth friendliness of a service. One example is the YFHS-WHO+ questionnaire. It consists of 49 items covering different subscales such as equity, parental support, accessibility (Haller et al., 2012).
- Special attention should go to the level of stability that is provided by adolescent care services. Adolescents are in a turbulent phase in their life and it is important that professionals can provide a certain amount of stability (low turnover of staff, regularity in opening hours and provision of care, etc.)
- When implementing youth friendly services, legal and economic aspects of accessibility need to be addressed. It should be addressed clearly what adolescents can expect when they are under 18 and they do not want their parents to know that they are visiting a care service. In addition, services need to be affordable in order to increase the level of accessibility. This is especially important for adolescents who are not financially supported by their caregivers. To work out a good regulation on legal and economic aspects, services will need to collaborate with policy makers.

Youth friendly staff

- Professionals should be able to construct a positive therapeutic alliance by for example expressing empathy.
- Professionals should have knowledge of the many changes in life that are experienced by adolescents.
- Professionals should always be respectful and understanding.
- Professionals working with adolescents need to hold a developmental perspective. They need to be able to approach the problems of adolescents from a developmental perspective.
- It might be beneficial that adolescents come in contact with good role models (i.e., adolescents who experienced similar problems in the past). These role models should receive a proper training.
- Adolescents must have the right to choose the professional that treats them and should have the right to switch professionals when they don't feel comfortable.
- Mental health care services should pay attention to burn-out in caregivers. When professionals are not motivated, they cannot offer youth friendly care. Research and interventions on this topic should be stimulated.

2.5. Topic 5: Prevention

- Primary prevention (i.e., preventing the onset of specific diseases via risk reduction) is essential. Research demonstrates that protective factors preventing the development of mental health problems are: protective parents, a good school environment, a positive peer group and spirituality. We therefore need to implement strategies to reinforce these factors.



- An important question for professionals, policy makers and researchers is how to implement preventive strategies in the everyday life of adolescents. This is not an easy task and researchers and professionals working on this topic must be involved when such prevention and mental health promotion programmes are set up.
- Professionals such as teachers, youth workers or school nurses have a lot of expertise on how to communicate with adolescents, how to adjust programmes to adolescents' needs, etc. These professionals should be invited to work together with specialised mental health professionals and experts on topics such as prevention.
- An important actor that needs to be involved when constructing and implementing good programmes are youth organisations.
- Severe mental health problems can be prevented due to swift action. For this, prevention programmes should focus on empowerment and stimulate help-seeking behaviour.
- Information spread via the internet can increase mental health literacy and help-seeking behaviour. Via the internet, adolescents dare to ask specific questions concerning their own mental health (e.g., "I think I am depressed. Can you check that?"). As such, it is related to prevention.
- Professionally designed e-health tools such as websites, apps, etc. should be part of prevention programmes.
- Having a good and protective home environment is important. In some cases, lessons on parenting during pregnancy and early childhood may be offered. During these lessons, professionals can detect and try to target certain issues to prevent intergenerational effects of violence.
- Adolescent peers can recognise mental health problems in their friends more quickly than adults and thus can play an important role in prevention as well. It can be useful to train adolescents in identifying problems, to inform them about existing services so they can refer peers to services, to support them in how to communicate about mental health problems³, etc.

Prevention in schools

- Most prevention programmes should be implemented in schools because it is the place where young people mostly are. However, in order to reach children who do not attend school, prevention should also occur in other settings.

³ Example: the Check-in app on <http://www.youthbeyondblue.com/do-something-about-it/thecheckin>

- Prevention and mental health promotion programmes must be implemented at primary school. If society waits until the age of 14 to promote mental health and to prevent problems, it is too late as many problems already exist by then. Prevention should start before the age of 11. School prevention programmes should move away from “the teaching-style method” as it is not appealing for adolescents. Instead, life skills should be taught, paralleling the Life Skills Approach. This approach refers to the interactive process of teaching and learning which focuses on acquiring knowledge, attitudes and skills which support behaviours that enable us to take greater responsibility for our own lives; by making healthy life choices, gaining greater resistance to negative pressures, and minimising harmful behaviours”.
(www.unicef.org/teachers/teacher/lifeskil.htm).
- It is important that teachers focus on building resilience. When resilience building is done in a class group, it can be considered as a form of peer support since class mates can help each other. Of course, resilience building and classes on mental health must be done in confidentiality so that private information does not leave the classroom.
- Schools and professionals need to act quickly when children stop attending school. In such cases, parents, teachers and counsellors should work together to detect what is going on.
- Today, several evidence-based programmes on health promotion in students and teachers exist⁴. The Gatehouse project is an example of such a programme. The project consists of the following three strategies:
 - A coordinated school-wide approach is used instead of carrying out defragmented actions
 - A positive classroom climate is promoted
 - A curriculum promoting social and emotional skills is introduced

The intervention had an effect on the mental health of pupils and teachers but also on the ethos of the school. After two to three years, there was an improvement on mental health due to pedagogic changes⁵.
- It should be made mandatory that every school has a school psychologist/counsellor.
- An existing good practice is that of a general practitioner giving once a week consultation to adolescents on a public location. After a couple of weeks, there was a queue outside the room. Adolescents finally were in the opportunity to talk about their health and made use of

⁴ Emotional well-being and mental health: an exploration into health promotion in young people and families. Coverdale, & Long (2015)

⁵ ‘Changing schools, changing health? Design and implementation of the Gatehouse Project’ and ‘A pilot whole-school intervention to improve school ethos and reduce substance use’

this. Most questions, however, related to their physical health. Yet, the general practitioner made contact and that is an important prerequisite to detect other problems.

2.6. Topic 6: Accessibility

- Accessibility means making services more accessible for everyone. It is important not to forget people with physical disabilities, people who may not be able to afford services, etc.
- The accessibility policy of services should be clearly communicated to adolescents, so they know what to expect. Self-referral should be possible at every age, however, it is important for professionals to inform and/or involve the parents. But even with a clear policy, problems can still arise. For example, when professionals prescribe antidepressants, this medication needs to be paid and thus parents must be involved. At that point, parents may become dissatisfied, as it is mostly their wish to be involved as early as possible in the treatment process. In the UK some good guidelines exist for general practitioners on how to deal with self-referral of minors.
- In many cases, treatment is too expensive for adolescents. Some adolescents cannot afford services because their parents cannot afford it. In other cases, parents can afford services, but the adolescent does not want his parents to know that he/she is being treated.
- An important manner to improve accessibility is by using e-health tools. Many adolescents are daily connected to the internet and this can be used to offer information or some basic support and to motivate adolescents to seek more specialised help.
- Accessibility is an indicator of “adolescent friendly services”.
- In the UK, local authorities have set up one-stop shops, which are places offering multiple care services and free and confidential advice to all citizens. They are very popular in the UK because of their high level of accessibility.

2.7. Topic 7: Participation and shared-decision making

- Participation is part of the child rights convention⁶. Children and adolescents have the right to participate in all decisions that affect them, to communicate their concerns and to express themselves.
- Participation exists at different levels:

⁶ Convention on the Rights of the Child: <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

- On the **micro-level** adolescents have the right to participate in their own care. Every professional working with an adolescent must ensure participation by working out common treatment goals, asking for agreement, stimulating shared decision-making, etc. Therefore, regular meetings should be organised with the professional team and the adolescent. Professionals and the adolescent should try to reach a certain level of consensus regarding the treatment. However, full consensus is not always possible and should not be the ultimate goal. There should be room for a “we agree to disagree” attitude, especially when difficult decisions need to be made (for example in the case of admission to a hospital). In those cases, a supporting attitude of the professional is very important. In addition to the meetings with the professional team and the adolescent, meetings should be organised with professionals only so they can express their feelings and concerns among each other.
 - On the **meso-level**, adolescents should be able to participate in the design and the organisation of the service, the care provision (e.g., peer support, group therapy, self-support groups, etc.), aspects that determine the quality of services (monitoring with periodic surveys), etc. Services should also develop a charter for adolescents – together with adolescents. In this charter, there needs to be a specific topic on confidentiality specifying:
 - How professionals should handle the confidentiality between the adolescent and the parents/carers
 - Which personal information about the adolescent can and cannot be shared with other professionals
 - The fact that permission of adolescents is asked prior to sharing information with other professionals
 - The right of adolescents to access their patient file
 - Ethical aspects
 - Finally, adolescents can participate at a **policy level (macro-level)**. Policy makers must regularly assess what adolescents need and what ideas they have to improve care.
- When participation of adolescents in their own treatment is stimulated, treatment plans will change regularly as adolescents frequently change their mind. Professionals should be able to offer flexible care but at the same time respect the importance of continuity in care.
 - It is important that family members and peers can participate in treatment. Families who live with an adolescent with mental health problems are also suffering or experiencing problems and hence they should be taken care for as well.
 - When professionals cannot rely on the parents to provide proper care and support for their child, another adult should be involved (for example a teacher, peer, etc.). When a teacher is involved, he becomes an outreaching professional by proxy.

2.8. Topic 8: Evaluation

- Good care is integrated, participatory and offers a balance between psychosocial and medical interventions. Hence, for the evaluation at least one indicator for each domain is necessary.
- Even in the evaluation process, a participatory approach is recommended. For example, an adolescent can be supported by another adolescent to offer feedback.
- Each evaluation includes process indicators (e.g., the care that the service offers, how many people are treated by the service, whether people are satisfied with the provided care) and outcome indicators (e.g., the extent to which services are reaching their goals, the effectiveness of an intervention).
- Factors that need to be addressed when evaluating services are the level of empowerment (i.e., did the adolescent learn how to cope with his/her problems and learn how to ask for help in the future) and the level of drop-out.
- Except for registering symptom improvement or improvement in well-being, it is important to monitor how treatment impacts everyday life (e.g., attending school, relationships with sister or brother). For this, very specific goal-based outcomes can be used (e.g., days at school, hours spend on homework, coming back home before midnight, less fighting, etc.).
- The factors taken up in the evaluation should be appraised by the professional, the adolescent and the family of the adolescent.
- In order to know whether the treatment has a long-term effect, outcomes should be registered after one year.
- Evaluation should have a broad scope and not only address satisfaction with the individual treatment. The cost-effectiveness of a service and the satisfaction of the professional staff (e.g., days missing, turn-over rate, etc.) are important indicators as well. High turn-over of staff is very detrimental for the care of adolescents. Every organisation should have attention to the staff's well-being and work satisfaction.
- The evaluation of the whole service can be done by the service itself. Yet, it can also be beneficial when an independently funded research organisation carries out the evaluation.
- When examining the effectiveness of a service, the results should be communicated to the service and the general public. When communicating the results to the service, it is important that this is done in a supportive manner – offering recommendations and pathways for services on how to improve their quality.

3. Output workshop with experts

During the workshop with experts, the following eight topics were discussed:

- Topic 1: Epidemiological data
- Topic 2: Assessment of needs and treatment gap



- Topic 3: Training and education and the sub-discipline of adolescent psychiatry
- Topic 4: Psychosocial interventions
- Topic 5: Integrated care and shared information
- Topic 6: Balanced care
- Topic 7: Prevention and mental health promotion
- Topic 8: Evaluation

3.1. Topic 1: Epidemiological data

- Epidemiological data should be collected and analysed by different centres across EU member states. These centres must hold a leading position in the field of collecting epidemiological data. Moreover, the centres should be interconnected in an EU network so that information can be shared.
- It is important to be clear about which indicators to collect (e.g., psychiatric diagnoses, symptoms, etc.) and how to collect and measure these indicators. This will make the collected information more comparable and interpretable. Governments, researchers and professionals should develop an overall framework for this.
- In addition to prevalence rates, data on other issues (suicide, suicide attempts, pregnancy, sexual abuse, traumatic events, violence, and aggression) need to be collected. Such data are collected by other sectors (e.g., justice, health, etc.) and thus collaboration is needed.
- It is also important to collect data on positive indicators and protective factors.
- There are several problems regarding data registration:
 - Different services do not have a common database or common registration system which makes it difficult to link data. In some countries, a lot of information is available but appears to be invalid. It is important to collect and integrate valid data that already exists (e.g., data collected by the police on young offenders). Before constructing data gathering systems, it is crucial to do some scouting in each country on the available data and registration systems.
 - Hidden problems like sexual abuse are unlikely to be registered.
 - Professionals receive little training on how to register data. To improve the quality of the data that is collected, professionals need training and sufficient time to enter registration data.
- As there are many ethical issues with collecting data of minors, professionals do need some guidelines on the content and the process of data collection.

3.2. Topic 2: Assessment of needs and treatment gap

- Treatment gaps can be measured by comparing the prevalence rate of mental health problems with the number of psychiatric beds. Based on the prevalence data of the ESEMeD study (2001) (this data did not include minors), the treatment gap in Belgium was calculated. The analysis showed that there is a real treatment gap.
- Other ways of calculating treatment gaps must be considered as only taking into account the number of psychiatric beds is not sufficient. For severe mental health problems, the number of beds is a good indicator for calculating the treatment gap. For mild mental health problems, the number of psychologist/psychiatrists is a good indicator.
- There is a difference between the prevalence of problems and the need or demand for care. Not every person with problems needs help. In contrast, some adolescents might not realise that they are having mental health problems and thus do not seek for help even though they might benefit from receiving help.
- The Strengths & Difficulties Questionnaires (SDQ) (<http://www.sdqinfo.org/a0.html>) is a good questionnaire to assess mental health. It not only measures pathology, but also measures positive emotions. Moreover, it is free and available in 60 languages.
- When studying the treatment gap, it is important to incorporate the accessibility of services. Even when services are available, different barriers may exist that prevent adolescents to seek for help (e.g., stigma). Thus, the accessibility of services also has an impact on the amount of care that is provided.
- To increase accessibility, it is essential to support adolescents in their natural environment and to stimulate spontaneous consultation via the internet. This can create a bond with the service and lower the threshold to visit the service later on.
- The treatment gap can be diminished by introducing prevention and early intervention programmes within the educational system.
- Addressing the treatment gap will include addressing stigma as this may inhibit people to look for help.

3.3. Topic 3: Training and education

- Developmental psychology must be used as a general perspective in the training of all professionals who get in touch with adolescents. It is important that professionals have sufficient knowledge of the changes that adolescents experience. A developmental focus is also important for diagnostics. As adolescents change rapidly, every clinical diagnosis will be subject to change.
- Communication with an adolescent must be trained. During their communication, professionals should present an attitude that stimulates collaboration. In Belgium, a specific training in communication with adolescents exists in a master after master education.



- Developmental neuroscience must be implemented in the curricula of psychiatrists and psychologists. These professionals should learn that some brain parts are not fully developed until the age of 25.
- Next to developmental aspects, socio-cultural aspects are important as well. It is for example important to know what keeps young people busy (their interests, concerns, leisure time, activities on the internet). It is important to assess these aspects during treatment and everyday contact with adolescents.
- Another important training topic is risk identification (i.e., detect who is at risk to commit for example suicide). Yet, there is more evidence that mental health promotion works than that risk identification works. So, risk identification must be a training topic in addition to teaching professionals how to work on health promotion.
- Professionals working with adolescents (e.g., school nurses, teachers, GP's, etc.) should be aware of well-validated screening tools. An example of such a tool is the Strengths and Difficulties Questionnaire (SDQ). Yet, using such tools is not necessarily time efficient. Also, when there are insufficient mental health services, screening can be detrimental – it creates a demand for help while no care opportunities are available.
- Professionals should be (continuously) educated in existing evidence-based interventions.

The sub-discipline of adolescent psychiatry

- In total, 23 countries make a difference between adult and child psychiatry. Yet, it is not only important to know whether a distinction between the two types of psychiatry exists, but it is also important to know whether continuity in care exists (i.e., when adolescents go from an adolescent service to an adult service). In many countries, there is a big gap between both services. It is important to give training on how to establish continuity of care.
- The risk of creating a sub-discipline is that the gap between adolescent and adult mental health care will not decrease. When a sub-discipline exists, it is crucial that adult and adolescent psychiatrists have sufficient knowledge of each other's discipline in order to improve continuity of care.
- One way to address the gap between adolescent and adult mental health care is forcing adult psychiatrists to work for a certain amount of time in a clinical adolescent setting. Conversely, adolescent psychiatrists should work for a certain amount of time in an adult service. Another possibility to facilitate the transition of care is to involve an adolescent psychiatrist in every adult care service and vice versa.

3.4. Topic 4: Psychosocial interventions

- A good treatment consists of the following three components: psychological support, social interventions and medication.

- Psychosocial interventions are interventions that are offered in the social environment – they may or may not be carried out by social workers. Next to psychosocial interventions, psychotherapy, relational therapy and family therapy are important.
- In some countries, the function of psychotherapist is not legally defined and thus everyone is allowed to give psychotherapy. The function of psychotherapist should be clearly defined and linked to a specific type of training.
- Professionals should provide evidence-based interventions that are adapted to the individual. For this, it is important to review the existing evidence and to provide good guidelines on what works for which target group. A list of evidence must be distributed across European schools, profession groups, etc.
- Post-school activities offered by motivated and trained adults play a role in prevention and promotion. To ensure that all adolescents can benefit from post-school activities, these must be free for (some) adolescents.
- In some countries, certain types of mental health problems are too easily addressed by offering (only) medication. The prescription of medication should be more in accordance with the current protocols. In the UK for example, some medication can only be prescribed after offering psychosocial interventions.
- During any intervention, it is important to focus on continuity and coordination of care. All social, psychological and other interventions must be geared to one another.

3.5. Topic 5: Integrated care

- In many countries, the collaboration between different services and departments should be improved in order to help adolescents who come into contact with justice. Justice departments should collaborate with educational professionals, mental health services and the police department.
- Often, parents also suffer when their children have mental health problems. Therefore, sufficient attention should be provided to their well-being also. When necessary, therapy should be offered to adolescents and their family. Yet, it is not recommended that one therapist offers therapy to both the adolescent and the parent.
- Coordination of care should occur at two levels:
 - Coordination of services within a region at the organisational level
 - Coordination of professionals working together to treat one individual adolescent
- At all times and especially when treatment or referral is failing, it should be clear for the adolescent where to go to. When different services work together, one team could be made responsible for the coordination (often a duo consisting of a coordinator or a case manager). However, other care models exist where the coordination of care is carried out by a network of organisations or by a case manager. Also, the professional who initially referred the adolescent can stay responsible as a care provider until referral took place. In each case, the



coordination of care should be the duty of the caregivers who are involved – it should not be the task of the patient.

- Currently, legislation and funding systems are hindering integrated care and need to be updated.
- Coordination is not only about taking responsibility in care but also about knowing other professionals' services, roles and duties.

Shared information

- Continuity in care between primary and specialised mental health services is important. There is a demand for implementing a tracking or monitoring system to make sure that the transition between the levels of care occurs efficiently.
- There must be a direct communication link between mental health care givers and social services.
- In order to coordinate care, different services need to share necessary patient information. Hence, a common record file to share information between those who are involved is important. However, this file should be protected and it should be layered so only relevant information can be accessed. In addition, only information that is useful for the care of the adolescent should be registered.
- The permission of the person is required when sharing data files. Adolescents should be informed about the information flow.
- Data registration will increase the workload of GPs, wards, etc. It is an option to hire for example data nurses to enter all information so that the workload of GPs does not increase.
- Some ethical dilemmas with information sharing need to be resolved (e.g., with whom and when can information be shared?).
- Also, regulation and legislation should be updated. It is recommended to have an overview of all legislations in different countries and to examine what the problems and pitfalls are.
- It is important to include information about adolescents and their progress collected through various sources (e.g., parents, teachers).

3.6. Topic 6: Balanced care

- The adolescent and caregiver should decide together whether a more specialised level of care is needed. Hence, patient-centred care, shared-decision making and participation are important aspects.
- In some countries, referral to a more specialised level of care is regulated by outcomes on tools, diagnosis, etc. Such outcomes should be used in a flexible way. The decision to refer should be based on the opinion of the adolescent, his parents and the involved professionals and not solely rely on the output of a diagnostic tool. Also, the decision of referral should not be influenced by insurance companies.
- Psychiatrists should work more through outreaching in order to bring specialised knowledge to the community and to provide help in the natural environment of adolescents.
- It is important that all levels of care are available at all times. Now, only hospitals are open 7 days a week and 24 hours a day. Yet, community-mental health services must also offer support outside the normal working and school hours.
- There are community-based services on the one hand and home-based and residential services on the other hand. Yet, in some cases, the problems of adolescents are too severe for community-based services but not severe enough to become hospitalised. There is currently a lack of services that provide semi-residential support for some days or weeks.
- Social workers must offer prevention programmes in public places where young people spend their leisure time, for example prevention initiatives on drugs and alcohol in dance halls.

3.7. Topic 7: Prevention and mental health promotion

- Currently, there is a strong focus on secondary prevention or selective/indicated prevention. However, primary or universal prevention for everyone is also important (i.e., how to promote mental health in adolescents?). GP's, teachers, etc. should be involved in primary prevention strategies.
- Basic psycho-education to all adolescents can offer many advantages when adapted to the needs, habits and interests of adolescents.
- It is crucial that prevention and mental health promotion take place in the everyday life of adolescents, for example via schools, social networks, online games, etc.
- Each country should identify its vulnerable groups so that targeted prevention activities can be implemented. Researchers and professionals should not only focus on sport organisations or schools to identify vulnerable groups since they are less likely to frequent these.
- A lot of invisible risk behaviours exist (e.g., smoking or drinking too much, spending too much time on the internet, lack of movement or sleep) that need to be addressed. A study demonstrated that 60% of adolescents expose healthy behaviours, 10% expose overt risk behaviours, and almost 30% expose invisible risk behaviours.



- Adolescents can benefit from good social networks and role modelling (e.g., scouts, teachers, etc.).
- A difficult albeit important way to decrease the risk of mental health problems is to address inequalities in society.
- It is vital to encourage teachers to promote mental health by informing them about healthy life styles. However, teachers should not be overloaded by this, as they already have a lot of responsibilities. Moreover, not every teacher is interested in taking responsibility concerning mental health. Therefore, teachers should collaborate more with school nurses or the school psychologist.
- Bullying and truancy (i.e., when you are skipping school) occur repeatedly in certain schools and not at all in other schools. It seems to be related to the school culture. In schools where bullying occurs regularly, teachers are often not involved in what is happening with their students. Bullying can be prevented by introducing plans in schools on how to prevent and deal with bullying. Schools must act as communities that promote healthy behaviour and they need to create a good environment for adolescents with mental health problems.
- The resilience of adolescents should be strengthened to conquer problems like peer pressure, bullying, etc. Mediation or conflict programmes can be used to solve problems.
- School psychologists and school nurses should be active in the class room.
- Prevention and mental health promotion is a shared responsibility of the whole community. Parents play a central role in prevention as well. Concerning parents, services often focus only on the individual adolescent and forget to focus on the natural environment of the adolescent. Sometimes there are difficulties with parents who are also mentally ill. In those cases, treating adolescents alone is not sufficient.

3.8. Topic 8: Evaluation

- Quality of life (QOL) and symptom improvement should be measured regularly and at the same time. Research shows that QOL often increases quickly during treatment. But if symptoms do not improve, then QOL decreases again.
- Most of the time, there is a focus on quantity of services, but not on quality. Important indicators for quality of and satisfaction with services are waiting times and being good informed about the different treatment options.
- Adolescents should be directly asked about how they experienced treatment.
- Services that are able to make some progress or deliver good quality of care should be given incentives.
- The DSM IV “global assessment scale” is a very good instrument to evaluate an intervention. It can be rated quite easily by a 30 minute interview.
- The WHO has good recommendations on quality indicators which were used to develop the WHODAS (WHO Disability Assessment Schedule 2.0). The WHODAS is an instrument that



measures six domains of functioning (e.g., participation, cognition, mobility, etc. Both a 12 and a 36 item version of the questionnaire exists (<http://www.who.int/classifications/icf/whodasii/en/>).

- An important indicator for the quality of care is the ratio of adolescents who are in treatment and at the same time are completing their studies.
- For every service, it is important to do a cost-effectiveness analysis to study the relationship between resources and outcomes. In each cost-effectiveness study, the intensity and the duration of the treatment, the long term effects, and the scope of the treatment (e.g., expensive high level treatment that can reach 10 people versus a treatment that is a little less effective but that can reach 500 people) should be taken into account. Yet, there is little consistency on which measures are needed to conduct a cost-effectiveness analysis. In addition, outcomes are often not publicly available.
- A good scale to measure service quality is the Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOSCA). It is a short scale measuring the child's symptoms and social and physical functioning. The scale can be used to assess the needs of the child and to detect progress. (<https://www.rcpsych.ac.uk/pdf/HoNOSCA%20Glossary.pdf>).
- Often, instruments are not well-administered and data not well-processed. In the UK, a centre called "NICE" analyses data of different services. They bring together and share existing knowledge on health care aiming to support and advice regions in the development and improvement of care. They also develop guidelines and recommendations. Such a centre or a network of centres should be designed at a European level.
- Policies can be evaluated as well. An important indicator for a good policy at a national level is the extent to which framework agreements are made between different departments (justice, mental health, education, etc.). Such an overarching agreement facilitates collaboration.

