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Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Center

ORGANISATION DES SOINS DE SANTE MENTALE POUR ENFANTS ET ADOLESCENTS: ETUDE DE LA LITTERATURE ET DESCRIPTION INTERNATIONALE





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HEALTH SERVICES RESEARCH

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PRÉFACE

La souffrance psychique des enfants ne peut laisser aucune société contemporaine indifférente. Même si, dans certains cas, c'est précisément cette même société qui est à l'origine de ces souffrances. Spontanément, on ne peut que penser qu'aucun effort ne doit être épargné pour aider ces enfants.

Malgré cet élan souvent unanime, on ne peut que constater que l'accueil des jeunes confrontés à des difficultés psychiques est souvent insuffisant ou qu'il nécessite pour le moins une révision approfondie. Les initiatives prises pour prendre le taureau par les cornes, tant nationales qu'étrangères, sont nombreuses. Une fois ces initiatives prises, se pose ensuite la question de savoir quelles leçons on peut en tirer. Dispose-t-on de bonnes évaluations, susceptibles d'apporter aux décideurs politiques des données sur lesquelles façonner une organisation efficiente des soins de santé mentale pour les enfants et les adolescents?

C'est la question que le SPF Santé publique a posée au KCE. Nous allons y répondre en deux temps. Dans un premier temps, nous avons recherché des données probantes, poussant à recommander l'une ou l'autre forme d'organisation de ces soins et nous avons également examiné comment les autres pays abordent cette question. Les résultats de cette étude sont présentés dans le présent rapport.

Avant de formuler et diffuser des conclusions définitives à partir de ce rapport, nous allons cependant, dans un deuxième temps, développer différents scénarios en concertation avec les principales parties prenantes (stakeholders) dans ce domaine. Les résultats de cette deuxième partie de l'étude peuvent être attendus dans le courant de la première moitié de 2012. Le présent rapport fournit déjà des données utiles dans le cadre de cet exercice ultérieur et nous tenons à remercier les équipes du Service Universitaire de Psychiatrie – Section de psychiatrie infanto-juvénile de l'UZ Gent et le Département de Santé Publique de l'Universiteit Gent pour leur large et précieuse contribution à ce projet.

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RÉSUMÉ

INTRODUCTION

Au cours de la dernière décennie du siècle dernier, des réformes importantes sont intervenues dans les pays occidentaux dans le secteur des soins de santé mentale (SSM). Dans les SSM pour adultes on a vu progressivement s'installer un modèle de “balanced care” ou soins équilibrés : les soins proposés sont aujourd'hui, dans la mesure du possible, organisés directement dans la communauté de vie du patient et les institutionnalisations ne sont plus organisées qu'en cas de nécessité. Simultanément, il est nécessaire de garantir une transition fluide et ininterrompue d'un service à l'autre.

Les problèmes de santé mentale de l'enfant et de l'adolescent ne sont pas rares. L'OMS (Organisation Mondiale de la Santé) estime la prévalence dans les pays occidentaux à environ 20%. Environ 5% nécessiteraient une intervention clinique.

Le secteur des SSM pour enfants et adolescents ne s'est développé que beaucoup plus tard que le secteur des adultes et repose sur une autre structure de soins. Les principes de réforme esquissés plus haut sont néanmoins valables pour le secteur des enfants et adolescents. Les soins pour enfants et adolescents nécessitent souvent une approche qui dépasse la seule sphère des SSM. Médecins généralistes et pédiatres, par exemple, traitent de nombreux problèmes dépistés pour la première fois à l'école. Les SSM pour enfants et adolescents tiennent donc compte aussi de ce qu'on appelle les “secteurs connexes”: action sociale, justice, soins aux personnes handicapées, enseignement.

OBJECTIF

L'objectif du présent rapport est de rassembler les connaissances sur les aspects organisationnels des SSM pour enfants et adolescents dans le cadre du contexte expliqué plus haut. Le contenu spécifique des soins n'est pas abordé. Le rapport est divisé en deux parties: une revue de la littérature et une description de l'organisation des SSM pour enfants et adolescents