4. Output workshop with end-users

In the sections below we summarise the results obtained during the three exercises:

- Seven statements on adolescent mental health care
- Good places and strategies to help young people who need help
- If I ruled the country

4.1. Exercise: Seven statements on adolescent mental health care

For the first exercise results are described for each of the seven statements separately. First, the number of adolescents and adults that agreed, disagreed or was undecided about the statement

is presented (table 13). Accordingly, the feedback provided by the adolescents and the adults is summarised point by point.

Table 14: Frequencies on each of the seven statements during the end-user workshop

Statements	Adolescents			Adults		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Statement 1: It is important to have mental health services where only young people between 12y and 24y have access to.	4	0	14	2	1	6
Statement 2: When a young person is feeling bad, he should be able to talk about this with persons in his natural environment such as a teacher or school nurse.	2	6	9	1	4	6
Statement 3: At school young people should get a class on mental health, so they learn how to deal with difficult situations and problems	0	3	14	0	3	8
Statement 4: When young people receive help, their parents must be involved in the care.	-	-	-	-	-	-
Statement 5: Under the age of 18, young people cannot decide for themselves which help they get	15	2	0	6	3	2
Statement 6: Online technologies like apps, websites, and chats will lead to more young people finding the help they need.	3	11	2	0	5	6
Statement 7: Young people who need help, often don't know where they can find help, don't look for help or refuse help.	0	6	10	1	3	6

Statement 1: It is important to have mental health services where only young people between 12y and 24y have access to.

Feedback provided by the adolescents:

- A 12-year old does not have the same needs than a 5-year old. Yet, they reside in the same service.
- Suddenly, when you become 18 years old, you are seen as an adult and you can be in the same service with someone who is 20 years old.
- I do not agree with the age boundaries. I went to a centre with open age boundaries. There were people between 18 and 30 years old. Even someone of 30 is actually still young.



- I agree that there should not be a strict age boundary at the age of 18. If you are 18, but you don't feel 18, you might benefit from contact with younger people. When you think of boys, they usually become mature later in life compared to girls. Thus, they may want to receive support in services where younger people reside, perhaps even 12-year-olds.
- I saw things done by older patients that I would better not have seen. When you are 12, you are too young to live with adult patients.
- Also kids of 8 years old should be welcome at a service. They often experience negative things from which they cannot escape. They can learn a lot from older children that experienced the same negative things.
- It can be very beneficial for people of the same age to meet each other. They are going through the same things in life. They learn to see that they are not the only ones that are facing problems.
- For services offering care to a specific age group (e.g., 16 to 18 years old) it is an advantage that they can offer very specialised care specifically adapted to that age group.
- Separate centres should exist for children between 5 and 10 years old and for adolescents until 24. These two groups have different needs.
- Adolescents and adults need different services. Since adolescents are changing a lot, they need a different type of support.
- Services do not have to be defined by age. There should be three types of services – one for children, one for adolescents, and one for adults – but with open age boundaries. The three age groups should not be linked to strict age boundaries, because this may inhibit someone to ask for help. With open age boundaries adolescents are not withhold to go to a service because they think they are too old or too young for that specific service.

Feedback provided by the adults:

- It is important to clarify what is meant by “services”. In case it refers to a psychiatrist, it is important to offer continuity of care. When an adolescent becomes 18 they are officially considered as an adult. Yet some 18-year-olds may want to visit the same psychiatrist that they visited in the years before. It is then better to wait until the person is older, let's say 24, to change to an adult psychiatrist. Either way, the patient should be able to make that decision – not the professional.
- Also people younger than 12 years old experience problems. Thus, adolescent services should provide care to young people from 9 to 24 years old.
- We meet youngsters between 10 and 20 years old. At 10 years, they are often more mature than others of that age due to the problems they encountered. Also, nowadays children become an adolescent more early in life. As a result of these facts, we help all people between 10 and 20 years old, but we also help those who are 8 or 22 when needed.



Statement 2: When a young person is feeling bad, he should be able to talk about this with persons in his natural environment such as a teacher or school nurse.

Feedback provided by the adolescents:

- It is important to have a choice in this. In primary school, I talked to a teacher about my problems. In high school, however, there were no teachers that I trusted. Hence, I went to a service.
- In Spain there is a psychologist at school which is a positive thing. Yet, they seem not well-trained.
- Teachers should also have a little knowledge on mental health issues. Some teachers give a wrong advice because of their lack of knowledge.
- Sometimes teachers do see that something is going wrong, talk to the student about it and refers him to a psychologist at school. This is a very good approach and helps to feel happy again.
- If I do not know the adult, I cannot trust him. It has to be someone who I can see regularly and who I feel comfortable with.
- Every adolescent should have the possibility to go to someone at school who has the ability to make a referral to a specialist. However, adolescents should not be obliged to go and see a school psychologist.
- Teachers are busy with teaching. Unintentionally, they can reject a student, making things worse.
- Teachers are not well-trained in mental health issues. They should be able to follow extra training in this domain. However, in a lot of countries schools have no budget to finance additional training.
- In some schools, when you talk to a teacher about your problems, they immediately refer you to another person, and this continues the whole time. Teachers should learn how to listen and how to refer properly.

Feedback provided by the adults:

- It does not always have to be a teacher. You can also trust someone in the community, for example a priest. Adolescents need to find someone who is trustworthy and accessible for them.
- When a teacher does not know how to react on a student with mental health problems, he should be able to go to a specialist working at the school for advice. That specialist can coach the teacher on how to talk to and support the adolescent.
- First, teachers should be trained on mental health issues in adolescents. Second, every school should have an open-door (counsellor, psychologists) where students are free to go to without feeling stigmatised.



- Teachers need to be trained and nurses need to be added to the school.
- Teacher should be able to recognise mental health issues in adolescents and refer them to a more specialised service – an open-house, where they can go to with all of their questions and that is far away from school.
- Teachers and nurses will never become specialists. They need to do what they are paid for: teaching. Hence, it is important to bring other services in the school and to organise interaction between the school and different mental health care services.

Statement 3: At school young people should get a class on mental health, so they learn how to deal with difficult situations and problems

Feedback provided by the adolescents:

- Nowadays, adolescents learn how their body works, but they do not learn how their mind works. Classes on mental health must be integrated in the curriculum to reduce stigma and misunderstandings.
- There should be a class on how to deal with difficult situations. Such a class will also help to reduce stigma.
- In a perfect world organising such classes are a positive thing. However, children can be really evil and bullying can become worse when you express your depressed feelings in the classroom.
- The more people know about mental health problems, the more intelligent they become. This may stop them from bullying others.
- Mental health classes are a good way to increase understanding of symptoms and to stimulate empathy. It is a way of offering additional information to peers.
- Mental health issues should be addressed in school rather than via out-scholar activities, because those adolescents who are most vulnerable often don't take part in out-scholar activities.

Feedback provided by the adults:

- In the UK, classes on mental health exist, but they are not liked.
- Classes on mental health for students suffering from mental health problems should be offered outside the school system.

Statement 4: When young people receive help, their parents must be involved in the care.

Feedback provided by the adolescents:

- Adolescents should receive help even if they don't want their parents to be involved. Parents can feel bad if they see that their child is having problems.
- Parents should meet the therapist in order to help their child.



- Parents should not know all the details about the problems of their child, but a little information should be offered to them. Otherwise, it would be hell for parents to see their child suffering without knowing what is going on.
- When the adolescent's condition is risky and action needs to be taken, parents should be involved as they need to decide for the adolescent then. However, when the situation is not risky, an agreement should be sought between the adolescent and the parents on the extent to which the parents will be involved in the treatment.

Feedback provided by the adults:

- If there is a problem, it is important that parents can receive support, but this must be done in open communication with the youngster. Adolescents should know what exactly is being told to their parents and what type of support they receive.
- In the beginning, it is important that adolescents are helped in a service without having to say their name.
- Often parents are part of the problem that adolescents encounter. Professionals should invite the parents and try to mediate, but the youngsters are the king or the queen – they should decide about this.
- When a professional provides psychotherapy to an adolescent, he or she should not treat the parents also.
- Services need to include a right's section: parents have the right to be involved in the care of their child; they are legally responsible, even if they are part of the problem.

Statement 5: Under the age of 18, young people cannot decide for themselves which help they get

Feedback provided by the adolescents:

- It is ridiculous to state that adolescents cannot decide for themselves when they are younger than 18. Suppose that you are 17 years and 11 months, this means that you cannot decide, but one month later, you suddenly do have the skills??!!
- It depends on your level of maturity. Everyone develops at a different rate.
- If you are at risk, other people should decide in your place because at that moment you are not able to do this for yourself anymore.

Feedback provided by the adults:

- If I am in a crisis, I know that I cannot decide for myself.
- Some adolescents are mature more early than others. It is an option to let a professional decide whether an adolescent is mature enough to decide for himself.



Statement 6: Online technologies like apps, websites, and chats will lead to more young people finding the help they need.

Feedback provided by the adolescents:

- Some websites and apps are not trustful. It is up to the adolescent to find a trustworthy website. There are websites with horrible pictures of people hurting themselves and many adolescents do not want to suddenly open such a website when they are already feeling bad.
- For adolescents who feel ashamed about their problems, it is good that they can anonymously visit websites.
- Websites and apps are not good. It is not possible to work in a personally adapted way.
- Doctors providing treatment via the internet are not familiar with your specific situation.
- Many adolescents do not even know about the existence of such apps or websites.
- Websites and apps may be good tools. You can for example link it to teachers so they can have additional information about the adolescent's mental health problems.
- Concerning chats, there may be an overload of people on the chat that precludes you from getting an answer on your questions. If adolescents need to wait, they become discouraged and feel that they are being put aside.

Feedback provided by the adults:

- Some services do have a chat function on their website. Many adolescents like to anonymously chat with professionals or volunteers. Often, after a chat session, they decide to bring a visit to the centre and agree with a treatment.

Statement 7: Young people, who need help, often don't know where they can find help, don't look for help or refuse help.

Feedback provided by the adolescents:

- Adolescents are often too scared to ask for help as they do not know what that will entail (e.g., confidentiality, stigma, shame, etc.).
- It is true that adolescents do not always say to their parents what they feel.
- Since everyone is different, each person should receive a specific treatment.
- Adolescents often do not find help. Yet, only a minority will really refuse help. When in distress, most cry out for help, but this is done via friends, websites and thus may not be picked up by adults.
- Adolescents are often in a very bad condition when they receive help, especially when they refused help in the past. So we must focus on preventing problems or on intervening in an early stage.

Feedback provided by the adults:



- Young people always search for help, but they may not ask for it very clearly in the eyes of adults. If they are not helped, their problems may further increase.
- Close relatives do not always understand the problems that adolescents experience. This makes the adolescent feel alone.
- Often adolescents that refuse help didn't receive any help earlier or were ill-treated in the past.
- Problematic behaviour (e.g., misuse of marihuana) is often seen as the problem, while it is often a form of self-medication. Youngsters start using it because they are feeling bad or don't see a way out.
- Some adolescents have the feeling that they don't belong in this world. They believe it is already too late for them to receive help. Professionals should be truly convinced that the adolescent can have a promising future and convey this belief to adolescents.

4.2. Exercise: Good places and strategies to help young people who need help

Question: What are the most important places for young people to find help for mental health problems?

Reactions group 1:

- Young people need to know where they can go to when help is needed. More awareness should be raised on the existing services using leaflets, posters in schools, etc. If you are not a professional who is familiar with the jargon, it is difficult to find help.
- Services need attractive decoration and a friendly staff.
- Good websites exist, but they are hard to find.
- Youngsters must have a voice in shaping services.
- Specific strategies must be worked out so that young people find and attend services. Both self-referral and referral by parents or teachers should be possible.

Reactions group 2:

- The centre should be accessible for a broad range of questions in different areas. Otherwise people who see you go to that service know that you have a mental health problem.
- The place must be free of charge.
- It should not look like a hospital – it must feel like a home.

Reactions group 3:

- Different places should be available providing different levels of care.



- You should not have to change your therapist if you change to another place.
- We need different specialised centres as people with an eating disorder are not having the same problems as someone with an emotional disorder.
- Often there are long waiting lists for specialised care services treating adolescents with eating problems. While you are on the waiting list, they put you in a place that cannot provide you with the right care and where adolescents with other problems reside. Although you can talk about your eating problems there, only specialised services can really help you to eat again.
- You should be able to live at home while receiving help.
- Strategies to use:
 - Schools must be aware of the help that exist
 - Personalised treatment
 - Shared-decision making
 - The right to change your therapist
 - No waiting lists
- Prevention is very important. A good prevention strategy is training teachers in mental health issues and the existing services, so they have the necessary skills to recognise when an adolescent is experiencing problems and to send that adolescent immediately to the most appropriate centre. This way, problems can be treated in an early stage before they escalate. In the end, many problems and also the long waiting lists will decrease.

Reactions group 4:

- Internet is a useful tool, but adolescents should be supported by a professional in interpreting the information that is provided on the internet. Otherwise, adolescents might believe they have schizophrenia simply because they show a few similar symptoms.
- It is easy to formulate ideas and strategies, but implementing them is very difficult.
- Pictures are sometimes better to describe emotions.
- Mental health care is very generic, but mental health problems and people with mental health problems are all very different. Everybody needs other things.
- Motivation is often lost due to long waiting lists.
- Most cannot shape the service they are in and feel excluded.

4.3. Exercise: If I ruled the country

Reactions group 1:

- Schools should put less pressure on adolescents. Education is important, but feeling good is equally important.
- Attitudes towards adolescents should become more positive.



- There should be enough attention for environmental issues. Healthier seas and living conditions will have a positive impact on mental health.
- Citizens need to be interconnected more – they should share things and help each other out. Important values such as loyalty and real friendship seem to disappear.
- When you have mental health problems you get tagged in a negative way. Stigma should be addressed.
- Prevention of mental health problems is very important. In addition, prevention is less expensive than treating problems.
- Minor mental health problems in adolescents should not be seen as a disease that requires specialised mental health care.
- It is very important to have some continuity in care. It's beneficial if an adolescent is treated by one psychotherapist with whom he has a good working alliance. When adolescents are transferred to another service, it should be possible that they are being treated further by that same psychotherapist.
- It's important to build bridges between the therapy setting and "the real world" (the home situation). When hospitalised, professionals should support adolescents to go back to normal life. The normal life is the life where the problems arose, so the home situation should be addressed as well.

Reactions group 2:

- Young people should be actively involved when decisions about services or care are being made: nothing should be decided about us without us.
- Professionals should trust their patients more.
- Services need to be flexible – when, where and how should depend the needs of the adolescents.
- Early intervention and prevention should be stimulated by making mental health care more accessible. This can be realised for example by offering low-level support, when services are working together in order to provide the right support or when adolescents are brought into contact with other adolescents who experienced the same problems.
- Media often portray people with mental health problems as negative – for example as violent or dangerous.

Reactions group 3:

- Investing only 6% in mental health care is too little. It is important to invest in the best treatment form and not in the easiest or cheapest form. A good treatment is generally a treatment that includes as little medication as possible.
- Prevention should receive more attention.



- There should be more places that are especially designed for adolescents with mental health problems. Characteristics of these places are:
 - They are open and welcoming
 - They are atmospheric – not too clean
 - Youngsters were involved when designing them
 - Everybody has respect for each other, for the building, and for themselves
 - There is honesty
 - There is confidentiality
 - Professionals are passionate – this has a positive effect on the therapy outcomes (sometimes it is perceived as if caregivers are just doing their job)
 - Support is offered at places where youngsters are (clubs, bars, skate parks, etc.)
 - There are different rooms with different functions (quiet places, place where you can do wild things, etc.)
 - There are male and female professionals
 - There is no stigma
- There should be more youth centres. Each centre should have an open door so adolescents can choose freely whether they want to go to the centre or not.
- More jobs for youngsters should be created to help them integrate into society.
- Adolescents that emigrated from another country after years of living there should be treated with more respect and should receive more support.
- Discrimination should be penalised.

Reactions group 4:

- There is a lot of pressure on youngsters to have a hobby, an income, a driving license, good grades, friends, etc. This is too much, not everyone wants to have all of those things or needs them.
- Although some adolescents need care till they are 24 years old, sometimes public funding of care stops at the age 18 and therapy has to be terminated then due to high costs.
- Support groups that work with volunteers who are much more passionate are sometimes better than care that is provided by professionals. However, inadequate funding limits volunteer work.
- It is important to offer follow-up care. Sometimes the number of provided treatment sessions is not enough. Some people need more help.
- Flexibility is important. If someone is feeling depressed or anxious, it can be important that the professional works outreaching and provides treatment at home.
- Meditation, hypnosis, Indian head massage, etc. should also be offered free of charge to those who do not (yet) want to go in therapy.
- Treatment is more expensive than prevention. When societies do not invest in prevention, many people will continue to need treatment. This creates long waiting lists. When things are



going bad and they put you on a waiting list, you may feel rejected and unimportant, which makes things worse.

- The media sometimes glamorise self-destructive behaviour. Governments should restrict that.
- The media are powerful – it's important to work with the media to shed a more positive light on mental health problems and to break the stigma.
- The social network has a negative effect on young people. Everybody seems to have a spectacular life according to their posts on Facebook. This puts a high pressure on adolescents.
- Passionate workers obtain better therapy outcomes.
- When new healthcare workers are being recruited, the opinion of service users should be taken into account.
- Older therapists need to evolve in order to overcome the generation gap between them and their younger clients.
- New issues such as transgender problems are often not well known or respected.
- It's important to invest in the best treatment instead of in the cheapest or easiest treatment.

4.4. Additional comments

- It is important to increase knowledge concerning mental health.
- Breaking stigma is important, but it is also important to be aware of self-stigma!
- Isolation should be addressed. One of the causes of isolation is that isolated groups are often not listened to.
- A patient is neither a clinical case nor pathology. Patients are persons! We are not our illness!
- Sometimes parents are the reason why adolescents are not searching for help. Some parents do not allow their children to show "signs of weakness" (i.e., mental health problems). Other adolescents do not want their parents to know that they are suffering.
- Adolescents should have a voice in their own care, so that each person is treated in an individually adapted way.
- It's important to raise awareness on where adolescents can find the help they need (e.g., leaflets in places where adolescents come). Also, good websites are hard to find.
- Acute interventions should be kept as short as possible and focus on getting the patient home as soon as possible.

Chapter 6

Answering the research questions

In this chapter we aim to formulate an answer to the research questions that were asked in chapter 1. The answers are based on the information gathered throughout the ADOCARE research activities and the literature study. Information that is derived from the ADOCARE research activities (e.g., first high level conference, surveys, and workshops) is marked with an asterisk (*). References are included for information that originates from other sources or studies. Within the chapter we regularly use verbatim quotes coming from other scientific publications. Such quotations are presented in italics.

Eight topics are focused on in this chapter:

- The current state of mental health and mental health problems among adolescents in Europe
- Types and availability of mental health care services for adolescents
- Quality of mental health care services for adolescents
- Focusing on adolescent mental health in the school setting
- Integrated care
- Policies and legislation on adolescent mental health
- Epidemiological research
- Prevention and mental health promotion

Each section is further divided into a number of specific research questions.

1. Current state of mental health and mental health problems among adolescents in Europe

In the current section we provide an answer to the following research questions:

- What is the overall state of adolescent mental health in Europe?
- What data on adolescent mental health exist in the ADOCARE member states?
- How do mental health problems develop?
- What are vulnerable groups in Europe?
- What problems with new technologies are encountered in adolescents?
- What other problems are encountered in adolescents today?

1.1. What is the overall state of adolescent mental health in Europe?

A recent literature study reviewing 19 epidemiological studies across 12 countries on young people's mental health shows no worsening of mental health symptoms in recent cohorts of children and toddlers compared to earlier cohorts (Bor, Dean, Najman, & Hayatbakhsh, 2014). For adolescents, the findings are mixed. The burden of externalising problems appears to be stable. However, internalising problems seem to increase – especially among girls. This latter finding can be linked to factors such as girls being exposed earlier to sexualisation, experiencing increased pressure of educational and personal successes, and being subject to changing media and cultural expectations (Bor et al., 2014; Carli et al., 2014). Thus, there is a partial increase in the incidence of mental health problems in adolescents. This is in part due to the fact that the recognition of mental health problems among adolescents has increased (Bor et al., 2014).

These results do not imply that the state of mental health among adolescents is good. Globally, at least one in four to five adolescents suffer from at least one mental disorder in any given year. For Europe, it is estimated that 8 to 23% of children and adolescents has a mental health disorder (Patel et al., 2007; Suhrcke, Pillas, & Selai, 2008). The most common disorders in adolescents are (Kessler et al., 2007a; Kessler et al., 2007b; Paus, Keshavan, & Giedd, 2008): anxiety disorders (31.9%), behavioural disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%).

In many adults with a mental disorder, problems started in childhood or adolescence, mostly between 12 to 24 years (Paus et al., 2008). Half of the people, who meet the criteria for a major DSM-IV diagnosis at the age of 26, had a first diagnosis between 11 and 15 years. Almost 75% of them had a first diagnosis before the age of 18 (De Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). Of all psychiatric disorders, those that have their onset in childhood or adolescence tend to be more severe. Therefore, it is crucial to recognise mental health problems in an early phase so treatment can be initiated before problems start to escalate (De Girolamo et al., 2012).

Not only are mental health problems common among adolescents, but also the burden of disease is high. Adolescents experience mental disorders as the highest accountant of Disability-Adjusted-Life-Years (DALYs) of non-fatal diseases (Kraus, Stronski, & Michaud, 2003; Sawyer et al., 2012). In addition, mental health problems do not only affect adolescents, they also affect their surrounding and the country's economy (Sawyer et al., 2012). For example, costs resulting from antisocial behaviour posed in childhood till adulthood are 10 times higher if someone was seriously antisocial during childhood (Scott, Knapp, Henderson, & Maughan, 2001). Conversely, someone's economic situation has a significant impact on his or her state of well-being. As argued by Fanjul (2014), the economic recession causes feelings of insecurity and stress, making people more prone to develop mental health problems (Fanjul, 2014).

These results indicate that adolescent mental illness can have a huge continuing burden over the whole life course of a person. Therefore, it is important to tackle problems as soon as possible.



Yet, studies show that adolescents and young adults with a psychiatric disorder often fail to receive treatment or do not receive adequate care (Farmer, Burns, Phillips, Angold, & Costello, 2003; Horwitz, Gary, Briggs-Gowan, & Carter, 2003; Leslie, Rosenheck, & Horwitz, 2001 in Copeland et al., 2015). In one study, only half of adolescents meeting DSM-IV diagnostic criteria received some treatment in the past three months. In young adulthood, only one in three receives a treatment (Copeland et al., 2015). This low access to mental health care can be due to (anticipated) stigma, lack of parental support, structural and cultural flaws within the existing care systems, and the failure of society to recognise the importance of adolescent mental health and accordingly to invest money in adolescent mental health care (McGorry, Goldstone, Parker, Rickwood, & Hickie, 2014). In addition, not all adolescents are keen to seek mental health care and thus show poor help-seeking behaviour (Breland et al., 2014)

However, there is reason for optimism. When episodes of adolescent mental disorders are kept brief, they often confine to the teenage years, with further reduction of symptoms in the late 20s. Hence, providing a proper treatment during adolescence, can prevent morbidity later in life (Patton et al., 2014). Shortening episodes also has an indirect impact on other aspects in future life. When adolescents are adequately helped, chances of educational underachievement are reduced and thus employment outcomes become more positive (van Batenburg-Eddes & Jolles, 2013).

1.2. What data on adolescent mental health exist in the participating states?

Within the ADOCARE research, we asked policy makers about recent existing data on the prevalence of adolescent mental health problems in their country. Although most countries have administrative data and national statistics on adolescent mental health, in only half of the countries (Finland, Germany, Italy, Sweden, and the UK) these data are analysed and thus can be used to get a clear image on the mental well-being and the needs of adolescents. Reasons for not processing these data are diverse: they are scattered across different data systems, representatives have no knowledge of the existence of these data, there are no financial resources to process the data or there is no research institute assigned to process the data.

During the first high level conference, it was argued by professionals, experts and policy makers that not all countries should invest in the collection of prevalence data, since data are quite similar across countries. Some countries already have research centres or organisations that engage in gathering prevalence data. It is important that these centres are linked to each other and constitute an EU network so that research can be upgraded and data can be shared.

Apart from data on mental health problems, data on other issues should be collected. For example, rates on suicide and suicide attempts, teen pregnancy, sexual abuse, traumatic events, violence, and aggression. These data are often collected by various sectors (e.g., justice, health,



etc.) and thus it requires collaboration to obtain these data. Other essential information is data on protective factors (e.g., family support, well-being, religion, etc.).

1.3. How do mental health problems develop?

Aetiological studies in adolescents show that mental health problems are associated with diverse types of risk factors: biological, psychological, social, school-related, and community-related risk factors (table 14) (Patel et al., 2007, p. 1304). Children or adolescents can be confronted with one or multiple of these and other risks. In that case, one often speaks of adverse childhood experiences (ACE's)⁷. ACE's are diverse and comprise for example bullying, parental mental health problems, and sexual or other abuse. ACE's are linked to negative health outcomes in adulthood such as substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality (Centres for Disease Control and Prevention, 2010; Kalmakis & Chandler, 2015). Especially when four or more ACE's (the threshold value) are experienced, the likelihood of adverse health outcomes increases (Dong, Anda, Dube, Giles, & Felitti, 2003). In addition, several studies report a correlation between ACE's and suicidal ideation or attempts (Kalmakis & Chandler, 2015).

In adults, around 63% has one or no ACE's whereas 15% has more than four ACE's (Centres for Disease Control and Prevention, 2010). The most common ACE's are in descending prevalence: a substance-abusing household member (29%), parents being separated/divorced (27%), verbal abuse (26%), and a mentally ill household member (19%). In an adolescent inpatient group suffering of severe mental health problems, approximately 22% has at least four different ACE's. By contrast, within a regular group of adolescents only 2% reports four or more ACE's (Ryttilä-Manninen et al., 2014).

The link between ACE's and health outcomes is influenced by the accumulation of ACE's, the severity of ACE's, and the time of occurrence. First, a cumulative effect of ACE on health exists: the more ACE's a child experiences, the greater the effect on health and behaviour. Second, certain forms of ACE's have a greater influence on adult health outcomes. Parental mental illness, physical, sexual and emotional abuse, and witnessing violence at home are found to have a larger impact. Third, the time at which ACE's occur has a significant effect on the health outcomes (Kalmakis & Chandler, 2015). Abuse that occurred in adolescence is a more important risk factor

⁷ ACE's can be measured using online tools such as on <http://acestoohigh.com/got-your-ace-score/> or <http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean>.

for early initiation of smoking among girls than abuse in early childhood, (Kalmakis & Chandler, 2015).

Table 15: Risk factors for adolescent mental health (non-exhaustive), retrieved from Patel et al. (2007, p. 1304).

Domain	Risk factors
Biological	Exposure to toxins (e.g., tobacco, alcohol) in pregnancy Genetic tendency to psychiatric disorder Head trauma Hypoxia at birth and other birth complications HIV infection Malnutrition Substance abuse Other illnesses
Psychological	Learning disorders Maladaptive personality traits Sexual, physical, emotional abuse and neglect Difficult temperament
Social Family	Inconsistent care-giving Family conflict Poor family discipline Poor family management Death of a family member
School	Academic failure Failure of schools to provide appropriate environment to support attendance and learning Inadequate or inappropriate provision of education Bullying
Community	Transitions (e.g, urbanisation) Community disorganisation Discrimination and marginalisation Exposure to violence

In conclusion, professionals should question their patients about possible ACE's so that important risk factors are not overlooked (Kalmakis & Chandler, 2015). When done in a supporting environment, asking about ACE's can even facilitate disclosure. When ACE's are identified, appropriate support should be offered to youngsters with low threshold symptoms. Only then, support can be offered before problems start to escalate (Rytilä-Manninen et al., 2014). In addition, professionals should stimulate social support: support from friends protects adolescents against internalising disorders while support from family protects them against externalising disorders (Rytilä-Manninen et al., 2014). According to recent findings, a lack of social support is linked with more severe mental health problems (Kalmakis & Chandler, 2015).

1.4. What are vulnerable groups in Europe?

During the ADOCARE research it was stated that invisible high risk groups; Roma children and adolescents; adolescent refugees; lesbian, gay, bi, transgender, and questioning youth (LGBTQ); and pregnant teens are vulnerable groups that deserve extra attention.

Invisible high risk groups

A recent European study on risk behaviours in adolescents shows that many problem behaviours remain invisible (Carli et al., 2014). Generally, adolescent pupils can be subdivided in three groups: a (very) low risk group (57.8%), a high-risk group (13.2%), and an invisible risk group (29%). The invisible risk group shows high use of internet/TV/videogames for reasons not related to school or work, conducts a lot of sedentary behaviour, and exhibits reduced sleep. Moreover, they show a similar prevalence of suicidal thoughts, anxiety, and depression than the high-risk group. Hence, the invisible group is an important target group for interventions aiming to reduce psychopathology in adolescence (Carli et al., 2014).

Roma children and adolescents

Regarding Roma children and adolescents there is an overall lack of studies on the mental health needs of this minority group (Horsley & Hollingworth, 2014). The few studies that do exist, show that their mental health is worse compared to for example a matched comparison group of urban deprived residents (Horsley & Hollingworth, 2014; Van Cleemput & Parry, 2001). A study conducted in children shows that Roma children report more mental health problems (e.g., phobias, separation anxiety disorders, major depressive disorder, oppositional defiant disorder, ADHD, and conduct disorder) compared to their non-Roma counterparts (Lee et al., 2014). Moreover, they are faced with poverty and they regularly experience stigma and discrimination (Lee et al., 2014).

Adolescent refugees

Regarding refugees, there is a growing number of unaccompanied refugee minors in Europe (Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). Compared to indigenous white children (15%) and ethnic minority children (9%), refugee children (27%) have more clinically significant mental health problems (Fazel & Stein, 2003). Refugee and asylum-seeking children are exposed more often to traumatic and adverse childhood experiences, and daily stressors which results in more cases of depression, anxiety, and posttraumatic stress disorder (Vervliet et al., 2014). For these children, access to support is difficult to achieve due to linguistic difficulties and a lack of understanding about mental health services. An important role is set aside for stable settlement, social support in the host country and the school environment (Fazel, Reed, Panter-Brick, & Stein, 2012). School-based mental health services can address some of the reported barriers (Fazel, 2015).

Lesbian, gay, bi, transgender, and questioning youth (LGBTQ)

Studies show that youth with concerns regarding their sexual orientation face a difficult time during their school years. They report a higher prevalence of physical (40% vs. 8%) and sexual assault (16% vs. 1%) compared to students without concerns regarding their sexual orientation (Cotter et al., 2014). Moreover, 82% of students are verbally harassed due to their sexual



orientation and school staff is often unwilling to respond properly to these harassments (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012).

As a result of the stress, victimisation, isolation, and marginalisation that LGBTQ youth encounter, they are disproportionately more exposed to preventable health risks (Catallozzi & Rudy, 2004). LGBTQ students report an increased prevalence of attempted suicide (29% vs. 2%) and substance misuse (Cotter et al., 2014). Although professional support can be beneficial, LGBTQ youth find it difficult to ask for help, and to articulate emotional distress (McDermott, 2014).

Hence, professionals should be properly trained to question and support sexual minority groups. Mental health professionals and school staff need to understand what social and other difficulties LGBTQ youth may experience (Catallozzi & Rudy, 2004). Professionals must be especially attentive for possible disruptions in important social/interpersonal relationships as the broader social environment and the familial context have an impact on mental well-being of LGBTQ youth (Starks, Newcomb, & Mustanski, 2015). A recent study shows that mental health in later adolescence and young adulthood among sexual minority youth is associated with the security of attachment to peers and parents in earlier adolescence (Starks et al., 2015).

Pregnant teenagers

The ADOCARE network regularly mentioned that some European countries have high rates of teen pregnancies. Within Western Europe, the UK has the highest teen pregnancy rates: 19.7 births per 1,000 women aged between 15 and 19 years (Eurostat data, compiled by the Office for National Statistics of the UK). Teen mothers often face a number of environmental and psychosocial stressors (Hodgkinson et al., 2014). They are more likely to be poor, to live in a low-income community, to have parents with low educational and low employment achievements, to be abused during childhood, to reside in chaotic home environments, and to have limited social support networks. These adverse living circumstances may have a negative impact on their mental health. Research confirms that adolescent motherhood is often accompanied by a whole range of adverse mental health outcomes such as depression, substance abuse, and posttraumatic stress disorders. Negative maternal health outcomes in turn may negatively affect the well-being of their child (Hodgkinson et al., 2014). Hence, teenage mothers are in some European countries a vulnerable group requiring additional support.

1.5. What problems with new technologies are encountered in adolescents?

The European Parliament is explicitly interested in the topic of “new technologies”. Therefore, we questioned professionals of the ADOCARE network which problems with new technologies they encounter in their daily practice: addiction to new media, cyberbullying, and sexting. We briefly describe the mentioned problems supplemented with findings from the literature.



Internet use, gaming and mobile phone use

Addiction to new media refers to excessive use of video or online games, smart phone, social networks, TV, internet, etc. Professionals of the ADOCARE network report that addiction often leads to severe social withdrawal and is related to obsessive and compulsive problems and an inversion of the sleeping rhythm.*

The following research findings are reported concerning internet addiction and pathological internet use:

- A U-shaped relationship exists between intensity of internet use and adolescents' mental health: both no (or little) and heavy internet users are at increased risk for poorer mental health (Bélanger, Akre, Berchtold, & Michaud, 2011).
- Sadness and depression, boredom, and stress are triggers of intensive internet use (Bélanger et al., 2011).
- Heavy internet use increases the risk for many negative problems such as somatic health complications, sleep deprivation, educational under-achievement, and failure to engage in face-to-face social activities (Bélanger et al., 2011; Li, O'Brien, Snyder, & Howard, 2015). These problems are caused directly by excessive internet use and indirectly by sleep deprivation which is one of the main consequences of excessive internet use (Do, Shin, Bautista, & Foo, 2013; Lam, 2014).
- The SEYLE study, performed in schools of 12 EU countries demonstrates that 13.5% of adolescents show maladaptive internet use (MIU) and 4.4% show problematic internet use (PIU) (SEYLE, 2015). Overall, female students have a slightly higher prevalence of MIU, while males report a significantly higher prevalence of PIU. Female problematic internet use is correlated with conduct problems and hyperactivity/inattention. For males, there is an association between PIU and symptoms of depression, anxiety and peer relationship problems. PIU is also strongly related to psychopathology and suicidal behaviours. However, this association is influenced by socio-cultural factors such as gender and country.
- Adolescents are vulnerable to misuse of internet. Luckily, they are also susceptible to detection and prevention in the early stages of internet-related disorders. Therefore, children and youngsters should be helped to cope with the challenges of internet (Fontalba-Navas et al., 2015; Kaess et al., 2014b).
- Addictive gaming (particularly massively multi-player online role-playing games) and the use of other electronic media (e.g., smart phones) are associated with sleep problems which in turn are related to depressive symptoms (Lam, 2014; Lemola, Perkinson-Gloor, Brand, Dewald-Kaufmann, & Grob, 2014).
- Access to a mobile phone, and the frequency and intensity of its use are associated with health compromising behaviours (e.g., alcohol use and smoking) (Leena, Tomi, & Arja, 2005). The median number of texts sent and received by young American adults (18-25y) is 46-60 per day. About 1 in 6 young adults send or receive more than 120 texts per day.

Cyberbullying

Cyberbullying is frequently mentioned as a problem by ADOCARE professionals from Spain, Belgium, Finland, Sweden, and Germany.* Cyberbullying is defined as *“being cruel to others by sending or posting harmful material or engaging in other forms of social aggression using the internet or other digital technologies”* (Willard, 2007, p. 265). Incidences vary across studies but has been shown to be a common experience for many young people (Willard, 2007). The average of students that has been victimised online once varies between 20 to 40% (Tokunaga, 2010). Moreover, 58% does not mention their experience with cyberbullying to parents or other adults (Keith & Martin, 2005).

Today several valuable practices exist to address cyberbullying. Examples are the project “Delete Cyberbullying”, the Cybersmile Foundation, and the website “bullying and cyber”.

Delete Cyberbullying – an interactive app full of resources on cyberbullying

The DeleteCyberbullying app is an interactive quiz on cyberbullying for teenagers, parents and teachers that provides customised feedback based on the responses to the quiz. The aim is to redirect persons to the most relevant information sources, material or to relay those who are experiencing cyberbullying to the call centre.

Other features of the app include:

- An integrated awareness raising video about cyberbullying
- A “one touch” help button for direct assistance
- Information about the project and a “What’s New” section

The app is developed with funding of the European Commission (Daphne III programme) and available in several languages: English, French, German, Spanish, Finnish, Hungarian, Bulgarian, Dutch, Croatian, Greek, Swedish, and Danish.

A manual for teachers is also available including a set of activities or lessons on specific issues related to cyberbullying. The activities or lessons are modular and can be used independently in order to shape the overall lesson in class according to the interests, comments and questions of students.

More information can be found on the website: www.deletocyberbullying.eu

The Cybersmile Foundation – a help centre with online educational programmes to tackle all forms of digital abuse and online bullying

The Cybersmile Foundation is an anti-cyber bullying non-profit organisation committed to tackle all forms of digital abuse and online bullying. The organisation provides two types of

services:

- There is a help centre providing information, advice and support to young people, their parents and other adults (teachers) concerning many different new phenomena such as cyberbullying, cyber self-harm, doxing, gaming, netiquette, sexting swatting, etc.
- There are online educational programmes for young persons, parents, and educators to combat the growing threat of cyberbullying and to create a much safer, more enjoyable digital environment for all. The workshops consist of several downloadable exercises.

More information can be found on the website: www.cybersmile.org

Bullying and cyber – a website with practical tips on how to prevent cyberbullying

The website www.cyberandbullying.net contains advice and practical tips for parents and teachers on:

- How to protect children and adolescents against the risks of new technologies
- How to prevent cyberbullying
- How to recognise warning signs
- How to support victims of cyberbullying

The website is hosted by a research team that conducted in the past decade several European projects to fight and prevent bullying and cyberbullying with funding of the European Commission Justice.

Sexting

Sexting is defined as “the act of sending sexually explicit or suggestive photographs via text message” (Benotsch, Snipes, Martin, & Bull, 2013, p.2). A major survey conducted in 11 to 16-years-old in 20 European countries (EU Kids Online) shows that 15% of adolescents saw or received sexual messages on the internet in the 12 months preceding the survey. In addition, 3% reported to have sent or posted such messages themselves (Livingstone & Görzig, 2012). The prevalence of sexting is especially high in the Czech Republic ($\pm 10\%$) and Sweden ($\pm 11.5\%$). Country characteristics like GDP and broadband internet penetration (i.e., percentage of a country’s population that is subscribed to the internet) have no direct effect on adolescent sexting (Baumgartner, Sumter, Peter, Valkenburg, & Livingstone, 2014). On the individual level, factors such as age, sensation seeking, and frequency of internet use predict sexting (Baumgartner et al., 2014).

Little or no gender differences exist concerning sexting: 1 to 5% boys between 11 and 16 years versus 1 to 4% girls engage in sexting (Baumgartner et al., 2014). In a study of older US adolescents (18-25 years) 43.8% males versus 44.7% females report sexting (Benotsch et al.,



2013). In more traditional countries, some gender differences are reported with boys being more engaged in sexting than girls (Baumgartner et al., 2014).

For many adolescents, sexting is a way to attract attention and to prove that they are involved in a relationship (Pellai et al., 2015). Usually, sexting does not have any consequence. In only 4% of the cases, malicious behaviour such as sexting for money or threatening someone has been reported (Pellai et al., 2015). In the past decades, however, reports of online harassment start to increase, often involving young women (Pellai et al., 2015).

1.6. What other problems are encountered in adolescents today?

Other problems that are encountered by professionals of the ADOCARE network among adolescents are: crashing (situations in which adolescents feel anxious due to high levels of perceived stress), binge drinking, gambling (poker or sports betting), virtual relationships (building and maintaining relationships online), social exclusion, and the experience of a generational gap in second-generation immigrants (a lack of common goals, understanding and support between parents and their children).

2. Types and availability of mental health care services for adolescents

In the current section we formulate an answer to the following research questions:

- How is adolescent mental health care organised in Europe?
- What is the availability of adolescent mental health care services in the participating states?
- How to improve the availability of adolescent mental health care services?

Availability is defined here as *“having acceptable services and supports in sufficient range and capacity to meet the needs of the target populations”* (Inniss et al., 2009).

2.1. How is adolescent mental health care organised in Europe?

The organisation of child and adolescent mental health care is very heterogeneous across EU member states (Remschmidt & Belfer, 2005). Overall, the following five conclusions can be drawn with respect to adolescent mental health care in Europe (Remschmidt & Belfer, 2005):

- Apart from traditional inpatient services, outpatient services, day patient facilities, and community-based services can be distinguished (see Table 15).
- There is a tendency to implement specialised services but only for certain disorders. In these services, highly qualified personnel and effective and efficient treatment is provided.

- A growing number of services and treatments are evaluated. Therefore, indicators are being developed. Yet, more progress is required.
- The prevalence of private psychiatric practices for children and adolescents strongly depends on country and local circumstances.
- Although collaboration is increasing, coordination of different services remains insufficient and more integrated care is required.

Table 16: Types of adolescent mental health services in Europe (Remschmidt & Belfer, 2005, p. 149)

Inpatient services	Inpatient services at university hospitals Inpatient services at psychiatric state hospitals Inpatient services at general community hospitals or paediatric hospitals
Outpatient services	Child and adolescent psychiatrists in private practice Analytical child and adolescent psychotherapists in private practice Outpatient departments at hospitals Child psychiatric services at public health agencies Child guidance clinics and family counselling services Early intervention centres, social paediatric services
Day patient services	Day patient clinics (two types: integrated into inpatient settings or independent) Night clinic treatment facilities
Community-based complementary services	Rehabilitation services for special groups (e.g., children with severe head injuries, epilepsy) Different types of residences Residential groups for adolescents

2.2. What is the availability of adolescent mental health care services in the participating states?

When improving the provision of care within a country, it is crucial to have a clear picture of the available and missing services. However, most countries are poorly aware of the available mental health care services and initiatives for adolescents*.

Throughout the ADOCARE research, we asked experts of the network to estimate on a 5-point Likert-scale the availability (1=very poor and 5= very good) of the following four types of mental health care services for adolescents in their country:

- Residential care services (hospital and non-hospital)
- Day care services
- Home-based services and outreaching care
- Outpatient ambulatory care

In addition, we asked experts to indicate whether mental health care services exclusively for adolescents are available in their country.



The results show that except for Hungary and Lithuania, all participating member states do have mental health care services treating only adolescents. Nevertheless, European professionals report a lack of mental health care facilities specifically dedicated to adolescents*. In many countries, facilities are oriented towards either children or adults, with only few services attending to adolescents. Moreover, within a country the availability of adolescent mental health care services varies widely across regions: in some regions the demand and the availability of care are quite in balance whereas in other regions the demand for care exceeds the availability. Overall, the availability of each of the four types of mental health care services for adolescents is in most countries rated to be poor, very poor, in between or unclear (see table 5 in chapter 2). Only in Finland, the availability of the four types of services is rated to be good. Hence, European member states still have a long way to go (Remschmidt & Belfer, 2005).

2.3. How to improve the availability of adolescent mental health care services?

The availability of adolescent mental health care can be improved by:

- Applying the principles of balanced care
- Estimating the magnitude of the treatment gap
- Stimulating treatment in primary care
- Building more mental health care services for adolescents only

Balanced care

Within a comprehensive mental health system, different types of mental health facilities should be available so that each person is able to receive the type of care that matches with his preferences and needs (Thornicroft & Tansella, 2013b; Thornicroft & Tansella, 2004). The following types of services are necessary:

- **Primary health care** to treat people with more common mental health problems. These services conduct case finding and assessment, brief talking and psychosocial treatments, and pharmacological treatment.
- **General mental health care** treating people with more complex problems and consisting of five components: outpatient/ambulatory clinics, community mental health teams, acute inpatient care, long-term community-based residential care, and support in work and occupation.
- A series of **specialised mental health services** in each of the five categories of general mental health services to provide more intense/expert interventions (i.e., specialised outpatient/ambulatory clinics, specialised community mental health teams, alternatives to



acute inpatient care, alternative types of long-stay community residential care, specialised forms of work and occupation support).

This is referred to as a balanced care offer. Moreover, a balanced care model implies that both community and hospital care are available, and provided in a pragmatic and balanced way (Thornicroft & Tansella, 2013; Thornicroft & Tansella, 2004). This means that in the case of countries with many residential services, the number of beds will need to decrease. Although in most EU countries the number of psychiatric beds is indeed decreasing, there was in 6 of the 27 EU member states a small increase in number of beds in 2008 and 2009 (i.e., in Bulgaria, Germany, Hungary, The Netherlands, Romania and Turkey) (Thornicroft & Tansella, 2013b; Thornicroft & Tansella, 2004).

Another important aspect of balanced care is that mental health treatments are integrated within non-specialised primary health care. This way, the principles of stepped care can be implemented more easily. According to these principles appropriate non-specialised care is provided first and people step up to a more specialised level of care when this appears necessary (Silva & de Almeida, 2014). Integration of mental health care into general health care involves (WHO, 2003, p. 36):

- Integration of mental health services into primary care settings and general hospitals by for example training staff in mental health promotion and prevention or making sure there is equipment for specialised tests
- Development of an adequate referral system in order to allow good referrals and to create a proper coordination between primary, secondary and tertiary care: regular meetings, protocols, etc.
- Integration of mental health care into other established health and social programmes
- Creation of formal and informal community mental health services: halfway houses, supporting families to take up support

In sum, it is the government's task to define what health services should be minimally available in their country based on the recommendations formulated by Thornicroft and Tansella concerning the different types of mental health services that are necessary within a balanced care model (Thornicroft & Tansella, 2013a). The different services mentioned by Tylee and colleagues are also important to consider as they focus on offering health support to adolescents in different settings (Tylee et al., 2007).

Balanced care offer for adolescents

The information mentioned above does not only apply to adult mental health care, but is also applicable to adolescent mental health care. Thus, balanced care for adolescents implies that different types of services and treatments should be available for adolescents. Due to their



specific needs and the fact that their social contexts differ from that of adults and children, care will need to be provided in different contexts. Tylee and colleagues (2007) propose the following six contexts to provide mental health care to adolescents (Tylee, Haller, Graham, Churchill, & Sanci, 2007, p. 1567):

- Centres specialised in adolescent health set up in hospitals. These may contain in-patient services, a drop-in service and/or provide support to other services.
- Community-based health care providing health care to all segments of the population (e.g., a general practice, or a family-planning clinic). It can consist of stand-alone units (non-governmental organisations or private institutions), individual mental health care providers or governmental units that are an integral part of the health system.
- School-based or college-based health services and centres linked with schools or colleges. They provide prevention and curative health care in accordance to the premises of schools or colleges.
- Community-based centres providing different services (e.g., health information, recreation, help with literacy or numeracy skills).
- Pharmacies and shops. Although they do not provide health services, they do sell health products (e.g., condoms).
- Outreach information and service provision. In many countries, efforts are made to provide health information, health products, and health services to young people at places where they congregate, work or study.

In sum, mental health care should be integrated within general primary care services. For example, youth houses should provide information on mental health and should offer basic support to adolescents with minor mental health problems. Also, general practitioners and other primary care services should be stimulated to recognise, diagnose, and manage adolescent mental health problems (Vallance, Kramer, Churchill, & Garralda, 2011). Similarly, during the workshop with end-users, one of the adolescents stated that minor mental health problems should not be seen immediately as a disease requiring specialised mental health care in the first place*.

Estimate the magnitude of the treatment gap

Countries should estimate the magnitude of the treatment gap which is defined as *“the absolute difference between the true prevalence of mental health problems among adolescents and the treated proportion of adolescents with mental health problems”* Kohn, Saxena, Levav, & Saraceno, 2004). An alternative definition is the percentage of individuals who require care but do not receive treatment. The paper of Kohn et al. (2004) describes how the treatment gap can be estimated. Also, various barriers are discussed that prevent people from receiving help:



- The tendency to delay initial treatment for many years
- The failure to seek for help because the problem is not acknowledged
- The misperception that treatment is not effective or that the problem will solve itself
- The desire to deal with problems without outside help
- A lack of knowledge about mental health and mental health care
- Stigma toward mental health care
- The high costs that accompany mental health care
- The limited availability or lack of services

In adolescents, mental health problems often remain unrecognised until the moment they start to escalate, as adolescents are reluctant to share their worries and concerns with adults. Indeed, adolescence is a period in which young people get acquainted with their own autonomy. As such, many adolescents prefer to do things on their own beyond the knowledge of their parents or another adult. Also, many adolescents don't want to disturb their parents with their problems or are scared to ask for help as they do not know what this will entail*.

Although countries should make an effort to address all of these barriers, the limited availability of adolescent mental health services is a problem where most countries struggle with. A first step to improve the availability is estimating how many adolescent psychiatrists, adolescent psychologists and places in different mental health services are required for 10,000 adolescents. Accordingly, governments should take all necessary actions in order to reach the required numbers.

Stimulate treatment in primary care

During the ADOCARE research it was stated that adolescents are sometimes too quickly referred to specialised services. Professionals and parents should realise that mental health problems do not always require specialised care and that much can be done within primary or community-based care. However, such an approach requires two preconditions:

- Primary care workers should be well-trained in providing such services.
- Specialised services should be sufficiently available in order to allow proper referral.

Assessment tools for professionals exist which may help them to decide whether more specialised residential care is necessary. However, the final decision to refer an adolescent to specialised care should be based on the opinion of the adolescent, his parents and the professional, and thus not solely rely on the output of a diagnostic tool.

Moreover, governments may install legislation to ensure that only adolescents with severe mental health problems are referred to specialised care services. In Finland for example, legislation exists



on maximum waiting times in specialised care services. This forces primary care services to refer only adolescents with severe mental health problems to specialised services and to treat adolescents with mild problems themselves.

Build mental health care services for adolescents only

The results of the ADOCARE research show that most countries do have services exclusively for adolescents, however, their availability appears to be low. According to adolescents, there is definitely a high need for services where only young people have access to. Some adolescents need a different kind of support and are simply too young to live with adult patients*.

Importantly, it was frequently emphasised that such services should not apply strict age boundaries as this may inhibit someone to search for help. Some people between 18 and 30 years old are still young and prefer to be treated by an adolescent mental health service.



3. Quality of mental health care services for adolescents

Within the literature many definitions of quality of care exist. A generic definition that is referred to often is that of the Institute of Medicine (2001). They define quality in health care as *“the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”*. A similar definition is used by the WHO (2003): *“quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice”*.

In the current section we focus on the quality of mental health care services for adolescents by providing an answer on the following research questions:

- How is the quality of adolescent mental health care in the participating states?
- How to improve the quality of adolescent mental health care?
- How to improve the knowledge, skills and competences of professionals?
- What should youth friendly services look like?
- How to evaluate the quality of adolescent mental health care services?

3.1. How is the quality of adolescent mental health care in the participating states?

During the ADOCARE research, experts were asked to score on a 5-point Likert scale (1=very poor and 5=very good) how they perceived the quality of the four types of MHC services in their country.

The results (table 5) show that the quality of adolescent mental health care is not outstanding. Overall, the quality is rated to be good or very good in Belgium, Finland, France, Germany, and Hungary. In the other countries (Italy, Lithuania, Spain, Sweden, and the UK) the quality is rated to be in between, poor or unclear. Some additional remarks that were made by the experts of the participating states are:

- In Germany, mental health care services supporting adolescents poorly meet the demand for care, but the provided care is rated to be (very) good.
- In Finland, health and social services will be provided by the same organisation in the near future. It is expected that this will facilitate cooperation between adolescent psychiatric and (child) adolescent welfare work.
- In Lithuania, the quality of mental health care services is compromised because the biomedical paradigm is still the dominating model. This is partially retained because the Lithuanian health insurance system is reluctant to cover psychosocial interventions.
- Even within countries, the quality of adolescent mental health care services varies widely.

3.2. How to improve the quality of adolescent mental health care?

In the current section we focus on some general principles to improve the quality of care that were introduced by the different stakeholders throughout the ADOCARE research:

- Use a developmental approach
- Recognise mental health problems in an early phase
- Provide a treatment plan to fulfil the multiple needs of adolescents
- Use evidence-based practices
- Be aware of the needs of family members and important others
- Ensure continuity and coordination of care
- Attend to the transfer of adolescents to adult mental health services
- Allow participation of adolescents in their own treatment (microlevel)
- Allow participation of adolescents in the design, the function and evaluation of services (mesolevel)
- Allow participation of adolescents in the design and evaluation of policy making (macrolevel)

Use a developmental approach

Adolescence is a phase of life that is characterised by transition requiring a developmental approach acknowledging that each adolescent has different and changing needs depending on age, level of maturity, the environmental context, etc. (Remschmidt, 2001; Remschmidt & Belfer, 2005). Hence, practitioners should have knowledge of the (social, mental, physical) developmental stage of adolescents in order to formulate a treatment plan in accordance to these needs. Moreover, professionals should be aware that every clinical diagnosis and all assessed needs are subject to change, as adolescents undergo rapid changes over a brief period of time (World Health Organisation, 2005a). The treatment plan should therefore be seen as a work-in-progress: adolescents frequently change their mind and that what once was effective for an adolescent may no longer be effective after a couple of months*. Finally, professionals should be familiar with the socio-cultural environment in which youngsters live today (e.g., their interests and concerns, the things that they do in their leisure time).

Recognise mental health problems in an early phase

Professionals underscore that it may be difficult to identify mental health problems in adolescents.* Adolescents often keep their problems for themselves or tend to report somatic problems only.* Therefore, professionals may underestimate the severity of the psychological problems experienced by adolescents and/or attribute them to somatic problems.



Hence, professionals should be trained on how to start a working alliance with adolescents, how to ask adolescents about possible mental health problems, and how to recognise signs of mild suffering that could become worse. In Belgium, a specific training in communication with adolescents exists in a master after master education. Overall, professionals should present an attitude that stimulates collaboration with the adolescent. Also, they should be trained to ask adolescents about the following topics, referred to as the HEEADSSS acronym: Home environment, Education and employment, Eating, (peer-related) Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence (Cappelli et al., 2012; Klein, Goldenring, & Adelman, 2014). An adapted HEEADSSS-ED tool is available and provides direct feedback on the actions that are required within the different areas of an adolescents' life.

HEADS-ED tool – a tool for physicians to guide to assessment of mental health concerns in children and youth

HEADS is a mnemonic widely used by physicians to take a psychosocial history in children and adolescents. The mnemonic stands for: (1) home, (2) education, (3) activities and peers, (4) drugs and alcohol, (5) suicidality, (6) emotions, behaviours, thought disturbance, and (7) discharge resources.

The HEADS mnemonic is modified into a tool assessing the 7 key areas with an embedded scoring system associating points to each variable (0=no clinical action needed, 1=needs clinical action but not immediately, and 2=needs immediate clinical action).

The tool is validated and freely available on the following website: www.heads-ed.com.

At the start and during treatment, it is worthwhile to use an evidence-based assessment (EBA) approach. EBA refers on the one hand to the assessment of the adolescent's and family's needs and strengths, the identification of their mental health concerns, and the selection of appropriate treatments. On the other hand, EBA refers to the on-going progress of monitoring the adolescent's response to the treatment and to outcome evaluation (Bohnenkamp, Glascoe, Gracey, Epstein, & Benningfield, 2015). For this purpose methods and tools are used that are based on empirical evidence in terms of reliability, validity and clinical usefulness (Mash & Hunsley, 2005). The Psychotherapy Expectations and Perceptions Inventory (PEPI) is an example of such an instrument (Stewart, Steele, & Roberts, 2014). The questionnaire measures the adolescent's expectancy about psychotherapy and can be administered at the start and during the treatment process. Research demonstrates that assessing adolescent's expectancies facilitates engagement in the therapy, leads to a positive therapeutic relationship, and fosters more therapeutic change (Stewart et al., 2014). Other assessment instrument such as the Brief Problem Monitor can be used to evaluate the effects of interventions (Achenbach, McConaughy, Ivanova, & Rescorla, 2011; Achenbach & Rescorla, 2013).

Provide a treatment plan to fulfil the multiple needs of adolescents

For each person, a specific treatment plan should be developed relying on a multidisciplinary approach and shared decision making. A treatment plan should comprise the most appropriate and effective combination of treatment techniques in order to meet the complex and multiple (mental, social, functional, etc.) needs of adolescents* (Remschmidt, 2001; Remschmidt & Belfer, 2005). Generally, psychosocial interventions should be regarded as the first line of treatment (Bohlin & Mijumbi, 2015) supplemented with medication, when needed.

Psychosocial interventions

According to Reichow et al. (2013) and Uitterhoeve et al. (2004) the term “psychosocial interventions” refers to a variety of interventions, including counselling/psychotherapy, social support, education, provision of information or training. Each intervention aims to improve behaviour, overall development or specific life skills without the use of drugs (Reichow, Servili, Yasamy, Barbui, & Saxena, 2013; Uitterhoeve et al., 2004).

One important intervention that should be provided is **psycho-education**: educate adolescents and their parents so they learn to understand their own problems. This has the potential to increase access to information (parental knowledge about symptoms, greater use of appropriate services), problem solving skills, and social support (increased positive emotions and family interactions) (Lucksted, McFarlane, Downing, & Dixon, 2012).

Next to psycho-education, individual, group and family-based **psychotherapies** are important interventions that should be provided when treating adolescents*. Although the chosen therapy should be consistent with the personality and the needs of adolescents, clinicians should not forget to choose therapies that have proven to be successful. Therefore, psychodynamic, cognitive behavioural, client-centred, and many other therapies are all worthwhile (Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013). Each of these frameworks can be part of long-term therapies or brief therapeutic interventions (Wells & Giannetti, 2013). A good overview of existing psychotherapies and their evidence is presented in the recent book “What Works for Whom” (Fonagy et al., 2014).

Psychological interventions can be supplemented by other activities such as art therapy (music, community art projects) (Cortina & Fazel, 2015; Patterson et al., 2015), wilderness therapy (Keith, 2012; Tucker, 2015), etc. which are believed to have a beneficial effect on the mental well-being of adolescents as well*.

Medication when necessary

There is no doubt that some serious mental disorders require medication*. Yet, throughout the ADOCARE research, it was frequently mentioned that in some countries, certain types of mental health problems are too easily addressed by offering (only) medication. Also, for some disorders there is an on-going debate concerning the use of medication: what type of medication is



appropriate, at what time in therapy is medication best started, what dosage is best used, etc. (Bohlin & Mijumbi, 2015).

It was argued that the prescription of medication should always be offered in accordance with the current medicine-based guidelines and in combination with psychotherapy and/or other psychosocial interventions. Different sources summarising these guidelines exist and should be known by professionals (e.g., British Association for Psychopharmacology, “What works for whom” by Fonagy et al. (2014) or the NICE guidelines on mental health). Although the effects of medication are already well-known, there is a need for more research on the effects of medication on adolescents on the one hand and on the combination of medication and psychotherapy on the other hand (Kieling et al., 2011). Lastly, during their training, professionals should be sensitised about the overuse of medication in certain circumstances and should be informed about new evidence on the effectiveness of medication.

E-health

An important reference should be made to the world of e-health, web-based interventions and mobile applications (i.e., m-health). Many adolescents are daily connected to the internet, so this medium has the potential to (Price et al., 2014):

- Increase access to care (e.g., for adolescents who feel ashamed about their problems, it is good that they can first visit a website in full anonymity*.)
- Inform adolescents about care
- Engage adolescents more actively during treatment (follow-up, diary keeping, additional support, information, etc.)
- Pursue care after formal treatment is concluded

During the ADOCARE research, however, adolescents did formulate some concerns with respect to e-health and m-health*:

- Websites and apps for adolescents should have a quality label. It should not be the task of adolescents to determine whether a website or app is trustful or not.
- Adolescents should be supported by a professional in interpreting information that is provided on the internet.
- It's important that online chat services supporting adolescents are sufficiently staffed so that adolescents do not need to wait in order to receive an answer to their questions. When there are waiting times, adolescents may feel discouraged and pushed aside.
- Websites and apps are not adequate as they do not allow a personally adapted treatment.

Nevertheless, web-based mental health tools are increasingly being developed and until now reviews find mixed results concerning their efficiency. Thus, more research is definitely needed (Boydell et al., 2014; Reyes-Portillo et al., 2014; Ye et al., 2014).



A recent review study conducted by Reyes-Portillo et al. (2014) examined the research evidence for web-based treatment and prevention programmes for depression, anxiety, and suicide prevention in children, adolescents, and young adults. The authors classified the studied interventions according to level of evidence: well-established evidence, probably efficacious, possibly efficacious, experimental, and of questionable efficacy. Based on the results, three apps were categorised as being probable or possibly efficacious: BRAVE ONLINE, MoodGYM, and Master Your Mood. BRAVE ONLINE is an online programme for the treatment of anxiety in young people. It was developed by a team of researchers from the University of Queensland (Australia) and is unfortunately only available for Australian youngsters. Master Your Mood (www.gripopjedip.nl) is a Dutch web-based tool for adolescents with symptoms of depression. The tool consists of 6-sessions, is based on cognitive behaviour therapy, and therapy-assisted. The MoodGYM tool is a 5 session, self-guided, CBT-based internet program to treat or prevent depressive symptoms in adolescents (www.moodgym.anu.edu.au). The tool is developed by the Australian National Institute for Mental Health Research and available in Norks, Suomi, Dutch, and English.

Finally, we would like to mention the iFightDepression tool as well (see p. 59 of this report). The effectiveness of the tool is not yet demonstrated as it is a rather new tool, but it has been developed according to scientific standards and following a systematic review process. Contrary to the other interventions, the tool is available in eight European languages (English, French, Spanish, Portuguese, Italian, Hungarian, Bulgarian, and Estonian). In addition to the tool, there is a website providing comprehensive information about depression and its consequences.

Use evidence-based practices (EBP)

Evidence-based practice in adolescent mental health can be defined as *“practices that are consistently science-informed, organised around client intentions, culturally sensitive, and that continually monitor the effectiveness of interventions through reliable measures of the adolescent and caregivers’ responses, contextualised by the events and conditions that impact on treatment”* (Fonagy et al., 2014, p. 4). The procedures and steps of the treatment are systematically outlined in a protocol. EBP is not solely offered by researchers to clinicians, but is a process of co-creation involving adolescents, researchers and clinicians. EBP is thus more than a definite and definitive list of practices that proved successful in research (Fonagy et al., 2014).

As stated by the WHO (2013), the use of EPB’s by professionals will lead to good-quality mental health services (WHO, 2013). Although EBP’s yield better results compared to regular care practices, the EBP advantage is only modest and there is still room for improvement (Weisz et al., 2013). Therefore, at least 10% of adolescent mental health funds should be invested in implementing and studying evidence-based programmes (Resnick, Catalano, Sawyer, Viner, & Patton, 2012). When evidence-based practices exist, protocols should be made freely available for



clinicians, and professionals should be supported when implementing these programmes in their daily practice. Also, regular updates of practices and protocols are necessary.

In addition to EPB, professionals can use guidelines that provide an overview of existing evidence-based interventions for the treatment of different kinds of mental health problems (Hopkins, Crosland, Elliott, & Bewley, 2015). For example, the WHO⁸ recently developed the Mental Health Gap Action Intervention Guide (mhGAP-IG) to facilitate the delivery of evidence-based interventions in non-specialised health care settings (World Health Organisation, 2010). The guide is based on a review of all available evidence in this area and contains an overview of evidence-based interventions useful to manage a number of priority conditions (e.g., depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, alcohol use disorders, drug use disorders, etc.). Also, the National Institute for Health and Care Excellence (NICE) in the UK⁹ has many evidence-based guides to support practitioners in managing specific conditions in adults and children/young people. These guides also include what is best not offered to the target group.

Despite the fact that many EBP's exist, they are used by only a minority of professionals*. This is due to the difficulty to implement EBP's into practice. Professionals are often in conflict between offering a flexible and unique treatment for every adolescent on the one hand and providing standardised protocol-guided interventions on the other*. They argue that each adolescent has his or her own identity and believe that one size does not fit all adolescents*. Thus, there should be room for flexibility and individuality when implementing and offering interventions.

During the ADOCARE research, professionals and experts formulated additional remarks regarding the implementation of evidence-based interventions:

- Professionals should receive support on how to implement an evidence-based intervention in a standardised way during an individualised treatment (i.e., standardising the process/implementation of interventions)*.
- Not all interventions need to be tested via a randomised controlled trial as these trials are often not compatible with the complexity of the clinical setting.* More research in clinical practice is necessary. Professionals should also take into account interventions that are not yet validated but are not invalidated by studies either*.

⁸ http://www.who.int/mental_health/mhgap/en/

⁹ <https://www.nice.org.uk/>



- Both the type and the modality of the intervention should be adapted to the socio-demographic characteristics of the target group (for example migration status, religion, etc.)*.

Be aware of the needs of family members and important others

According to the ADOCARE professionals, parents are a crucial partner within the network of the adolescent. Therefore, a general rule should be that professionals inform and involve parents as much as possible (though there should be room for exceptions). When a treatment is started, this is one of the first issues that a professional should discuss with the adolescent. Parents have the right to know about their child's situation, even if adolescents themselves do not want their parents to know about their problems*. However, professionals should try to achieve a good balance between respecting the privacy of adolescents on the one hand and involving parents and family in treatment on the other*.

Secondly, family members – in particular parents – who live with an adolescent with mental health problems, are often suffering or experiencing problems themselves. Sometimes dysfunctional relationships within the family lie at the basis of the adolescent's problems or maintain their problems. Therefore, it is important to support the adolescent's family as well, even when adolescents do not want their parents to be involved. In this latter case, therapeutic support is best offered by another professional than the one supporting the adolescent.

Importantly, involving family in therapy can be beneficial for adolescents themselves (Young & Fristad, 2015). The review of Kaslow, Broth, Oyeshiku, and Collins (2014) provides an overview of efficacious family-based prevention programmes, psychotherapies and psycho-educational interventions such as multi-systemic therapy, multidimensional family therapy, dialectical therapy or the problem-centred systems therapy of the family (Kaslow, Broth, Smith, & Collins, 2012; Ozechowski & Liddle, 2002; Small & Huser, 2012; Young & Fristad, 2015). The latter is part of the McMaster approach to families. This approach is worth mentioning as it integrates a practice-based theoretical model, assessment tools, and a treatment model. Results show that adolescents perceive more support from family members when this approach is used (Miller, Ryan, Keitner, Bishop, & Epstein, 2000; Ryan, Epstein, & Keitner, 2005).

Efficacious family-based therapies share some common components such as psycho-education, problem-solving, communication, social skills building, and cognitive reframing (Young & Fristad, 2015). It is especially effective in conditions such as conduct disorder and substance abuse (Sharma & Sargent, 2015), and it is often combined with individual therapy for the adolescent (Young & Fristad, 2015).

When professionals cannot rely on the parents to provide proper care and support for their child, another adult should be involved in the treatment, for example a teacher, peer, etc.* Within a country clear legislation should be available on the rights and obligations of such “carers by proxy”.*



Ensure continuity and coordination of care

Continuity of care has been defined differently by many authors and is closely related to concepts such as coordination and integration of care (Uijen, Schers, Schellevis, & van den Bosch, 2012). In the current report, we consider continuity of care as *“the quality of care over time from the perspective of both the patient and the care provider”* (Gulliford, Naithani, & Morgan, 2006).

Continuity includes both longitudinal continuity (i.e., uninterrupted series of contacts over a long period) and cross-sectional continuity (i.e., coherence of interventions between and within different service providers) (Bruce & Paxton, 2002; Thornicroft & Tansella, 1999). As a result, coordination of care is thus seen as part of continuity of care.

To experience continuity of care, patients should be satisfied with both the long-term interpersonal aspects of care and the coordination of care. Therefore, the care provider should try to offer a “seamless service” (Gulliford et al., 2006). As stated by Durbin et al. (2006) “systems integration” is a possible solution to achieve continuity of care (Durbin, Goering, Streiner, & Pink, 2006). Generally, systems integration refers to an approach to service delivery wherein providers and agencies within and across service sectors work collaboratively and efficiently to meet the needs of patients and are held clinically and fiscally accountable for the provision of care. Professionals and services should work together at two levels, namely at an individual case-based level and at a regional level*. On the regional level, efficient networks of services working together need to be established so that management and arrangements procedures can be created to optimise care, such as: inducing a system wide implementation of intensive case management, forcing centralised access to services, and creating fewer service sectors. This latter strategy is pursued in Finland. There, health care and social services were originally financed via the municipalities (there are over 300 municipalities). As a result, the health and welfare system in Finland was quite decentralised. Currently, a reform is taking place to bring the health care and social services together within 5 regional entities instead of within 300 municipalities. This reform is expected to have a great impact on the coordination of services. Moreover, research confirms that there is a positive association between systems integration and experienced continuity of care (Durbin et al., 2006).

During the ADOCARE research a few professionals stated that continuity of care is highly improved when team members from different disciplines work under one roof*. Also, adolescents stated that it is important to assure more continuity in the professional staff that treats them*. Adolescents report that they often see many different professionals, especially when they are being transferred to another service. Being assigned to a new professional is very unfortunate, in particular when adolescents already built a strong working alliance with the previous treating professional*.

A necessary prerequisite to realise continuity of care is that patient information is shared between different professionals and services using a tracking or monitoring system*. Thus, a common



record file to share information between those professionals who are involved is necessary. Importantly, this file should be protected and layered, so professionals can only access information that is relevant for the care that they provide. In addition, adolescents should be informed about the information flow and should give their permission when data are shared*. In Germany, such a system was implemented in Gesundes Kinzigtal. There, different care providers use a system wide electronic health record that is owned by the patient (Busse & Stahl, 2014).

Inter-sectoral collaboration is strongly determined by the broader organisation of the government and by the way departments and ministries create a common framework for the different sectors (WHO, 2005a). Up to now, legislation and funding systems often hinder coordinated care. As a consequence, collaboration is necessarily based on ad hoc arrangements.* Hence, it is important that governments stimulate collaboration by (WHO, 2005a):

- Reforming legislation
- Highlighting the benefits and advantages of working together
- Addressing fears and resistance towards working together
- Allocating resources (time and funding) to inter-sectoral collaborative actions
- Creating job opportunities that cross traditional boundaries
- Creating incentive and reward systems linked to inter-sectoral collaborative actions
- Reimbursing collaborative activities such as meeting other professionals involved in the treatment of the adolescent*
- Centralising information on existing initiatives. In the UK, all initiatives are listed on one website (www.mynhs.uk). This not only helps professionals but is also an interesting tool for (future) service users to coordinate their own care.
- Creating local committees to supervise the quality of the care that is provided and to steer collaboration across services*.

Mental health care services and professionals can improve coordination and collaboration by:

- Including the general practitioner as a team member. This is essential to offer good primary care and to intervene at the lowest level possible. This point is also addressed in the publication “Comprehensive mental health action plan 2013-2020” of the WHO*.
- Adopting a recovery-oriented attitude. This way, professionals from different sectors and services will feel more jointly responsible for working out and implementing a care plan. Such attitude should be conveyed during education.
- Appointing one professional who has the final responsibility of the care that is provided to adolescents. This is especially important when a whole network of professionals is involved. Coordination of care should be the duty of the caregivers who are involved – it should not be the responsibility of the adolescent or his parents.



- Ensuring that referral to another service or professional proceeds well*. The referring professional should stay responsible for the adolescent until referral took place.

When quality of care is assessed, inter-sectoral collaboration should be considered as an important evaluative criterion (WHO, 2015c)*. Services can analyse collaboration and coordination using the framework of D'Amour (2008). According to the model an active collaboration should take into account the following indicators (D'Amour, Goulet, Labadie, Martin-Rodriguez, & Pineault, 2008):

- All partners have common goals centred on the needs, expectations, and preferences of the client
- There is a grounded trust between professionals
- There is a strong central body that provides clear direction and fosters consensus
- There is shared consensual leadership
- There is expertise to support professionals in the introduction of new and innovative practices
- There are many venues for discussion and participation
- There are consensual agreements that sets out each partner's responsibilities and there are jointly defined rules and procedures that each partner should follow in case of conflict
- There is a common infrastructure for collecting and exchanging information

Finally, some client-based measures exist to assess the degree to which service users experience continuity of care. Examples of such tools are the Alberta Continuity of Services Scale-Mental Health (Durbin, Goering, Streiner, & Pink, 2004) or the Continuity of Care in Children's Mental Health (C3MH) (Tobon, Reid, & Goffin, 2014). Unfortunately, these tools target respectively adult and child service users. Hence, some modifications are required before they can be used within the context of adolescent mental health care. Services can use these tools to monitor the extent to which they offer continuity of care and to make the right adjustments.

Attend to the transfer of adolescents to adult mental health services

The transition from adolescent mental health care services to adult mental health care services deserves special attention (Lamb & Murphy, 2013). In Europe, many countries make a difference between adult and child/adolescent psychiatry. This means that many people with mental health problems in early life periods are – at some point in their care pathway – transferred from child/adolescent mental health services to adult mental health services. During this transition period, young people can get lost (Singh et al., 2010a; Singh et al., 2010b). Professionals of the ADOCARE network stated that in many countries the quality of transitional care is perceived to be low*.

The main barriers that disrupt transitional care are: system fragmentation, a lack of leadership, a lack of prioritisation of this target group, poor communication, stigma, a policy-practice gap, lack



of studies, a lack of joint transition protocols and a general paucity of information about services (Paul, Street, Wheeler, & Singh, 2014; Royal College of Psychiatrists, 2013). In practice, it is often seen that a transfer fails due to the clinicians' failure to refer or due to services refusing to accept referrals or discharging young people who did not attend the first appointment offered (Paul et al., 2013). Yet, not all barriers to quality transitional care are linked with the service system. Transfer can also fail due to young people's refusal to accept referral to adult services (Paul et al., 2013).

Disruption of care during transition, however, can have a negative impact on the health and well-being of adolescents and thus efforts should be made to cross this gap. Improvement of quality of transitional care, and thus continuity of care, will not be easy as there exists a lack of high-quality transitional care models (Paul et al., 2014).

According to the TRACK study two approaches can be used to improve transitional care in Europe: (1) improving the interface between existing adolescent and adult mental health services, or (2) developing a completely new and innovative service model of integrated youth mental health services. Both approaches should take the developmental needs of adolescents into consideration (e.g., changing legal status, education and employment).

Currently, within the Milestone project new transitional care models for EU services are being developed and tested. More specifically, transition specific outcomes measures are developed and validated, guidelines for improving care and outcomes are created, and training packages for clinicians across EU are developed and implemented (De Girolamo, 2014).

In the meantime, we list some valuable recommendations that were generated by the TRACK study (Singh et al., 2010a) and the ADOCARE research*:

- When developing and implementing protocols to improve transitions:
 - The needs of the service user (the adolescent) should be the main priority
 - Collaboration with adolescents, their care and services is necessary
 - Time frames and everyone's responsibility should be clearly defined
 - The best way to prepare the adolescent for the transfer should be described
 - A backup procedure should be described in case adult mental health care services are unable to accept the transfer
 - The age range of services should be applied in a flexible way
- When an adolescent is transferred to an adult service:
 - Transition should occur at a moment that the adolescent's condition is stable; young people should not experience a relapse first before access to an adult service is permitted.
 - Agencies should try to avoid multiple simultaneous transitions.
 - Active involvement by the adult service is required before the adolescent service is allowed to discharge a case.



- Collaborative work between the adolescent and adult service is required, with cross agency working or periods of parallel care in order to facilitate the transition of care.
 - Services should use a standardised record keeping system and transfer all correspondence and contact summaries when an adolescent is being transferred.
-
- Local adolescent and adult mental health services and voluntary services should be regularly mapped (i.e., their scope of operation, communication networks and key contacts).
 - Professionals should be trained on how to establish transition of care.* Such trainings need to: tackle negative attitudes concerning referrals to other services, increase knowledge of other services and improve self-efficacy and skills (Singh et al., 2010a)*.
 - Policy plans should contain strategies to improve the transition from child and adolescent mental health care services to adult mental health care services*.
 - Transition should be evaluated using four criteria (Singh et al., 2010a): perceived continuity of care, parallel care, a transition planning meeting, and information transfer.

Allow participation of adolescents in their own treatment (micro-level)

As stated in the child rights convention¹⁰, adolescents have the right to participate in all decisions that affect them. Or, as mentioned by adolescents themselves during the ADOCARE research: *“Young people should be actively involved when decisions about their treatment are being made – nothing should be decided about us without us.”*

During the ADOCARE research, it was argued by professionals that the degree of participation of an adolescent in treatment decisions should depend on his level of maturity. Hence, it is the task of the professional to determine for which decisions the adolescent is mature enough to be involved in the process of shared decision making.

Either way, every professional working with adolescents should be trained in working out common treatment goals, asking for agreement, and stimulating shared decision making.* The latter means providing information and supporting the decision making process in such a way that individuals can have a say in important decisions affecting their quality of life (Elwyn et al., 2012). To accomplish shared decision making in clinical practice, Elwyn et al. (2012) propose a three-step model, consisting of: (1) introducing that there are choices to be made, (2) providing detailed information about the possible options, and (3) supporting patients in exploring preferences and making decisions.

¹⁰ Convention on the Rights of the Child: <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>



A recent study conducted by Abrines-Jaume et al. (2014) demonstrates that shared decision making allows young people to make more explicit choices. Decisions of adolescents often relate to the duration of the treatment sessions, and whether or not to come to a treatment session. For example, shared decision may enable adolescents to postpone a meeting until after an important life event (such as exams) rather than just not showing up for an appointment. Moreover, Abrines-Jaume et al. (2014) do argue that shared decision making in adolescent mental health care requires positive clinician behaviours such as being willing to let young people decide for themselves, applying shared decision making in a flexible way, and showing trust in young people.

During the ADOCARE research, it was argued by professionals that in practice it is not always possible to apply shared decision making. In rather exceptional circumstances adolescents do need a treatment that they actually do not want. For example, sometimes an unwillingly hospital admission is of vital importance for an adolescent. In those cases, a supporting attitude of the professional is very important. The professional and the adolescent should consent then that there is no consensus between them and both should adopt a “we agree to disagree” attitude *.

The previous paragraph relates to the participation of adolescents in their own treatment which is generally referred to as “participation on a micro-level”. Except for that, participation of adolescents is also possible on two other levels: on a meso-level and on a macro-level.

Allow participation of adolescents in the design and the functioning of services (meso-level) and in policy-making (macro-level)

Apart from participation in the own treatment, participation at the meso- and marco-level is possible. Participation at the meso-level implies that adolescents are actively involved in the service design, the care delivery (e.g., peer support, group therapy, self-support groups, etc.), the evaluation and the monitoring of a service (Bielsa et al., 2010). For example, in some services, adolescents are involved in the development of the service charter which defines things like confidentiality, opening hours, treatment offer, rights of adolescents, ethical aspects, etc. In addition to adolescents, other stakeholders such as families, peers, religious leaders, school teachers, police officers, local nongovernmental organisations, etc. can be included when developing services or treatment plans (WHO, 2013). In reality, however, participation of adolescents on a meso-level rarely happens (Bielsa, Braddick, Jané-Llopis, Jenkins, & Dainius, 2010).

The same is true for participation of adolescents on a macro-level. When mental health policies are being developed, adolescents should ideally be involved. It is important that policy makers are aware of the needs of adolescents and their ideas on how to improve mental health care. In the section “policies and legislation on adolescent mental health” more information can be found on the participation of adolescents at the macro-level.



Try to prevent drop-out

Many mental health care services are confronted with drop-out from treatment. During the ADOCARE research it was suggested that it is important for services to regularly contact adolescents who dropped-out from treatment *. Some professionals reported that when they treat an adolescent, they often select a peer (a friend, teacher or parent) at the beginning of the therapy whom they can contact in case of drop-out. Accordingly, a meeting can be arranged with the adolescent and the peer to discuss the reasons for drop-out*.

Try to build bridges to the real world

During the ADOCARE research, adolescents emphasised that each intervention should – at one point or another – make a connection to the real world: *“It is important to build bridges between the therapy setting and “the real world” (the home situation).* When hospitalised, professionals should strive to get adolescents at home as soon as possible. They should support them to take up normal life again and to integrate them into society.

Work through outreaching

Young people seldom go to clinical services on a voluntary basis.* Therefore, professionals should visit places where young people hang out such as coffee bars, popular sport locations or places where homeless adolescents may temporally reside.*

When outreaching, it is important to focus in particular on young people with multiple problems*. They are often neglected by professionals because their problems are considered as being far too complex. However, in many cases mental health problems are the underlying cause. The same is true in case of truancy. Then, a school counsellor or youth worker should be obliged to look for the adolescent and to offer support. In Finland, this practice is obliged and it could be a valuable strategy for other European countries also*.

Moreover, outreaching methods are also a valuable way to check out the interests and needs of adolescents.*

Address ethical considerations when treating an adolescent

Generally, each service needs to follow the three major ethical principles stated in the Belmont Report (Michaud et al., 2010, p. 419):

- Principle of autonomy: individuals should be treated as autonomous agents and persons with diminished autonomy are entitled to protection
- Principle of beneficence: do no harm, minimise harm and maximise possible benefits
- Principle of justice/equity: make sure resources are fairly shared



In addition, the Barcelona declaration proposes that in clinical care, some other important values need to be stressed (e.g., participation, dignity, integrity and vulnerability) (Michaud et al., 2010). Such principles must be clearly stated in service charters developed in collaboration with adolescents. Such charters should contain aspects such as:

- How professionals should deal with confidentiality in the treatment of adolescents: Which personal information can be shared with parents and other care providers? Ask the adolescents' permission before sharing information with other professionals.
- The right of adolescents to access their patient file
- Ethical aspects

At the level of the care and treatment, ethical dilemmas must be addressed using a deliberative approach as every situation is different and unique. Such approach refers to a contextualised and prudent process of careful assessment of the role of moral values, the competence of the adolescent, legal codes, etc. (Michaud et al., 2010). Professionals must be able to receive feedback from objective ethical committees consisting of professionals and experts*.

Gender disparities when searching for help

Research demonstrates that in adults, men are far less likely to seek professional help than women when feeling depressed or suicidal (Cox, 2014). These gender differences begin very early in life: results show that during teenage years, boys have less knowledge about mental health, mental health services, and are less willing to use services (Chandra et al., 2006). Boys report hesitation to look for help as they are afraid to be perceived as being weak. The same study shows that parental approval is also a determining factor as parents tend to be less approving of their sons considering mental health services than their daughters. Gender differences can be reduced by enhanced mental health education and by providing mental health services in middle school. Also, efforts to minimize stigmatising attitudes toward boys should actively involve parents (Chandra et al., 2006).

Gender-related differences concerning mental health care needs were neither mentioned during the ADOCARE research nor did we find references within the literature in relation to this matter. Generally, mental health professionals should provide a personally-centred treatment approach in accordance to the needs of each individual patient. Gender is a crucial aspect of someone's identity, which automatically entails that the provided care should be gender appropriate.

3.3. How to improve the knowledge, skills and competences of professionals?

Strategies to improve the knowledge and competencies of professionals are:

- Implement uniform training standards



- Invoke postgraduate training for professionals
- Train the right mix of knowledge and competencies

Implement uniform training standards

In order to enable professionals to respond more effectively and with greater sensitivity to the needs of adolescents, professionals need to be properly trained (World Health Organisation, 2002). This means that professionals who frequently work with adolescents (e.g., adolescent psychiatrists, school nurses, psychologists, teachers, etc.) should receive specific, continuous and additional training. Professionals who come occasionally in contact with adolescents (e.g., nurses at hospitals) should also receive courses on adolescent mental health issues during their basic education*.

Currently, the master and postgraduate training of mental health professionals (psychologists and psychiatrists) have the strongest focus on child and adolescent mental health issues (Braddick et al., 2009). Undergraduate trainings do not always focus on child and adolescent mental health issues. The same is true for the curricula of primary care doctors, pediatricians and primary care nurses. For staff of juvenile detention centres, teachers, public health workers and social workers even less training in child and adolescent mental health issues is required (Braddick et al., 2009). Thus, the topic on child and adolescent mental health should be more included in the undergraduate training of relevant professions.

Moreover, across European countries, the training of mental health professionals does not have the same standards (**Union Européenne des médecins spécialistes, 2014**)*. Training and education programs are also difficult to compare due to a lack of uniformity across countries. Hence, it is essential that for certain professions – especially for psychiatrists and clinical psychologists active in the area of adolescent mental health – a common EU model for the educational curricula is set up.

In Europe, the European Federation of Psychiatric Trainees (EFPT) represents psychiatric trainee's organisations in more than 30 European countries and aims to improve psychiatric training in all branches of psychiatry throughout Europe. This is done by formulating statements on matters that are considered important with respect to the training of psychiatrists. Eventually, these statements are communicated to relevant training organisations across Europe to influence policies concerning training in psychiatry. Importantly, the EFPT statements say the following about training child and adolescent psychiatry:

“We recommend that the trainees should gain experience with 0-18 year old children with mental health problems within varying settings of care with access to relevant sub-specialty training that is provided by the training program. We recommend that there are clear training guidelines for child and adolescent psychiatrists in each country and that implementation of these guidelines is monitored. Trainees should have access to specific psychotherapy training opportunities, provided



within their training program. Trainees should be routinely supervised by child and adolescent psychiatric specialists at a level appropriate to the trainees' level of training."

The European union of medical specialists makes training requirements more specific. They state that child and adolescent psychiatrists should be trained for three years in which they have an ongoing caseload of 25-35 cases (Union Européenne des médecins spécialistes, 2014).

Moreover, during the ADOCARE research it was stated that all psychiatrists should have relevant work experience in child, adolescent, and adult psychiatry. This way, they have sufficient knowledge of each other's discipline which will improve the transfer of adolescents to adult services.

In order to create more uniformity in Europe regarding the provision of child and adolescent mental health care, the unit of Child and Adolescent Psychiatry within the "Union of European Medical Specialists" (UEMS) constructed guidelines on how to develop training programs for child and adolescent psychiatrists which have been implemented in several EU member states.

In conclusion, both the recommendations of the EFPT and the UEMS should be used to work out a common EU model for the educational curricula of mental health professionals.

Invoke postgraduate training for professionals

A useful way to educate and train professionals after graduating is to continuously offer interdisciplinary courses and discipline specific sessions covering diverse topics such as confidentiality, self-management and injury prevention (Kraus et al., 2003). In Europe, a multidisciplinary network of health professionals from Switzerland and elsewhere in Europe, called EuTEACH¹¹, developed training materials for trainers/teachers who train practitioners that are involved in adolescent health (e.g., clinicians, professionals involved in prevention and health promotion, public health officers, and policymakers). Every year, EuTEACH organises a summer school for those who are interested in enhancing their skills as trainers in adolescent health care. Also, EuTEACH provides advice and support for professionals who want to develop adolescent health training facilities in their home countries.

EuTEACH – summer school for trainers in adolescent health care

The EuTEACH programme is developed and maintained by a multidisciplinary network of

¹¹ <http://www.unil.ch/euteach/home.html>



health professionals from various disciplines from Switzerland and elsewhere in Europe. Collaboration exists with the WHO, the United Nations Children's Fund (UNICEF) and the United Nation Population Fund (UNFPA).

The goal of EuTEACH is to implement a training package for professionals interested in improving adolescent health care in their countries. EuTEACH provides a training curriculum based upon findings from the scientific literature and the experience of EuTEACH members. Every year a summer school is organised for those interested in enhancing their skills as trainers in adolescent health care. In addition, EuTEACH provides a network of professionals who can advise and support professionals who want to develop adolescent health training facilities in their home countries.

Key concepts used within the training curriculum are:

- Understanding the adolescent developmental process
- Developmental stages
- Rapid dynamic changes
- Family centred approach
- Interdisciplinary approach and networking
- Non-judgmental and empathic approach

More information can be found on the website: www.unil.ch/euteach/home.html

Except for postgraduate training courses, clinicians should receive feedback in the form of intervision and supervision on a weekly basis. Research demonstrated that this is beneficial for the mental well-being of adolescents (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Tsai, Moskowitz, Brown, Park, & Chorpita, 2015).

Train the right mix of knowledge and competences

In summary, mental health professionals working with adolescents, should have the following abilities¹²:

¹² This list of needed skills, knowledge and attitudes may differ in function of region, setting, target group, etc.



- Have knowledge of laws, legislation and policies regarding adolescent mental health (Union Européenne des médecins spécialistes, 2014; WHO, 2015a)
- Demonstrate understanding of normal adolescent development, its impact on health and its implications for health care and health promotion (WHO, 2015a)
- Promote good mental health and educate adolescents and their families about the possibilities to improve well-being (NHS England, 2015, p. 64)
- Have knowledge of places where support for adolescents is available
- Show empathy and try to be reassuring by adopting a non-authoritarian communication style and by listening actively (WHO, 2015a)
- Provide services in a confidential way (WHO, 2015a)
- Have knowledge of evidence-based psychosocial interventions.
- Evaluate proper functioning and treatment using quality indicators (Dua et al., 2011)
- Assure continuity and coordination of care through inter-sectoral collaboration (The community health worker initiative of Boston, 2007; Union Européenne des médecins spécialistes, 2014)
- Pursue continuity in care when adolescents are being transferred to an adult service. Therefore, adolescent and adult psychiatrists should be sufficiently familiar with each other's discipline.
- Refer appropriately to more targeted and specialist support if needed (NHS England, 2015, p. 64)
- Identify mental health problems early in children and young people (NHS England, 2015, p. 64)
- Approach every adolescent as an individual, with differing needs and concerns and assess these (WHO, 2015a, p. 8)
- Show respect for adolescents' choices as well as their right to consent or refuse interventions (WHO, 2015a, p. 8)
- Approach adolescents in a non-judgemental and non-discriminatory manner, respecting their human rights and individual dignity (WHO, 2015a, p. 8)
- Engage in partnerships with gatekeepers and community organisations to ensure quality health care services for adolescents (WHO, 2015a, p. 8)
- Establish and maintain (therapeutic) relationships with adolescents, families and important others (Union Européenne des médecins spécialistes, 2014)
- Work through outreach and adopt a culturally-based communication style and care approach (The community health worker initiative of Boston, 2007)



3.4. How should youth friendly services and a youth friendly staff look like?

Often the design of services and the attitude of professionals are not adapted to the developmental and cultural needs of young people (Ambresin et al., 2013; Breland et al., 2014; McGorry, Bates, & Birchwood, 2013; Tylee et al., 2007). In order to improve accessibility, equity and acceptability, services and staff should become more youth friendly. Within the literature, different studies examined the prerequisites for youth friendly services and professionals (Ambresin et al., 2013; Tylee et al., 2007; World Health Organisation, 2002). Within the ADOCARE research we did a similar inquiry by asking adolescents how a youth friendly service and professional should look like. In the current paragraph we also focus on how to evaluate the youth friendliness of a service.

Youth friendly health care services

In summary, youth friendly health care services should meet the following characteristics (Ambresin et al., 2013; Harper, Dickson, & Bramwell, 2014; McGorry et al., 2014; McGorry et al., 2013; Tylee et al., 2007; World Health Organisation, 2002):

- Involve young people actively when developing, implementing and evaluating services*.
- Be highly accessible so adolescents will ask more quickly for help: services provide drop-in services; have convenient opening hours (dependent of school hours); are accessible without the permission of parents; are affordable or free of charge; have reduced waiting times; are located near to public transportation; allow self-referral; work with e-health tools; have recreational domains, and an appealing and welcoming environment; ensure discrete entrance; and are positively rebranded.
- Invest in awareness raising activities (leaflets, posters, website, etc.) as adolescents often do not know where to go to when they need help.
- Create one stop shops where young people can come to ask for advice on various domains in life. Such shops should be free of charge, located at sites where young people are spending time (clubs, bars, skate parks, etc.), and work in a confidential way.
- Provide clear information on legal (confidentiality) and economic (affordability) aspects. For example, it should be clearly explained what adolescents can expect when they are under 18 and they don't want their parents to know that they are visiting a service.
- Guarantee continuity in therapeutic relationships with professionals for example by minimizing turn-over of staff (Harper et al., 2014). Adolescents are in a turbulent phase in their life. Hence, professionals should try to provide a certain amount of stability.
- Focus on gathering data and continuous quality improvement*.
- Let young people participate on decisions at the micro-, meso- and macrolevel. Although already mentioned above, we want to restate the importance of participation. Due to the



stigma towards mental health problems, it is important that stigma-free services are developed and adolescents know best how such services should look like.

- Engage good role models (i.e., adolescents who experienced similar problems in the past) as they have a beneficial effect on the well-being of adolescents.* These role models should receive a proper training (Kasahara-Kiritani, Masuda, & Ishii, 2015).
- Strengthen the mental health literacy of adolescents.*
- Provide diverse treatment forms: at the service, outreaching, individual treatment, family interventions, group interventions, etc.*
- Adopt a stepped care approach: provide primary mental care when possible and refer to specialised teams when necessary.
- Address integration into society (e.g., support in education, finding good housing or a good job, building trustful relationships with others).*
- Pay attention to the developmental stage of each adolescent (Harper et al., 2014). Every adolescent has different needs and struggles.
- Be sensitive for hierarchical differences: avoid creating a “we versus them” attitude, treat adolescents not as helpless persons.

HeadSpace – a youth friendly primary care model for youth mental healthcare

HeadSpace is an enhanced primary care model for youth mental health care in Australia, providing early intervention mental health services to 12-25 year olds. At this moment, there are more than 70 HeadSpace centres in Australia.

The centres are youth-friendly, highly accessible, and target young people’s basic needs by providing multidisciplinary care covering four key areas: mental health, physical health, work and study support, and alcohol and other drug services. The services provided are either free or have a low cost.

The centres are built and designed with input from young people so they don't have the same look or feel as other clinical services. Also, most centres have a drop in service that youngsters can visit anytime during the visiting hours. There is also an online counselling service available called eheadspace providing confidential online and telephone support seven days a week.

More information can be found on the website: www.headspace.org.au

Youth friendly staff

For adolescents, the attitude, competences and motivation of the professional staff is of major importance. In summary, professionals should have the following characteristics:

- Have technical competency but above all be motivated, honest, easy to relate to, respectful, passionate, and supporting (Ambresin et al., 2013; Tylee et al., 2007; World Health Organisation, 2002). During the ADOCARE research, adolescents stated: “It seems like some



*caregivers are just doing their job, whereas others are very passionate about their work which has a positive effect on the therapy outcomes”**.

- Treat all adolescents with equal care and respect.
- Adopt a developmental approach and have knowledge of the many changes in life that adolescents experience.
- Provide teen-oriented health information so adolescents can make free and informed choices (Ambresin et al., 2013; Tylee et al., 2007; World Health Organisation, 2002).
- Be able to construct a positive therapeutic alliance which is very decisive for the therapy outcomes. Adolescents should have the right to choose their own professional or to switch professionals when they are not able to build a positive working alliance with the professional who is currently treating them.
- Convince adolescents that in the end they will have a promising future. Some adolescents have the feeling that it is already too late for them to receive help. Professionals should convincingly disprove this feeling.

In conclusion, a youth friendly professional is passionate and enthusiastic. Hence, mental health services should be supporting so that professionals do not lose their enthusiasm or fall out by burn-out. Research and interventions on this topic should be stimulated.

Evaluate the youth friendliness of a mental health care service

Different instruments exist to evaluate the extent to which health care services provide adolescent friendly care:

- The YFHS-WHO+ Questionnaire measures the youth friendliness of primary care services from a client's perspective (Haller et al., 2012). It consists of 49 items covering different subscales such as equity, parental support, and accessibility (Haller et al., 2012).
- The revised You're Welcome (YW) quality criteria can be used by inpatient settings to check whether they offer youth friendly care (Hargreaves et al., 2013). Important quality criteria are: accessibility, publicity, staff training, joined-up working, etc. Moreover, a specific toolkit is available which helps services to implement these criteria.
- Simmons et al. (2014) developed a tool to measure the level of user satisfaction with youth-friendly early intervention services (Simmons et al., 2014).

The instruments listed above were all developed to assess the youth friendliness of health care services in general. Hence, there is a need to develop validated and reliable tools to evaluate the youth friendliness of mental health services in particular.



3.5. How to evaluate the quality of adolescent mental health care services?

Services should invest in evaluating the quality of the care that they provide, because it is important for them to know whether they are evolving in the right direction. Moreover, without an evaluation it is difficult for services to apply for further funding.

Important aspects to consider when evaluating the quality of adolescent mental health care services are:

- Select quality indicators
- Use instruments to measure the quality of care
- Appoint an independently funded research organisation to carry out the evaluation

Select quality indicators

In order to provide good mental health care, it is important that services continuously invest in quality improvement. This is achieved by an on-going, iterative process including developing policies, designing standards, establishing accreditation, and monitoring services (WHO, 2005a, p. 35). Measuring the quality of certain elements of the provided care (i.e., quality indicators) is an essential prerequisite for quality improvement. Within the literature, a quality indicator is defined as: *“a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care, and hence change in the quality of care provided”* Legido-Quigley et al. (2008). Quality indicators can be subdivided as macro-, meso-, and micro-level indicators:

- Macro-level indicators refer to the provision of structural quality on the national mental health system level. They relate to mental health education, mental health monitoring, and the general organisation of mental health services within a country.
- Meso-level indicators refer to aspects that relate to the internal structure of mental health systems such as structural requirements to ascertain the needs of patients, multi-professionality of services, access units, availability of technologies, workforce, etc.
- Micro-level indicators guide structures and processes within individual service units.

Furthermore, indicators can be classified in three categories:

- Structural indicators constitute the features of services such as facilities, equipment, human resources and organisational structures
- Process indicators relate to activities in giving and receiving care including the activities of healthcare providers
- Outcome indicators relate to the effect of care

Within the literature, two reports formulate quality standards for adolescent mental health care services in particular:

- User-generated quality standards for youth mental health in primary care developed by Graham et al. (2014)
- The Service Standards (seventh edition) constructed by the Quality Network of Inpatient Care of the UK (Thompson & Clarke, 2015)

It is not our intention to reproduce the exact indicators defined within these works. Instead, we generated a list of quality indicators that were mentioned by the experts, professionals, and policy makers that participated in the ADOCARE research activities. The indicators relate to individual adolescent mental health care units and are organised in table 16 as structural, process and outcome indicators.

Table 17: List of quality indicators generated by the ADOCARE stakeholders.

Structural quality indicators	The service is accessible: adolescents are able to obtain health care at the right time irrespective of income, physical location, and cultural background. There are no waiting lists; the service is affordable, and easy to reach.
	Resources are used in a cost effective way while attaining outcomes.
	Services are sustainable in terms of facilities, workforce, and equipment.
	Professionals are capable and skilled, and follow trainings on adolescent related topics on a regular basis.
	The service has an improvement plan that is implemented and the progress that is made is followed up.
	Structural requirements are implemented to ascertain patients' dignity and basic needs.
Process quality indicators	The provided care is appropriate in the sense that the interventions are relevant to adolescents' needs and are based on established standards.
	There is a balanced use of psychosocial, medical and other interventions.
	There is continuity and coordination of care (i.e., uninterrupted, coordinated care across programmes, practitioners, organisations and levels over time).
	There is collaboration with other services in order to provide integrated care.
	Services are able to be innovative.
	Professionals have a positive attitude toward adolescents. They behave in a respectful, honest, supportive, friendly, and trustworthy manner.
	Services and professionals apply the principles of shared decision making during practice.
	Services and professionals empower adolescents by teaching them how to cope with their problems and by encouraging them to ask for help when they are confronted with problems in
	Services address ethical principles and respect the human rights of adolescents.
Outcome quality indicators	The provided treatment has a positive impact on the symptoms of adolescents, on their everyday life (e.g., days at school, coming home before midnight, fighting behaviour, etc.), and on their quality of life.
	The positive effects resulting from the provided treatment are preserved in the long run (e.g., after one year).
	The desired outcomes are achieved within a reasonable time frame.
	The level of dropout it is reduced to a minimum.

	Professionals are satisfied with the work that they are doing. There are low staff turn-over rates, the number of sick-leave days among professionals is low and the incidence of burn-out is low.
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Use instruments to measure the quality of care

It is important that policy makers define for each of the quality indicators overarching standards. Accordingly, instruments need to be developed to evaluate the extent to which these standards are met, and the same instruments should be used across services, regions, and countries in order to allow comparison. When defining quality standards and developing instruments, adolescents, parents, professionals, and researchers should be involved as they each have their own point of view concerning good quality care*.

Finally, during the ADOCARE research, experts of the network referred to three instruments that can be used by professionals or services to assess the impact of a provided treatment on the wellbeing of adolescents:

- The WHODAS (WHO Disability Assessment Schedule 2.0): an instrument that is based on the WHO's recommendations on quality indicators and measures six domains of functioning (e.g., participation, cognition, mobility, etc.). Both a 12 and a 36 item version of the questionnaire exists¹³.
- The Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOSCA): a short scale measuring the child's symptoms and social and physical functioning. The scale can be used to assess the needs of the child and to detect progress¹⁴.
- The DSM IV Children's Global Assessment Scale: an instrument to evaluate the psychosocial functioning of a child or adolescent in daily life.

Appoint an independently funded research organisation to carry out the evaluation of quality of care

The evaluation of a service can be done by the service itself. Yet, it can also be beneficial to implement an accreditation programme (World Health Organisation, 2002) in which an independently funded research organisation carries out the monitoring of priority indicators*. After the evaluation, results should be communicated to the service in a constructive manner,

¹³ <http://www.who.int/classifications/icf/whodasii/en/>

¹⁴ <https://www.rcpsych.ac.uk/pdf/HoNOSCA%20Glossary.pdf>



providing recommendations and assistance for improvement (World Health Organisation, 2002). It is also important that evaluation results are communicated to the general public. In the UK, service consumers can view performance information of services on the website of the NHS (i.e., my.nhs).

Also in the UK, the National Institute for Health and Care Excellence (NICE) develops quality standards and performance metrics for those providing and commissioning health, public health, and social care services. They also produce guidelines and recommendation for health and social care services. During the ADOCARE research it was stated that such a centre or a network of centres should be developed at a European level.

4. Adolescent mental health in the school setting

As adolescents spend most of their time in school, they are well placed to promote mental health, prevent mental health problems, recognise problems in an early stage, and refer to treatment*. Adolescents using mental health services, most likely receive these services at their school (Farmer et al., 2003; Paternite & Johnston, 2005; Rones & Hoagwood, 2000; Weist & Paternite, 2006). In addition, school-based mental health services are a crucial gateway to mental health service use offered outside the school (Williams & Chapman, 2014).

Although much progress has been made within the school setting over the past decade, a lot of work remains to be done. In the current section we formulate an answer on one broad research question: “What can schools do to improve adolescent mental health?”

4.1. What can schools do to improve adolescent mental health?

Overall, schools can proceed in different ways to enhance the mental health of young people:

- Provide basic training to teachers in mental health
- Engage health professionals at school
- Collaborate with external mental health professionals
- Organise classes on mental health
- Implement screening programmes
- Attend to risk behaviours among students
- Make sure the school programme is well implemented

Provide basic training to teachers in mental health

Teachers are constantly present in the life of adolescents and thus well placed to detect problems in an early stage and to initiate valuable support. Therefore, it is important that teachers receive



basic training in mental health promotion, mental health problems, and how to prevent and recognise these problems.*

Engage (mental) health professionals at school

During the ADOCARE research, it was stated that teachers should not be burdened with providing support and care to adolescents themselves as they already have a high workload. Also, some adolescent mental health problems require the skills and knowledge of a more experienced professional. In those situations, teachers should be able to rely on a (mental) health professional (e.g., school nurse, school counsellor, school psychologist) who is working at the school. These professionals can either give advice to teachers on how to manage students with mental health problems or they can be engaged to provide direct support to adolescents or to make a good referral to an expert.*

In daily practice, health professionals at school (e.g., school nurses) most often deal with physical problems such as hearing problems or sexual topics. Mental health problems are not among the top five problems focused on by school nurses. Yet, health professionals at school need to acknowledge that mental health problems are widespread among students and perhaps even more common than physical problems. In addition, they should be trained in detecting mental health problems and providing counselling. Research shows that a school professional's self-efficacy to provide counselling is strongly related to his knowledge of evidence-based practices (in particular to treating depression) and the amount of practice (Schiele, Weist, Youngstrom, Stephan, & Lever, 2014).

Collaborate with external mental health professionals

In some cases, the support provided by teachers and school professionals is not sufficient and thus an external professional needs to be involved. Therefore, school professionals should have the ability to refer to and cooperate with mental health professionals that work outside the school setting. This requires continuous and thorough training (Kim et al., 2015). School professionals should have knowledge of local specialised services such as open houses where adolescents can go to with all of their questions.*

Today, several good practices exist to engage external professionals in the school context:

- Some schools implement the concept of “co-encounters” in which the school counsellor and an external professional are working in parallel*. This concept is especially interesting for adolescents that do not like to be referred to an external mental health professional.
- Community mental health clinicians can be placed on-site in schools. A recent study shows that this formula has a positive influence on the suspension rates, school attendance, and emotional and behavioural symptoms in adolescents as perceived by parents and teachers (Ballard, Sander, & Klimes-Dougan, 2014).



- General practitioners (GP) can be placed one or a few days a week on-site in schools. Although many questions of adolescents will relate to physical health in the first place, GPs are in the position to identify possible mental health problems.*

When external mental health professionals are engaged at school, this requires adaptations in policy and legislation to arrange several practical issues such as the reimbursement of professionals.

Organise classes on mental health

School curricula of adolescents should include the topic of mental health. During one of the ADOCARE workshop this need was well expressed by one of the adolescents: “Nowadays, adolescents learn how their body works, but they do not learn how their mind works. Classes on mental health should be integrated in the curriculum to reduce stigma and misunderstanding”*. However, adolescents also indicated that classes on mental health may unleash bullying. Hence, teachers should pay attention to signs of bullying.

Such classes should be given at an early age, adapted to the developmental stage of the child or adolescent, repeated on a regular basis, and be part of the educational curriculum. Thus, classes on mental health should not be given as an extracurricular activity outside the school context as the most vulnerable adolescents often don’t participate in out-school activities.* Classes should focus on issues such as: resilience building, respecting others, teaching social skills, how to deal with difficult situations, expressing feelings, promoting help-seeking as a personal strength, the strengths of youngsters, and promoting family involvement (Vidal-Ribas, Goodman, & Stringaris, 2015). The classes can be given by care teachers or health educators, but it is also an option to invite a mental health professional as a guest speaker. Meeting a professional in the classroom lowers for adolescents the threshold to visit a professional when that appears necessary in the future. In addition, classes on mental health should move away from “the teaching-style method” as it is not appealing for adolescents.* Instead, programmes should be based on the life skills approach which is an interactive process of teaching and learning where the focus lies on acquiring knowledge, attitudes and skills (www.unicef.org/teachers/teacher/lifeskil.htm).

In some EU member states lessons on mental health are already given in schools. It is important to list existing programmes and to examine their effectiveness. They can act then as a good example for other EU member states.*

The Youth Aware of Mental Health (YAM) programme for students is such a good example of a school program aiming to promote mental health. The programme is developed in the context of the “Saving and Empowering Young Lives in Europe” (SEYLE) project (Wasserman et al., 2015) and consist of the following components:

- Two interactive lectures on mental health (1h)
- Role-play sessions (3h) with interactive workshops
- A booklet that pupils can take home



- Six educational posters to hang in the classroom

Research shows that the programme is effective in reducing the number of suicide attempts and severe suicidal ideation (Wasserman et al., 2015).

Finally, schools should evaluate whether students like such classes on mental health.

Implement screening programmes

Generally, prevention and screening programmes within the school context are recommended. Such programmes require: gathering and screening data, using the results in a multidisciplinary school team, establishing protocols stating interventions based on screening profiles, and collaboration with external stakeholders when specialised care appears necessary (Dowdy et al., 2014).

During the ADOCARE research, it was regularly stated that screening should occur on a continuous basis.* A good example of a continuous screening programme is that of Finland. In Finnish schools, health care check-ups are organised for youngsters at the age of 7, 10, and 14. At these ages, well-being, needs, and treatment gaps for both physical and mental health are assessed. Check-ups are organised by school health services and conducted by school doctors or school nurses. All school children are personally invited for these check-ups, but participation is on a voluntary basis. Parents are also involved in order to assess the family's well-being and needs: they are asked to complete questionnaires and are invited for a talk. When a problem is detected, follow-up care is organised.*

Also, within the context of the “Saving and Empowering Young Lives in Europe” (SEYLE) project a school-based professional screening procedure is developed (Wasserman et al., 2015). In a first stage, a self-report questionnaire is presented to adolescents. Accordingly, students that seem at-risk for mental health problems (based on the questionnaire results) are interviewed by a health care professional via a semi-structured clinical interview. During the interview, both psychopathology and risk-behaviours are targeted. Thanks to the screening programme significantly more students who are in need of mental health care are detected (Kaess et al., 2014a).

But it was also stressed that screening programmes may have a detrimental effect when insufficient mental health care services are available. In that case, they may create a demand for help while care opportunities are unavailable.

Attend to risk behaviours among students

Schools should provide special attention to risk behaviours that are strongly associated with mental health problems, such as substance abuse, sensation seeking, delinquent behaviour, excessive use of media, self-injury, and truancy (Kaess et al., 2014a). In the case of truancy, the



school counsellor or a youth worker should be legally obliged to work through outreaching in order to make contact with the adolescent as is done in Finland.

Another important school-related phenomenon that should be countered is bullying. A study conducted in an adolescent in-patient group suffering of severe mental health problems shows that almost 43% of adolescent patients was once a victim of bullying (Kalmakis & Chandler, 2015; Ryttilä-Manninen et al., 2014). Thus, dealing with school bullying is an important strategy to prevent mental health problems in adolescents (Ryttilä-Manninen et al., 2014). When targeting bullying, it is crucial to provide individually tailored interventions for those who report being victims (Ryttilä-Manninen et al., 2014).

In some schools, depression among their students is very common, while in other schools it barely occurs. For schools that encounter depression among their students frequently, a school programme aiming to reduce depression and suicidality is recommendable. One such programme is the “Empowering a Multimodal Pathway Towards Healthy Youth” (EMPATHY) programme. The programme consists of an 8-session cognitive behavioural therapy (to increase resiliency) and rapid interventions for those who are suicidal or at high-risk (interview with the student and their family followed by offering a guided internet-based CBT programme). Preliminary results demonstrate a significant decrease in depression and suicidality (Silverstone et al., 2015).

Make sure school programmes are well-implemented

Generally, when school programmes are being implemented, they should comply with the following requirements (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Rones & Hoagwood, 2000):

- Target the classroom, the home situation and the peer context of adolescents
- Include parents, teachers, and peers
- A creative involvement by individual schools so programmes are aligned with the local context, attitudes, etc.
- Provide feedback, consultation, and support to teachers (e.g., refresher training sessions, classroom observation, small group discussions)
- Implement in a consistent way
- Integrate the programme content in the general classroom curriculum
- Communicate the expectations towards students in a transparent way (e.g., school rules, a reward system for appropriate student behaviour described in the student handbook)
- Use a multi-perspective (e.g., the combination of informational presentations with cognitive and behavioural skill training)
- Make sure that the programme components are developmentally appropriate
- Actuate the whole school to promote mental health



Today, several whole school evidence-based programmes on health in students and teachers exist. The Gatehouse project is an example of such a programme (Marks et al., 2010; Patton, Bond, Butler, & Glover, 2003). The programme consists of the following three strategies:

- A coordinated school-wide approach is used instead of carrying out defragmented actions
- A positive classroom climate is promoted
- A curriculum promoting social and emotional skills is introduced

Research shows that the intervention has a positive effect on the mental health of pupils and teachers as well as on the ethos of the school (Patton et al., 2003).

The Gatehouse project – a whole school approach to promote emotional well-being

The Gatehouse Project is a school-based prevention program aiming to promote positive school environments that enhance a sense of connectedness for students, and to build individual skills and knowledge through the curriculum. The project focuses on three priority areas for action:

- Building a sense of security and trust
- Enhancing skills and opportunities for communication and social connectedness
- Building a sense of positive regard through valued participation in school life

Within the project three types of resources have been developed:

- Team Guidelines for Whole School Change that guide school teams through a five-stage process to examine policies, programs and practices at the level of the school and its links with community. The guideline consists of three parts: a first part explains the objectives and principles underlying the whole school strategy; the second part provides advice on how to implement and evaluate the strategy; and the third part contains all necessary materials to accomplish parts 1 and 2.
- Teaching Resources for Emotional Well-being assisting teachers to explore teaching and learning strategies that contribute to a positive classroom climate, and assist young people in dealing with difficult feelings and situations.
- The Gatehouse Project Adolescent Health Survey is designed to provide schools with a profile of their social and learning environment as perceived by students.

A recent website of the Gatehouse project is not available, but all materials can be found on the internet.

5. Integrated care

In the current section we provide an answer on the following two research questions:

- What is meant by integrated mental health care?
- To what extent is integrated mental health care implemented in Europe?

5.1. What is meant by integrated mental health care

First a general definition and conceptual framework of integrated care is provided. Accordingly, we discuss what integrated care means within adolescent mental health care.

Definition and conceptual framework of integrated care

People with mental health problems sometimes have complicated and on-going needs which are partly medical, partly psychological, and partly social. Hence, they require a mix of services delivered sequentially or simultaneously by multiple care providers, in different settings (home-based, community-based, and institutional settings). In order to provide high quality care, integration of various levels of care is necessary.

In the literature, integrated care has many definitions: the term is often used by different people referring to different things (Kodner & Spreeuwenberg, 2002). One of the definitions most frequently used is that of Kodner and Spreeuwenberg (2002). They provide a patient-oriented and comprehensive definition of integrated care (Kodner & Spreeuwenberg, 2002, p. 3):

“Integrated care is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care, quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings.”

More recently, the WHO defined integrated health services as (WHO, 2015b, p. 7):

“Health services that are managed and delivered in a way that ensures people to receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course.”

Because of different reasons, it is often difficult to realise this mixture of services at the right time (Kodner, 2009; Kodner & Spreeuwenberg, 2002; Stange, 2009; WHO, 2008):

- The required services are the responsibility of many sectors, jurisdictions, institutions, and providers



- The various components of care are financed by separate funding streams and subject to conflicting regulations
- Health and social care services differ distinctively in terms of language, culture, professional roles, responsibilities, clinical approaches and service approaches

The specialisation, the differentiation, the segmentation, and the de-centralisation of services leads to a fragmentation of care which in turn causes suboptimal care, higher costs due to duplication, and poor quality of care.

Translating integrated care into practice requires strategies at various levels, ranging from the macro to the micro level (Gröne & Garcia-Barbero, 2001; Kodner & Spreeuwenberg, 2002; Mur-Veeman, Hardy, Steenbergen, & Wistow, 2003; Thornicroft & Tansella, 2003; Valentijn, Schepman, Opheij, & Bruijnzeels, 2013):

- System integration (macro-level) relates to policy makers and is the alignment of rules and policies within a system in order to counteract the fragmentation of services in a health system. Rules and policies need to link different levels of specialisation (e.g., integration of primary care services with secondary and tertiary services) as well as similar levels of care across sectors. Examples of strategies are: pooling of funds, joint commissioning, de-centralisation of functions, etc.
- Organisational integration (meso-level) relates to managers of care organisations and is defined as inter-organisational relationships including governance mechanisms to deliver a mixture of services to a defined population. Examples of methods are: co-location of services, discharge and transfer agreements, inter-agency planning and budgeting, jointly managed programmes, strategic alliances, care networks, mergers, creating an umbrella organisation, etc.
- Professional integration (meso-level) relates to professionals and refers to inter-professional relationships based on shared competences, clarity about roles and responsibilities, good conditions for shared accountability in order to deliver a comprehensive continuum of care. Examples of strategies are: joint training, case or care management, multidisciplinary teamwork, integrated information systems, etc.
- Clinical integration (micro-level) relates to patients and refers to the coordination of person-focused care across various professional, institutional, and sectorial boundaries in a system, placing special emphasis on a patient's needs. Strategies focus on shared understanding of the patient's needs, a common professional language, agreed-upon practices, on-going communication and feedback between patient and care provider. This can be reached via: joint care planning, shared clinical records, practice guidelines and protocols, continuous patient monitoring, etc.

Integrated care within adolescent mental health care



The previous paragraph relates to integrated care in general and thus does not apply specifically to the context of mental health care for adolescents. However, literature on integrated mental health care for adolescents is virtually absent. During the ADOCARE research, we asked experts and professionals what aspects are important to consider concerning integrated care in relation to adolescents with mental health problems. The following thoughts were formulated:

- It targets adolescents with mental health problems and/or behavioural problems, but also supports the family and surrounding caregivers.
- It addresses the different needs of adolescents: psychological, psychiatric, vocational, educational, and recreational needs.
- Care is provided by a multi-professional team comprising a psychiatrist, a psychologist, a social worker and a teacher. When possible the team members work under one roof as this is likely to enhance continuity of care.
- Cooperation within the professional team occurs in a transdisciplinary way. This means that the team functions as one coherent network with frequent and continuous counselling between disciplines. Also, the team shares a common care plan and is responsible as a whole for the implementation of this care plan.
- Necessary patient information should be shared between professionals who are involved taking into account the necessary ethical consideration (e.g., ask the permission of adolescents to share information, inform adolescents about the information flow).
- Professionals cooperate intensively with other partners in a clearly identified network consisting of: general practitioners, pediatric practices, psychiatric mental health care services, youth welfare services, services specialised in drugs and alcohol support, services specialised in sexual health support, schools and educational services, social services, mental health care services, employment services, etc.
- When working within a network, the coordination of care should be the duty of the caregivers and not be the task of the patient. Thus, the coordination of care is carried out by one of the organisations. Moreover, good agreements are made about the allocation of tasks and the responsibility of each partner, a case manager is appointed, and inter-personal contacts occur regularly.
- Care is provided in different settings and thus not only in the consultation room.
- A range of interventions are provided: group therapy, psychological therapies, psychiatric assessment and intervention, family therapy, and occupational therapy.
- It pursues recovery, the strengthening of resilience, empowerment, and self-management so adolescents learn how to deal with future problems.
- Ideally, an umbrella organisation is established, promoting the rights of adolescents with respect to mental health care in Europe.
- An independent authority is appointed to resolve tensions between agencies or disciplines.



5.2. To what extent is integrated mental health care implemented in Europe?

Because integrated care is differently defined across settings, research fields and countries, it is difficult to assess and describe which integrated care models are present in the European member states. We do know that countries such as Germany, Ireland, Finland, the Netherlands and the UK highly focus on implementing integrated care (Busse & Stahl, 2014; McGorry et al., 2013; Mur-Veeman et al., 2003). Germany, for example, introduced in 2004 a law removing existing barriers and providing financial incentives to stimulate the implementation of integrated care models (Busse & Stahl, 2014).

Moreover, transferring integrated care models between European member states is difficult. The very different health systems, regulations and social and cultural backgrounds need to be taken into consideration (Mur-Veeman et al., 2003). Nevertheless, members of the ADOCARE network believe it is beneficial to exchange experiences, good practices, pitfalls, etc. among different European member states and even among non-EU countries. Such exchange of experiences or international research projects comparing different integrated care models (e.g., Kinzigtal model, Dutch approach) should be stimulated (Busse & Stahl, 2014). Moreover, it was stated at the ADOCARE workshops and by the WHO that every country or region should investigate how legislation is hindering integrated care and what needs to be done to stimulate it (WHO, 2013).

Finally, during the ADOCARE research it was mentioned that among European professionals there is still quite some resistance toward opening up and adapting existing structures and services. Professionals tend to work independently as self-employers rather than to share competencies and actions.

6. Policies and legislation on adolescent mental health

The following research questions find their answer in this section:

- What are mental health policies, plans and legislation?
- To what extent do policies on adolescent mental health exist worldwide and in EU member states?
- Which relevant policies and legal frameworks related to adolescent mental health care exists in the participating states?
- What are challenges regarding adolescent mental health policy in the ADOCARE countries?

6.1. What are mental health policies, plans and legislation?

Policies

The WHO defines mental health policy as *“an organised set of values, principles and objectives aimed to improve mental health and to reduce the burden of mental disorders in a population. It creates a vision for the future and helps to establish a model for action. Policy also states the level of priority that a government assigns to mental health in relation to other health and social policies”* (WHO, 2004, p. 12). Thus, adolescent mental health policies show which priority is given by policy makers to adolescent mental health. Moreover, they provide a general blueprint of broad objectives and they facilitate agreements for action among the different stakeholders (WHO, 2004, p. 13). For this, it is important to include information concerning the following components (from WHO-AIMS version 2.2 WHO, 2005b):

- Organisation of (adolescent) mental health services (types, availability, accessibility and equity of access to mental health services across different groups)
- Human resources
- Involvement of adolescents and families
- Advocacy and mental health promotion
- Human rights protection of adolescent service users
- Financing
- Quality improvement
- Monitoring system

Plans

After a policy has been developed, it needs to be translated into a mental health plan that is defined by the WHO as *“a detailed scheme for action on mental health which includes setting priorities for strategies, and establishing timelines and resource requirements. A mental health plan usually includes activities to promote mental health, prevent mental disorders and treat people with mental illnesses”* (WHO, 2005b, p. 17).

It takes approximately 1 to 2 years to develop a policy and a policy plan (WHO, 2004). Subsequently, the plan is implemented, monitored, and evaluated. It is estimated that this whole process takes 5 to 10 years.

Legislation

When new policies are developed or old ones are adapted, mental health legislation may need to be revised. Mental health legislation refers to *“specific legal provisions that are primarily related to mental health”*. Adolescent mental health legislation should focus on issues such as (WHO, 2005b, p. 18):

- Rights of adolescent mental health service users, family members, and other care givers
- Competency, capacity, and guardianship issues for adolescents with mental health problems
- Voluntary and involuntary treatment
- Law enforcement and other judicial system issues for adolescents with mental health problems
- Mechanisms to oversee involuntary admission and treatment practices
- Accreditation of professionals and facilities

6.2. To what extent do policies on adolescent mental health exist worldwide and in EU member states?

In 2004, it was reported that no country in the world had a clearly defined and separate mental health policy concerning children and adolescents (Shatkin & Belfer, 2004). As a result, in none of the countries the need for adolescent mental health services was fully met (World Health Organisation & World Psychiatric Association, 2005). The same was true for Europe: in 2009, Vieth reported that most European countries had no mental health policy specifically for the adolescent target group (Vieth, 2009).

In Europe, the EU member states stipulated in 2008 in a non-legally binding Pact on Mental Health and Well-Being that policy makers should address mental health in youth through inter-sectoral, cross-policy initiatives. The pact was followed up by a European Parliament resolution on Mental Health calling for a fostering of action between EU institutions.

6.3. Which relevant policies and legal frameworks related to adolescent mental health care exists in the participating states?

Today, European countries seem to have moved forward. Within the ADOCARE research, we asked policy makers to report about existing policy plans and legislation on adolescent mental health in their country. Results show that most countries have policy programmes that target adolescents and six out of ten countries (Belgium, Finland, Italy, Spain, Sweden, and the UK) appear to have a mental health plan specifically for adolescents (see chapter 2). Moreover, in three of these countries (Finland, Italy, Sweden), policies on mental health are evaluated and supervised.

Below, a few good examples are given of adolescent mental health policies and legislation in the participating states:

- In Belgium, an act was launched in 2013 to promote on a local level the collaboration between different organisations providing care to children and adolescents in order to establish better care, to avoid overlap in care, to stimulate a common vision on care, and to create continuity in care.
- In Finland, a generic law exists enforcing maximum waiting times in child and adolescent psychiatry: elective referrals have to be evaluated within 3 weeks; patients should be assessed within 6 weeks; and treatment should be initiated within 3 months after the need is detected.
- In Finland, there are explicit criteria concerning the access to specialised care services. Criteria are formulated for all specialties – thus not only for mental health care. Priority rating tools are used by all medical specialties to ensure that the threshold to specialised level care is similar across the country. The access to specialised care is supervised by a national office.
- In Finland, there is a law stating that minors have to be treated separately from adults in inpatient mental health services.
- In Finland, it is ruled that schools should organise a broad psychosocial assessment of all children at the age of 7, 10, and 14 in order to allow a good psychosocial orientation at these ages.
- In Finland, young offenders between 15 and 21 years old who committed a crime need to be evaluated to determine whether they have social, educational, health or mental health needs that require an intervention.
- In Finland, quality criteria were developed to evaluate psychiatric services for adolescents aged between 13 and 22 years old.
- In Finland, the health and social system are currently being reformed. Health care and social services are brought together within 5 regional entities instead of within 300 municipalities. This is expected to improve the coordination and synchronisation of services.



- In Germany, the federal committee decided in 2014 that 20% of physicians and psychotherapists who offer psychotherapy should only treat children and adolescents.
- In Sweden, a policy plan for child and adolescent mental health care services exists that aims to stimulate coordinated effective service systems for mental health promotion, the prevention and the treatment of mental health problems and other related challenges in children and youth aged between 0 and 25 years old and their families.
- In the UK, a regional initiative called “Children and Young People’s Improving Access to Psychological Therapies” (i.e., CYP IAPT) exists aiming to transform child and adolescent mental health care services and to improve access to evidence-based psychological therapies.
- In the UK, the project “no health without mental health” exists aiming to develop new services for young people to prevent mental health problems and to establish early intervention services.
- The UK launched the action plan “Closing the Gap: Priorities for essential change in mental health” aiming to improve the transition from child and adolescent mental health services to adult services.
- In the UK, the provision of care in specialised inpatient mental health services for children and young people will be improved by: increasing the numbers of beds, recruiting case managers, and introducing standard criteria for the admission to and discharge of specialised care services.

Although countries are overall evolving in the right direction, there is room for improvement. A point of concern is that most countries have no idea how much money they reserve for adolescent mental health*. Only in the UK, funds allocated to adolescent mental health are clearly identifiable: 11% of health care funding is dedicated on mental health, with less than 1% being spent on children and adolescent mental health. We suspect that the allocation of funding to adolescent mental health is in the other European countries equally low.

6.4. What are challenges regarding adolescent mental health policy in the ADOCARE countries?

During the ADOCARE research, experts, policy makers, and professionals stated that when developing policy plans, adolescents should be considered as a specific target group with distinctive needs. In order to improve adolescent mental health, European policy makers should face the following challenges (Knapp, McDaid, Mossialos, & Thornicroft, 2006):

Install an overall vision on adolescent mental health

In most countries adolescent mental health care is no priority and an overall vision on adolescent mental health is lacking because policy makers are not aware of the needs of adolescents.



Understanding the needs of adolescents and informing policy makers is a shared responsibility for the EU Commission, lobbying groups, researchers, professionals, adolescents, etc.*

Recently, the European Member States and the EC were invited by the Council to build a Joint Action on mental health and well-being in Europe. In response to this call, the Joint Action for Mental Health and Well-being (JA MH-WB) was launched in 2013 (www.mentalhealthandwellbeing.eu). The Action involves 51 partners from 28 EU Member States and 11 European organisations who work in close collaboration aiming to develop a framework for action in mental health policy at the European level. In particular, the framework of action will contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders. One of the five key areas being addressed is the promotion of mental health in schools. A similar Joint Action to improve adolescent mental health care at a policy level in Europe would be desirable.

Define a core package of necessary services treating adolescents

It would be beneficial to define a core package of services that should be available for adolescents across the EU member states (World Health Organisation, 2002). Moreover, each country should try to move the balance of care away from old institutions, and foster better community-based systems of support and treatment (Knapp et al., 2006).

Except for Hungary and Lithuania, all participating states do have mental health services exclusively for adolescents. According to the adolescents who participated in the end-user workshop, specific services for youngsters are definitely needed. They also state that it is difficult to define strict age boundaries for these services as the developmental stage (level of maturity) of an adolescent is often more relevant than the actual age of someone. Therefore, the age boundaries of such services should be broadly defined ranging from 9 to 25 years and applied in a flexible way.

Allocate sufficient financial resources to adolescent mental health

Generally, governments should spend more financial resources to adolescent mental health than they do today. In some countries, recent policy changes have resulted in a reduction of funding which in turn hinders the development of new projects targeting adolescents*. In times of economic hardship, financial resources should be divided wisely. For this, it is important to understand the economic costs associated with complex and chronic mental health problems and the need to increase expenditure in order to save costs later on (Knapp et al., 2006). During the ADOCARE research it was stated that by increasing funding to adolescent mental health care, adolescents can be treated in an early phase, preventing complex mental health problems in adulthood that require expensive long term treatment.

Within policy plans it should be clearly stated how much of the gross national product is allocated to mental health in general and how much is spent on adolescent mental health in particular. Moreover, the budget for child and adolescent mental health services should be stable and equal



the amount of money spent on adult mental health* (World Health Organisation & World Psychiatric Association, 2005).

In many situations, there is a serious problem of understaffing. This understaffing means limitations in meeting young people's requests and needs. There seems to be a tendency of reducing the allocated budgets and resources for training.

Stimulate cooperation between sectors and professions

Governments should work out one generic framework to facilitate collaboration between sectors and professions. Such framework should clear out the responsibilities of each sector and incorporate an overarching plan on how to achieve more collaboration and integration. For this, financial and bureaucratic disincentives to collaborate should be identified and addressed (World Health Organisation, 2005c).

In Belgium, a project called “integrated youth care” exists in which local boards are set up assembling all care organisations that provide youth care within a region. The organisations within this board are tasked to work together actively in order to avoid overlap in care, to create one common vision on care, and to create continuity in care without losing expertise.

Implement clear legislation on the rights of young people

At the level of policy-making and legislation, it is important that governments clearly state they adhere to the Universal Declaration of Human Rights and the Convention on the Rights of the Child¹⁵. This convention should be the framework when designing new policies, legislation or when implementing services and offering treatment and care*. In addition, policy documents and interventions should stress the human rights approach*.

Moreover, governments should make efforts to implement clear laws on how adolescents can claim help without the permission of their parents and on the right of youngsters to co-decide (and thus also to refuse care)*. In some countries, the concept of mature minors is implemented. In those cases, minors are considered to have the capacity to understand issues linked with a decision regarding their own health and they are thus considered as competent for making decisions. It is the responsibility of the healthcare providers to assess the competency of the youngster (Michaud, Berg-Kelly, Macfarlane, & Benaroyo, 2010, p. 420).

Apart from legislation on adolescents' rights, parents' rights and duties should be clearly regularised as well.

¹⁵ <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>



Legislation is necessary allowing treatment against a patients' will in order to manage cases in which dangerous (self-) destructive behaviour occurs and to protect someone against himself and/or others.* Overall, restraining procedures should be kept to a minimum.

It is important to (re)formulate legislation that allows data gathering across services and sectors. This must be done at a European level and will mostly concern confidentiality issues. In addition, there are many ethical issues with collecting data of minors and professionals need some guidelines on the procedures of data collection. When registering data, people should always be clearly informed concerning how, why and what data are registered, and who will receive access to these data.

Finally, good legislation is needed on the development and the use of e-health.*

Let young people participate in the development of policy plans

Developing and implementing mental health policies and plans should be done in close collaboration with adolescents and parents as they know best what the needs and pitfalls are.*

Recognise certain professional disciplines

In Finland, Germany, Hungary, Italy, and Lithuania, the profession of adolescent psychiatrist is recognised as a separate profession. According to many professionals this is necessary.* It addresses the wish of some parents or adolescents to be treated by an adolescent psychiatrist in specific. In contrast, other professionals raised the concern that by creating the sub-discipline of adolescent psychiatrist, psychiatrists may stop seeing the bigger picture and forget that adolescence is a period in life that evolves into adulthood. Instead of creating the sub-discipline of adolescent psychiatrist, it is possible to train all psychiatrists in adolescent mental health issues, and to oblige postgraduate trainings for psychiatrists working with adolescents.

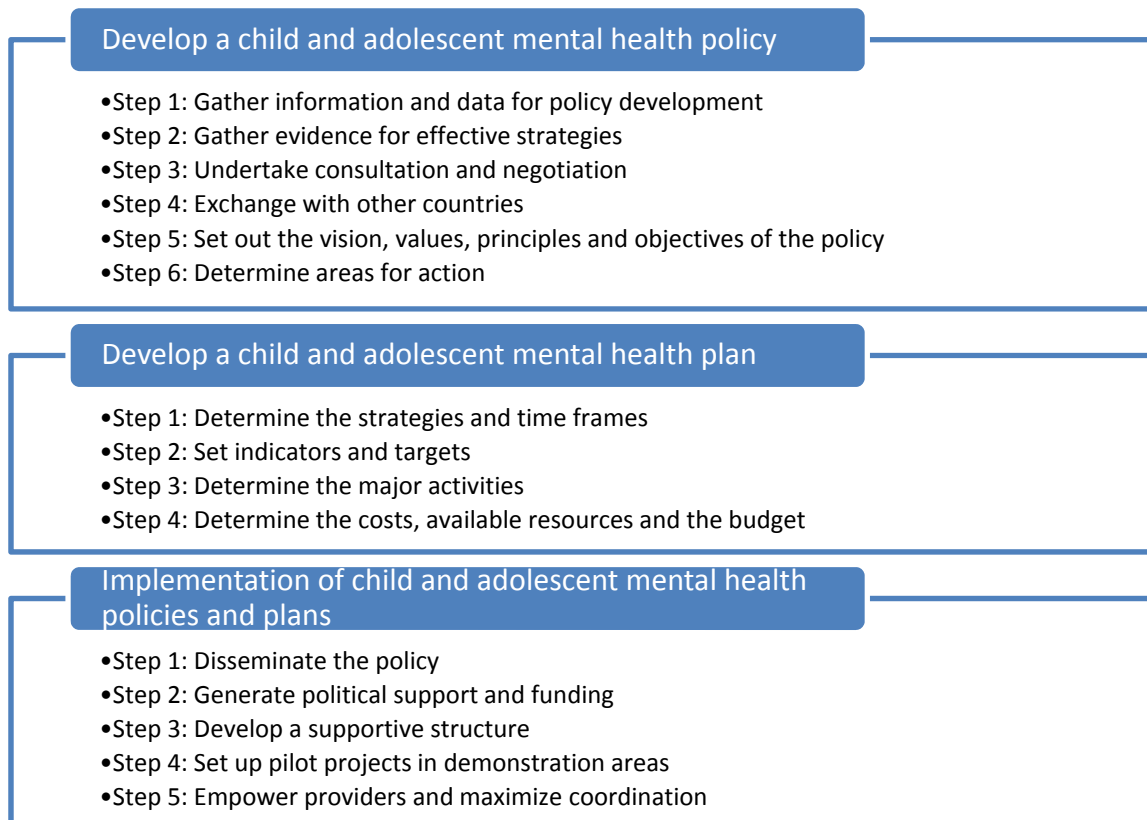
In some countries, the function of psychotherapist is not legally defined and thus everyone is allowed to offer psychotherapy. The function of psychotherapist should be clearly defined and linked to a specific type of training.

6.5. How to develop and implement adolescent mental health policies and plans?

To address all of these policy issues, policy makers need additional support. Without guidance, care systems may become (or remain) fragmented, ineffective, expensive, and inaccessible (WHO, 2005a). Therefore, the WHO developed a guidance package (a stepped plan) for policy makers on how to develop and implement specific child and adolescent mental health policies and plans (WHO, 2005a, p. IX). The package consists of three sections; and each section describes a number of successive steps (Figure 10). When taking these steps, it is important to consider the experiences of other countries or regions (Belfer, 2007).

When policies and plans are developed, it is crucial that they include a section on how policies will be evaluated. These evaluations should be scientifically sound and the results should be published so other countries can benefit from the work that has been done. The evaluation of policies and plans can be guided by the easy to use checklists developed by the WHO (2009).

Figure 10: A stepped plan to develop and implement adolescent mental health policies and plans (WHO, 2005a, p. IX)



7. Epidemiological research

In the next section, we briefly report why it is important to conduct epidemiological research on adolescent mental health and how research can be improved across Europe.

7.1. Why is epidemiological research of adolescent mental health relevant?

Epidemiological research is defined as *the study of the distribution and determinants of mental health disorders in human populations* (the BMJ, 2015). Hence, it provides an answer on questions such as (Remschmidt & Belfer, 2005, p. 148 from Verhulst, 2004):



- How many adolescents in the community have mental health problems?
- How many adolescents make use of mental health services?
- What is the distribution of mental health problems across sex, ethnic and other groups?
- Are there historical trends in the frequency of adolescent mental health problems?
- What etiological factors can be identified?
- What is the developmental course of mental health problems from childhood into adulthood?

Epidemiological research is valuable in many ways: it gives insight in the prevalence of adolescent mental health problems and the needs of adolescents in the society; it raises awareness; and it supports policy makers in setting priorities and working out public policies and mental health care programmes for adolescents. More specifically, research findings allow policy makers to develop programmes, interventions, and services that address existing gaps and that are delineated and tailored to the needs of the target group (Wittchen & Jacobi, 2005). Although epidemiological research is important, current findings are inadequate for effective policy and service planning (Carral Bielsa, Braddick, Jané-Llopis, Jenkins, & Puras, 2010; Patton et al., 2012; Wittchen & Jacobi, 2005)

Much epidemiological data are collected via administrative records (e.g., number of admissions, medication consumption, etc.). During the ADOCARE research it was mentioned frequently that in most countries administrative data lack reliability, are incomplete or difficult to compare. This is in part due to the fact that:

- Different services use different data systems, which makes it difficult to link data
- Data do not comprise all types of mental health care services or all regions of a country
- Data are not registered in a reliable way. Many professionals have a negative attitude towards data registration. They often experience difficulty in using registration systems and do not perceive it as beneficial for their clinical practice. In addition, professionals already have a high workload and mostly do not have the time to properly fill in complex data registration systems.

Also, although several countries do have administrative data, they are most often not analysed due to a lack of financial resources and therefore seldom used for policy making. Thus, the collection of administrative data via well-developed data registration systems and the analysis of these data sets via a well-established research centre can only be encouraged. Moreover, a well-developed data registration system may reduce the workload of mental health professionals. When governments decide to invest in the design of such a system, professionals should receive training and sufficient time to enter all administrative data*. The InterRAI Community Mental Health and the InterRAI Mental Health are well-known international standardised assessment instruments for clinicians working in community mental health settings and in-patient psychiatric settings respectively (see the website for more information: www.interrai.org/mental-

[health.html](#)). Both instruments evaluate the person's needs, strengths and preferences, and assess functioning, mental and physical health, social support and service use.

7.2. How can epidemiological research be improved across Europe?

First, more epidemiological research focusing on adolescent mental health is needed (Carral Bielsa et al., 2010; Patton et al., 2012; Wittchen & Jacobi, 2005) and should be collected on a regular basis as prevalence data are not static but evolve over time. Currently, many studies and databases focus on the prevalence of mental health problems in either adults (i.e., young adults and adults) or minors (i.e., children and adolescents). Thus, information on the prevalence of mental health problems in adolescents is dispersed across two broad age categories. Therefore, more epidemiological studies with adolescents as a separate target group are necessary. Moreover, as adolescence is often defined differently, it could be interesting to make all existing data available on an online platform with age being entered as a variable. This way, data can be viewed by age.

Second, during the ADOCARE research, it was stated that epidemiological data should not be collected in each country separately as this will exert financial burden on some countries' mental health budgets. Furthermore, it was argued that the prevalence of mental health disorders is fairly similar across Western countries. Nevertheless, some targeted epidemiological studies focusing on the prevalence of certain minority groups, delinquency rates, and substance use rates, within countries remain necessary as these figures do vary across countries. Some of these data are already registered by other sectors and thus should be retrieved and processed. Therefore, policy makers, researchers and professionals across the EU should be brought together to decide which and where epidemiological studies need to be conducted. This method was used by ROAMER, a comprehensive and integrated mental health research agenda within the perspective of the European Union Horizon 2020 programme. A comparable research agenda for adolescents can be set up (Haro et al., 2014).

Third, to make data comparable across countries, European research centres should work together and operate within a network to collect epidemiological data*. Some existing renowned research centres in Europe are:

- The Health and Social Care Information Centre in the UK. They are the national provider of information, data and IT systems for health and social care (www.hscic.gov.uk).
- The Public Health Outcomes Framework in the UK collects information related to public health (www.phoutcomes.info).
- SOTKA NET (www.uusi.sotkanet.fi/portal/page/portal/etusivu) in Sweden. They collect information on for example the use of psychiatric hospital services, health behaviour, psychic



symptoms, sick-leave for mental health reasons, recipients of reimbursements for antidepressants, involuntary care and psychiatric rehabilitation homes.

Fourth, when prevalence data are collected, countries should use a common procedures and similar indicators. The following indicators are valuable to study (Samele, Frew, & Urquia, 2013, p. 553; WHO, 2005a, p.4. Based on Thornicroft & Tansella (1999) and Lund (2002):

- Prevalence and incidence of mental illness
- Referral to specialist services and treatment for common and severe mental illness
- Number of beds: bed/population ratio, number of beds per type (inpatient units in general hospitals, public psychiatric care beds in hospitals or other facilities), bed occupancy rate
- Staff: staff number, staff/population ratio, staff/patient ratio
- Admissions: number of admissions, average length of stay, (unplanned) re-admissions
- Medication: consumption, availability of medication
- Suicide attempts and suicide per annum
- Sexual abuse
- Positive mental health indicators such as well-being, self-esteem, quality of life, and resilience. The Strengths and difficulties Questionnaire (SDQ) is a good instrument to measure positive emotions. It is free and available in 60 languages (www.sdqinfo.com).
- Prevalence of vulnerable minority groups: adolescent refugees, homeless people, Roma, etc.
- Other interesting rates: prevalence of divorces, teen pregnancies, adolescents at risk of poverty and social exclusion, school drop-out, etc.

Finally, epidemiological findings are seldom taken into account by governments when designing new policies, policy plans and legislation or when reorganising mental health care. Hence, it is important to provide more attention to communicate epidemiological data in an evocative way to policy makers and the broader public.

8. Mental health promotion and prevention

The current paragraph focuses on the following two questions:

- What about prevention and promotion in European countries?
- What can countries do to improve prevention and mental health promotion?

8.1. What about prevention and mental health promotion in European countries?

In 2009, a study showed that only 28 of 48 European countries have some kind of national screening and/or preventive health programme for adolescents (Ercan et al., 2009). Overall, very limited resources are dedicated to the prevention of mental disorders and the promotion of mental health. Moreover, across countries there is a huge difference in the amount of funding spent on prevention and promotion (Jané-Llopis & Anderson, 2005). Sixteen countries spend less than €30 per capita on prevention of ill health and public health. In contrast, the six countries spending the highest amount of money on prevention, devote €100 or more per head (Samele et al., 2013). Also, the existing programmes for adolescents differ widely in terms of aims, target groups, and approaches. More than half of the studied programmes (63%) focus on preventing mental health problems, whereas only 17% focus on promoting mental well-being. Most often, programmes target bullying or tackle stigma (Samele et al., 2013).

Generally, countries should realise that treatments are more expensive than prevention and promotion initiatives*.

8.2. What can countries do to improve prevention and mental health promotion?

Each European member state should have a country-based action plan to prevent mental health problems and to promote mental well-being in adolescents (NHS England, 2015). Such programmes should focus on reinforcing protective factors as they prevent the development of mental health problems (e.g., build resilience; stimulate adequate help-seeking behaviour; support parents in raising their child; create good school environments, positive peer groups; stimulate spirituality; increase empowerment; increase mental health literacy; etc.) (NHS England, 2015)*. In addition, programmes should address risk behaviours that contribute to the development of mental disorders (e.g., bullying, poverty, witnessing parental violence, harmful substance use, etc.) (Jané-Llopis & Anderson, 2005).

An example of a good practice is the website *Minded* (www.minded.org.uk). This is a free educational resource providing simple and clear guidance on children and young people's mental health, well-being and development to any adult working with children, young people and families, to help them support the development of young healthy minds.

Finally, when constructing a prevention and mental health promotion action plan, it is important to look at national programmes of other countries: what strategies appeared successful and what programmes were less successful. Jané-Llopis & Anderson (2005) wrote an overview of European actions on mental health promotion and mental disorder prevention. Actions that are relevant for children and young persons are:



- Increase parental support and skills especially in families at risk
- Decrease the use of alcohol, drugs, and tobacco during pregnancy
- Increase access to pre-school for children and families at risk
- Increase mental health promotion at school
- Increase measures of mental disorder prevention for at risk children and adolescents at school
- Increase the reach of education and mental health promotion and mental disorder prevention programmes for out of school and marginalised children and adolescents
- Improve the mental health and decrease the risk for mental disorders in populations at risk
- Increase the social inclusion for groups at risk (for example migrants and unemployed)
- Decrease the number of people suffering from depression
- Decrease suicide rates especially in countries and population groups with currently high rates
- Decrease aggression and violence in the community
- Decrease the harm done by alcohol and illicit drugs
- Increase the skills of health care providers for prevention in primary and secondary care to reduce mental health problems and substance use disorders
- Increase the implementation of preventive measures in primary and secondary care to reduce mental health problems and substance use disorders
- Decrease the number of people with socio-economic disadvantage
- Decrease social exclusion and discrimination
- Decrease the number of people that are socially isolated and stigmatised because of their beliefs or mental disorder
- Increase social support and cohesion in the community
- Increase partnerships with different sectors, in particular education, finance, housing, labour, nutrition, transport, and urban planning, to assess the impact and to promote the added value of different policy options on improving mental health and its associated social and economic benefits

Chapter 7

Reflections following the capacity building and awareness raising activities

The current chapter is a synthesis of the exchanges that took place between the different participants of the awareness raising and capacity building activities that were organised during the First High Level Conference and the four workshops within the framework of work package 2. During these occasions the concept of “Houses for Teens” was discussed in detail.

The concept of “Houses for Teens” answers to the need to have – at regional level or at a city level – a central structure that facilitates practical, multi-sectorial collaboration and networking.

Its aim can be summarised as follows:

- Creating links between the offers in care and prevention in the field of adolescent mental health (from 12 till 24 years)
- Constantly gathering clinical and functional data that help to adapt/orient the offers in care and to identify the non-attended needs so as to orient the policy makers and stakeholders in the implementation and the financing of new initiatives
- Centralising and distributing information on care/prevention services to professionals, end-users, stakeholders, political and administrative authorities
- Ensuring the networking and dialogue between end-users, professionals and policy makers
- Initiating reflection in order to develop collaborative pilot projects

The exchange of views during the capacity building and awareness raising activities resulted in:

- General principles that can be implemented all over Europe despite national or local differences.
- Operational functions that can be derived from those general principles and should be taken into account when creating Houses for Teens.

In the following two sections these general principles and operational functions are further outlined.



1. Five general principles to create Houses for Teens in Europe

1.1. Principle 1: Objectification

In each country, mental health policies for adolescents should be adapted to the identified and hidden needs of adolescents and the existing provision of care, considering all different sectors that are involved in the development of adolescents.

1.2. Principle 2: Implication

Professionals working in the field and the end-users (youngsters and their families), should be implicated in the different sectors concerned, and at three levels:

- The identification of the needs and the definition of the indicators
- The reflection on the general organisation of the services in the different sectors
- The conception, evaluation and the development of the different services and their articulations

1.3. Principle 3: Interdisciplinarity

Interdisciplinarity can be reached by:

- Considering the adolescent mental health's expressions in the six aspects of social life: family, culture, education, health, social care and justice
- Taking into account the existing dynamics not only in those six fields, but also between them
- Defining ways to organise dialogue, evaluation and effective networking within and between those six sectors
- Enabling adequate means to facilitate access to relevant and efficient information on existing services and professionals for end-users as well as for professionals themselves.

1.4. Principle 4: Training

Professionals should receive continuous training aiming to facilitate the three general principles that are described above (objectification, implication and interdisciplinarity). Therefore, trainings should:

- Stimulate openness to the different dimensions of adolescent mental health by training:
 - Necessary competences in the specific field of experience and practice
 - Familiarity with the available care offer



- Sufficient knowledge regarding the organisation of the other sectors of social life where adolescents and their families are confronted with
- Focus on networking and collaboration: train the ability to communicate, to take into account institutional dynamics, to organise and manage workgroups
- Occur at different levels of specialisation:
 - A basic general training should be provided to ensure adequate reception, comprehensive analysis, efficient orientation and support of every type of situation related to the field
 - Specialised training should be provided in a few more specific areas of this field

1.5. Principle 5: Prevention

Prevention appears as the result of the effectiveness of the four preceding principles. Special attention should be paid to:

- Sensitise youngsters, their families and of the social field, in a vision of information and de-stigmatisation of the processes of development of the adolescents and youngsters, as well as of the problems of mental health and the care services, put in the perspective of the social evolutions and their impacts
- Training of the teenagers and the young people in communication, in the development of social skills, in the consideration of the psychological real-life experiences and in their expression, in conflict management, in the implication as a citizen

2. Operational functions that can be derived from the five general principles

2.1. How to operationalise the “objectification”

In order to identify the hidden needs of adolescents and the existing provision of care answers should be sought on the following questions:

- 1 What needs or difficulties related to mental health are faced by young people and their families?
- 2 What type of care is required to address these needs or difficulties?
- 3 What groups of young people (and their family) receive or fail to receive care?
- 4 Is the provided care perceived by the care users and the professionals as appropriate and adequate?
- 5 What are the short-term and long-term effects of the provided care?



6 How can the provided care be improved?

During the capacity building and awareness raising activities, questions 1 and 2 provoked the following remarks within the ADOCARE network:

- Psychological difficulties are bound to multiple factors which interact with each other
- These difficulties can be expressed in many different ways and thus are picked up by professionals outside the mental health field as such, for example teachers, judges, etc.
- They can also remain hidden for a long time, in spite of a potential important morbid evolution (suicide attempts in particular)
- Depending on the professional, the definition of what is problematic or not will be different
 - Which young people and which families receive /do not receive a help / care
 - Is the help /care considered as appropriate and adequate by the users / by the professionals?
 - What are the short and medium-term effects / results?

Questions 3 and 5 provoked the following remarks:

- There are various manners to envisage mental health care (e.g., diseases to cure versus processes of personal development to support)
- These views determine objectives and also practices which do not only fail to coincide, but often lack adequate articulation
- The transposition in the field of mental health of the medical concept of "evidence based" raises problems as far as it conveys an ideology of medicalisation, which gives the priority to quantifiable indicators

Question 6 provoked the following remarks:

- The answer to this question seems to be the implementation of the process of participation of the interested parties, the professionals and the users (cf. infra)

2.2. How to operationalise the “implication”

Implication is important at the three levels of conception (design), evaluation and implementation of a mental health policy.

The following remarks were given:

- Measures are indeed often taken as things come, by the political and administrative authorities, in limited domains, originated from very unclear and partial considerations, and according to objectives that are little integrated into a wide political perspective



- Implication thus implies to establish a mental health policy for the adolescents on the widest possible vision of factors and actors who influence it. This inevitably means an effective mobilisation of the end users and the professionals in the field

The professionals in the field:

They should be involved in multidisciplinary and trans-sectorial working groups focussed on main problems related to the development of adolescents and youngsters.

The practical experience of the field professionals, having a real local insertion, should be given priority. At the instigation of public authorities and administrations, care facilities, representative associations, universities and centres of training and research can join these working groups to support their work and bring them specific skills.

Remark: A tender spot is the respect for the diversity of the approaches, and to work especially on a complementarity of the offer (no type of care / service can claim to suit all the patients / problems).

The end-users:

This goes through a different global attitude of the society and the adults (including mental health professionals) towards the teens and youngsters. There is a real need to listen and take into account what they have to say about the society, about the social pressure (especially the new emerging pressures) that they experience, about the lack of respect and the stigmatisation (especially regarding mental health problems), about the lack of possibility to really collaborate to the definition of what they need for their development (especially in the field of school and teaching).

Regarding mental health facilities, they feel a need:

- To improve the information and the access
- To develop specific trainings of the professionals in different areas where they are lacking (cf. ImRoc)
- To have a larger diversity of facilities
- To sustain and improve the continuity of mental health care between adolescence and adulthood, with the crucial age of 18 (cf. Milestones Project)
- To implement on a large scale (cf. the UK initiatives) the implication of youngster and parents in the construction of local mental health networks for adolescents and youngsters

Remarks:

- The experience of GIFT (UK) is particularly interesting, implicating patients and former patients in the reflection on how to improve the care services



- One of the problems encountered when end-users and parents participate in the conception, installation and evaluation of care services (in an obvious way for the care, but also in other sectors) is the difficulty to join the position of partnership that it implies, with the dissymmetric position in the relationship of care (but also in education, teaching, the judiciary ...)

2.3. How to operationalise “interdisciplinary”

The development of effective collaborations within networks in the various sectors and between the various sectors is a major stake for the promotion of the mental health of adolescents. But, the experience shows that neither the administrative implementation of structures of dialogue, nor the freedom left with the professionals to get auto-organised, give satisfactory results.

The only decisive experiences are the ones where public funding is assigned to the implementation, by various field actors, motivated to work together, of practical projects constructed together from identified needs on which the professionals join.

The “Maisons d’Ados” in France are inspired by such a model.

These experiences should include an effective and active participation of concerned end-users or their representatives. In particular, peers' integration in care (" peer support workers ", ImRoc) can improve the continuity of help and care.

One aspect that needs more specific attention is the information relative to the newly set up services, which too often remains confined to a restricted network of professionals.

Public authorities have an important responsibility in this domain. They have to provide , for the professionals and the end-users, accessible, understandable and usable information, facilitating the adequate orientation according to the identified needs (in obvious link with the missions of approval, financing, control and evaluation of which they are generally in charge).

2.4. How to operationalise “training”

Professional training should cover three different levels:

Specific training of the different professionals in order to improve and develop their theoretical and practical skills

- This includes the ability to “unlearn”
- These trainings include the work with the family and within a network around the adolescent
- These specific trainings concern:
 - The medical field

- The field of education
 - o the training of the teachers in the management of group-classes and in instigating participative dynamics, should be strengthened
 - o the importance to integrate the changes that internet brings in the processes of learning, should be a priority

Remark: the way of “learning” on the Internet leaves out the intervention of adults, while an important dimension of the learning is its transgenerational dimension

- the field of justice and the protection of minors
- the social field
- the field of employment (professionals involved in professional orientation and employment)

Training to develop the ability of collaborating/working together with professionals from other fields:

- Questions about confidentiality and privacy
- Open-minded approach of the limits of one’s own field and practices ; and consideration towards it’s conditions of effectiveness
- Common training on adolescent needs and challenges and in identifying the family and social evolutions and to understand their impact on adolescence developmental processes. To share a common view and agreement on these two basic topics seems very important

Training to develop organisational abilities:

- Intra-muros :
 - Adapt the goals / the means / the resources
 - Building creative institutional dynamics (cf. ImRoc)
 - Support the team working and prevent burn out
- Extra-muros :
 - To develop links and complementarity with the other structures, services and professionals
 - To identify and understand the position of one’s own service in the general organisation of the care system, but also education and welfare systems
 - To develop good communicational skills towards the end users, the general population, the administrative authorities and the politics, in order to promote adolescent mental health



2.5. How to operationalise “prevention”

- Prevention initiatives are best conceived by professionals in each field, but should closely involve end –users and stakeholders
- Specific prevention in each professional field should also be developed in a global perspective in order to avoid loss of effectiveness – or even adverse effects
- This could lead to integrated, multidimensional preventive initiatives.

Chapter 8

Recommendations

The present guidelines aim at supporting policy makers (macro level), services (meso level) and professionals (micro level) in their attempt to improve AMHC in their country. It does so by outlining concerted actions. Adolescence in this text spans the ages 12 to 24. The recommendations and actions proposed are the result of a two-year research process. The following groups were consulted on several occasions in a differentiated manner: policy makers, professionals and experts in the field of AMHC, teenagers and young people as well as their families, organisations which represent this age group. In addition we reviewed the most recent literature on MHC in general and AMHC in particular.

The recommendations concern ten areas European countries need to focus on to improve AMHC:

- Availability of AMHC services
- Quality of AMHC services
- Accessibility of AMHC services
- Personalised treatment
- Integrated care
- Transition of adolescents from AMHC services to adult MHC services
- Training of professionals
- Prevention and mental health promotion
- Policy and legal frameworks
- Research

1. Availability of AMHC services

Recommendation: Each country is committed to pursue a balanced care model.

Proposed actions at macro level:

- When establishing balanced MHC, the following types of services are considered necessary:
 - Primary health care services for persons with common mental health problems. These services are responsible for case finding and assessment, short psychological and social interventions as well as social treatments and pharmacological treatment.
 - General MHC services for persons with more complex problems. General MHC services comprise five components: outpatient/ambulatory clinics, community mental health teams, acute inpatient care, long-term community-based residential care and support in work and occupation.



- A series of specialised MHC services in each of the five categories of general MHC services to provide more intensive/expert interventions (e.g., autism, schizophrenia, eating disorder, addiction, severe depression and suicidality).
- A balanced care model implies that both community and hospital care are available and provided in a pragmatic and balanced way. This means that in countries with many residential services, the number of beds will need to decrease in favour of more community-based care and mental health promotion.
- The evolution towards more balanced care goes hand in hand with a more important role for primary care in mental health. Mental health interventions and treatments and non-specialised primary health care for adolescents are integrated. Examples of the latter are concerns about sexual health, career options, general health, bereavement support, campaigns to stop smoking.
- Services are linked in a regional network, they develop a joint mission and strategy and make sure their services are complementary. There is neither overlap nor are there gaps.
- Governments make sure the principles of stepped care are applied.

Proposed actions at meso level

- The guiding principle in the choice of treatment and interventions is stepped care:
 - Appropriate non-specialised care is provided first.
 - Adolescents are only referred to more specialised care when this appears necessary.
 - Professionals (especially primary care workers) but also parents acknowledge that not all mental health problems require specialised care and that much can be done within primary care or community-based care.

Proposed actions at micro level

- General practitioners and other primary care professionals are trained to recognise AMH problems.
- They are able to use short term interventions and are aware of assessment tools to decide whether more specialised care is required.
- They apply the principles of motivational interviewing and shared decision making to determine treatment and decide whether referral is needed.

Recommendation: Availability of AMHC services is guaranteed for all adolescents that need care.

Proposed actions at macro level:

- Countries need to obtain a clear view on their availability of MHC services for adolescents. It is essential to identify the treatment gap. This is defined as the absolute difference between the



prevalence of mental health problems among adolescents and the percentage that receives appropriate treatment.

- Once the required number of MHC facilities and professionals per 100,000 adolescents is defined, governments need to take action to close the potential treatment gap.
- Availability of each of the three types of health care services is guaranteed (primary health care services, general MHC services, and specialised MHC services). Balanced care is equally available throughout the country.

2. Quality of AMHC services

Recommendation: Each country has youth friendly services tailored to the needs of adolescents.

Proposed actions at macro level:

- Governments make sure that the three types of health care services needed to achieve balanced care operate in such a way that adolescents feel welcome and understood. Services are youth friendly.

Proposed actions at meso level:

- Services apply their age range (12 to 24) in a flexible way.
- Services are easy to access so that adolescent experience few barriers. This means :a welcoming and attractive environment, drop-in services, convenient opening hours, access without the permission of parents, low cost or free services, reduced waiting times, convenient location near public transport, discrete entrance and a positive image.
- Services provide clear information on legal (confidentiality) and economic (affordability) aspects.
- Young people and their parents are actively involved in service design, care delivery and procedures of a service. For instance, adolescents can be involved in the development of a service charter which addresses issues such as confidentiality, opening hours, treatment programme, rights of adolescents, ethical aspects.
- Services engage good role models in care delivery (i.e., adolescents who experienced similar problems in the past) as they have a beneficial effect on the well-being of adolescents. Examples are peer support, group therapy, self-support groups.
- Services guarantee continuity of care so that adolescents are preferably treated by the same team of professionals.
- Services reach out to adolescents in order to prevent drop-out of adolescents in need of help, to offer support and treatment.



Proposed actions at micro level:

- Youth friendliness is an important characteristic for staff working in AMHC. Besides their clinical competencies, professionals have a positive attitude towards the life and lifestyle of adolescents. They respect their target group and are highly motivated and honest. They are easy to connect with and they develop an empowering helpful relationship.

Recommendation: AMHC services adopt high quality standards.

Proposed actions at macro level:

- Governments define a set of quality standards that AMHC services should meet. Relevant indicators are amongst others the accessibility of a service, the capability and skills of professionals and the balanced use of psychosocial and medical interventions. For the selection of indicators we refer to the User-generated Quality Standards for Youth Mental Health in Primary Care (Graham et al., 2014) and the Service Standards (seventh edition) (Thompson & Clarke, 2015).
- Governments develop evaluation instruments to assess the quality of AMHC services. The same instruments are preferably used across services, regions and countries, to allow comparison.
- The evaluation is carried out by an independently funded research organisation. Services that do not comply, are offered assistance to improve their quality of care.

Recommendation: When providing care, ethical considerations and values are taken into account.

Proposed actions at macro level:

- An ethical committee is in place to provide feedback to professionals on ethical dilemmas.

Proposed actions at meso level:

- Services abide by the ethical principles of autonomy, beneficence and equity that are stated in the Belmont Report (Michaud et al., 2010).
- Ethical issues concerning confidentiality in treatment, the right of adolescents to access their patient record and to participate in their treatment are clearly outlined in a service charter. This charter is developed in collaboration with adolescents.

3. Accessibility of AMHC services

Recommendation: MHC services are highly accessible for adolescents.



Proposed actions at macro level:

- Governments and the media take action to overcome stigmatising attitudes toward mental health problems and the use of MHC. A recurring theme is that mental health issues are a normal part of life and that searching for help is no sign of personal weakness. Actions should particularly target boys as their mental health literacy is less developed and they are less willing to look for help.
- The knowledge of young people regarding mental health and MHC should be increased. This can be done by providing attractive, easy-to-navigate and read websites and by targeting mental health literacy through the school curriculum.

Proposed actions at meso level:

- Services provide online information on the support they give. The communication style appeals to youngsters and is very matter of fact. Concerns related to confidentiality are addressed in a transparent way.
- Services reach out in order to stay in touch or establish contact with the most vulnerable adolescents. This group hardly ever accesses help on a voluntary basis.

Recommendation: Mental health treatment is integrated as much as possible in non-specialised primary health care.

Proposed actions at meso level:

- General practitioners are stimulated and trained to recognise mental health issues at an early stage. During this type of intervention they assess different areas of life (home environment, education, employment, eating patterns, activities, drug use, sexuality, addictive behaviour, suicide/depression, signs of injury and violence) and they make sure the severity of psychological problems is not underestimated.
- Youth clubs can provide information on mental health and offer basic support to adolescents with mental health problems.

Recommendation: The internet can make MHC more accessible for adolescents.

Proposed actions at macro level:

- Web-based interventions are encouraged to increase access to mental health care, to inform adolescents about care, to engage adolescents more actively during treatment and to make sure care after treatment has been completed.
- Governments assign quality labels to websites, tools and apps so adolescents know that they are dealing with a reliable and youth friendly website.



Proposed actions at micro level:

- Professionals are aware of reliable internet-based interventions for adolescents.
- Internet-based interventions are preferably supplemented by professional support. The idea is to help adolescents interpret the information they find online and to guarantee a personalised treatment.

4. Person-centred treatment

Recommendation: Support, coaching and treatment is offered in a person-centred way and actively involves the adolescents.

Proposed actions at micro level:

- During assessment, professionals take the adolescent's bio-psycho-social functioning into account. They focus on the client's psychological problems as well as on his strengths and competencies.
- During treatment, professionals involve young people in the decision making process by applying the principles of shared decision making. Professionals clearly state that there are choices to be made, provide detailed teen-oriented information about the different options and support adolescents in exploring preferences and making choices.

Recommendation: Every adolescent receives an effective combination of bio-psycho-social treatments.

Proposed actions at macro level:

- In countries where the biomedical paradigm is the exclusive or dominant treatment model, governments take action to stimulate the use of the bio-psycho-social paradigm. This can be done for example by reimbursing psychosocial interventions in addition to pharmacological treatment.

Proposed actions at micro level:

- Psychosocial interventions are regarded by professionals as the first line of treatment. Most common are psycho-education and psychotherapy, but other interventions might be beneficial such as creative art workshops in which adolescents can express their feelings (music, writing, dancing, painting, etc.) or sports activities. An overview of current evidence-based interventions is available in the book "What works for whom" (Fonagy, et al., 2014).
- Psychosocial interventions do not only focus on cure and care, but also on resilience and strengthening one's competence.



- Medication for serious mental health disorders may be necessary, but it is offered in combination with psychosocial interventions. Professionals are sensitised about the possible overuse of medication and rely on guidelines when prescribing.
- Treatment, coaching and counselling strategies which have proven to be effective are given priority but one needs to keep an open mind for new developments. Guidelines are used as they provide an overview of existing evidence-based treatments (e.g., the Mental Health Gap Action Intervention Guide of the WHO, NICE, etc.). Professionals also resort to protocols on how to implement evidence-based interventions in a standardised way.
- Treatment outcomes are systematically monitored so as to determine whether interventions are efficacious.

Recommendation: Adolescent mental health problems are approached from a developmental perspective.

Proposed actions at micro level:

- Caregivers take into account how the adolescent has developed so far and what developmental issues and crises are influencing the current situation. The idea is to fully grasp the problems at hand and to determine the need for help and support.
- Caregivers acknowledge that the needs of adolescents are subject to constant change. The care plan must follow suit.

Recommendation: Every care plan builds bridges to normal life.

Proposed actions at meso level:

- Recovery and inclusion in society are primary objectives in every treatment plan. Professionals support adolescents in their education, in finding housing and employment and in building trusting relationships with others, so they fully assume their role as citizens. Therefore, collaboration with other sectors is essential.
- When and if possible care is offered in the natural environment of the adolescent. When hospitalised, professionals develop a strategy so that the adolescent has a perspective to go home.
- Supported employment and supported education are important aspects of care for adolescents with severe and enduring mental illness. This requires a systematic collaboration of mental health services with employment and education services.

Recommendation: Parents are involved if possible.



Proposed actions at macro level:

- Countries develop legislation on the rights and duties of parents in case their child needs AMHC.

Proposed actions at micro level:

- At the start of treatment, parents are informed. Adolescents are encouraged to involve their parents if this has a positive effect on their well-being.
- Parents should receive support when they are experiencing problems themselves or when a dysfunctional relationship is at the heart of the adolescent's problems. A good overview of existing family-based interventions is available for professionals (Kaslow et al., 2014).

5. Integrated care

Recommendation: Governments create a common framework spanning all sectors.

Proposed actions at macro level:

- Strategic alliances and care networks are organised at a local level. The aim is to link different levels of specialisation (e.g., primary, secondary and tertiary care services) as well as similar levels of care across sectors (e.g., housing, employing, justice, etc.).
- Local committees are created to steer networking across services.
- When professionals involved in the treatment of adolescents collaborate across sectors, there ought to be a financial incentive. To encourage collaboration, the benefits of working together should be highlighted, or job mobility encouraged across sectors.
- Information on current initiatives is available on one centralised website.

Proposed actions at meso level:

- Multidisciplinary teamwork is the standard, the general practitioner is included as a team member.
- Joined care planning is initiated. The team of professionals shares a common care plan and feels jointly responsible for its implementation.
- Venues for cross-sector discussion and interaction are provided.
- Intensive case management is established. One professional is appointed who has the final responsibility for each case.
- Consensual agreements are drawn up outlining each partner's role and responsibility and referring to procedures and rules that should be followed in case of discharge, transition or conflict.

- A common infrastructure for collecting and sharing patient information between different care providers within or across sectors is established.
- Joined training is organised for professionals of different sectors. That way competencies are transdisciplinary.

6. Transition of adolescents from AMHC services to adult MHC services

Recommendation: Governments, MHC services and professionals improve the transition of AMHC services to adult MHC services.

Proposed actions at macro level:

- Policy plans contain strategies to improve transitional care. Within the context of the Milestone project, guidelines for policy makers are developed to assist them in making informed and evidence-based decisions to improve health systems.
- Local adolescent and adult MHC services and voluntary services are regularly mapped and updated (i.e., their scope of operation, communication networks and key contacts).
- Mental health professionals are trained on how to optimise transition of care. Such trainings need to tackle negative attitudes concerning referrals to other services, increase knowledge of other services, and improve self-efficacy and skills. Similarly, within the context of the Milestone project, training packages for clinicians across the EU are being developed and will be implemented.

Proposed actions at meso level:

- Services develop and implement protocols to improve transitional care in line with the needs of adolescents. Within this protocol, the time frame and everyone's responsibility are clearly defined. There is a backup plan in case adult MHC services or the patient in question are unable to accept the transfer.
- Services are flexible when it comes to the age of clients. Adolescents who are not ready for transition to an adult service, remain in the care of the adolescent service.
- Services try to avoid multiple, simultaneous transitions, as one transfer already requires a lot of preparatory work.
- The adolescent and the adult MHC service co-manage the transition for a certain period of time.
- Active involvement of the adult service is required before the adolescent service is allowed to discharge a patient.
- Adolescent and adult MHC services use a standardised record system and transfer all correspondence and contact information.

- The transition to adult services is an important quality indicator when evaluating care. Within the context of the Milestone project, specific outcome measures are being developed and validated.

Proposed actions at micro level:

- Adolescents are well-prepared by professionals in the weeks prior to the transition and the transition occurs when the adolescent's condition is stable.

7. Training of professionals

Recommendation: The education of mental health professionals working with adolescents is tailored to that specific group.

Proposed actions at macro level:

- During their education, adolescent mental health professionals receive training on specific adolescent-related topics, such as normal adolescent development, assessment of mental health problems in adolescents, how to communicate with adolescents, shared decision making, evidence-based psychosocial interventions, how to work within an integrated network of services, transitional care, and policies and legislation regarding AMHC.
- Uniform standards are set up for the educational curriculum of adolescent psychiatrists and psychologists in Europe.

Proposed actions at meso level:

- Interdisciplinary training sessions and postgraduate courses are mandatory for clinicians in AMHC services.
- Learning networks are set up to stimulate continuous education on the work floor (cf., ImROC).
- Services organise intervision and supervision on a regular basis.

Recommendation: Professionals who occasionally encounter young people with mental health problems are trained in AMH issues as well.

Proposed actions at macro level:

- It concerns general practitioners, hospital nurses, school nurses, youth workers, public health workers, social workers, and teachers. They receive courses on AMH issues during their basic education.
- Helplines or websites are available. Professionals can consult these in case they have questions or concerns related to AMH.

8. Prevention and mental health promotion

Recommendation: Countries have an action plan to prevent mental health problems and to promote well-being in adolescents.

Proposed actions at macro level:

- Action plans include interventions to reinforce protective factors (e.g., encourage adequate help-seeking behaviour, support parents in the raising of their child, create good school environments, increase mental health literacy, etc.) and interventions to address risk behaviours (e.g., bullying, poverty, parental violence, substance abuse, etc.). These actions particularly target vulnerable young people and their families.
- Strategies and interventions that appeared successful in other countries are highly recommended.
- The media can play an important role in de-stigmatisation and the distribution of information.

Proposed actions at meso level:

- Health workers reach out to vulnerable adolescents who tend to remain out of view. They visit places where they frequently hang out (e.g., stations, squares, parks, public sport venues, pubs), and invite them to visit their service or give support onsite when needed.
- Certain programmes support the personal development and inclusion of these vulnerable adolescents. We think in this respect of special events or group activities (e.g., cleaning nature to protect the environment, small restorations of public buildings, assistance to the poor, neighbourhood parties, fund raising, etc.). This is a good way to empower adolescents as they learn to successfully engage, take responsibility, build social relations, etc.
- Parents obtain support on how to cope with mental health issues in their child. Websites can help parents identify mental health issues and show them what actions they should take in the best interest of their child.

Recommendation: Schools are a key setting to promote mental well-being.

Proposed actions at macro level:

- Teachers receive basic training in adolescent mental health, mental health promotion, and how to prevent and recognise mental health problems.
- Classes on mental health are integrated in the curriculum of adolescents. Classes focus on issues such as building resilience, respecting others, social skills, dealing with difficult situations, expressing feelings, promoting help-seeking behaviour and empowering youngsters.



- Health care check-ups can be organised in a school setting to detect students who are in need of MHC. Within the context of the “Saving and Empowering Young Lives in Europe” (SEYLE) project a school-based professional screening procedure was developed. However, screening programmes have a detrimental effect when a country has insufficient MHC services. They might create demand for help which is not available.

Proposed actions at meso level:

- Mental health professionals (school counsellors) are engaged at school to provide advice to teachers and/or to offer direct support to adolescents.
- Schools can collaborate with mental health professionals working outside the school setting. For example, external professionals can drop in at the school once a week.
- Classes on mental health can be given by care teachers or health educators, but it is also an option to invite a mental health professional as a guest speaker. In addition, classes are preferably given in an interactive manner to increase knowledge and work on attitudes and skills. Teachers should be attentive to possible signs of bullying which may be evoked by such classes.
- Schools pay special attention to risk behaviours strongly associated with mental health problems. Examples are substance abuse, sensation seeking, excessive use of media, self-injury, delinquent behaviour and truancy. In those cases, the school counsellor tries to establish contact with the adolescent to find out what is going on.
- Schools develop an action plan to address bullying. This is important to prevent mental health problems.

9. Policy and legal frameworks

Recommendation: Countries develop and implement specific policies and plans on adolescent mental health

Proposed actions at macro level:

- When designing new policies, legislation and frameworks for action, the Universal Declaration of Human Rights and the Convention on the Rights of the Child are a reference.
- Governments need to acknowledge that improving the quality of AMHC is a key priority and that adolescents have distinctive needs.
- The WHO developed a guiding package for countries describing the successive steps policy makers need to take in order to develop and implement AMH policies and plans (WHO, 2005).
- When policies and plans are being developed, adolescents and parents are closely involved. Policies are evaluated. For instance, by using the WHO checklist for evaluating a mental health policy (WHO, 2009). Results should be exchanged with other European countries to learn from one another.

- Governments draw up clear legislation stating how adolescents can claim help without their parents' permission, the right of youngsters to co-decide in their treatment plan, the rights and duties of parents, restraining order procedures (although they should be kept to a bare minimum), registration and access of patient records and the use of e-health.

Recommendation: Governments allocate sufficient financial resources to AMH.

Proposed actions at macro level:

- In policy plans it is transparent which percentage of the gross national product is allocated to mental health in general and how much is spent on AMH in particular.
- The amount of funding spent on MHC is distributed more evenly between adult MHC on the one hand and child and adolescent MHC on the other hand. By increasing funding for AMH, mental health problems can be detected at an early stage. This prevents complex mental health problems in adulthood that require more expensive, long term treatment.
- Governments make efforts to increase financial resources in order to obtain high quality AMHC.

10. Research

Recommendation: Epidemiological data are crucial to raise awareness and to support policy makers.

Proposed actions at macro level:

- Governments invest in well-developed data registration systems to collect administrative data. Good examples of standardised assessment instruments are the InterRAI Community Mental Health and the InterRAI Mental Health. Implementing such systems requires time to enter data and train users.
- Epidemiological research can be organised in a collaborative approach across EU countries (cf., the European Study of the Epidemiology of Mental Disorders, ESEMeD study).
- Research particularly focuses on AMH in specific and vulnerable target groups (such as refugees, adolescent Roma, etc.).
- Data on adolescent issues that are collected by other sectors such as dropout rates, youth crime, and sexual abuse are worth studying as well.

Proposed actions at micro level:

- Research centres make sure that epidemiological findings are communicated in a clear and lively fashion to policy makers and the general public so that results are used.

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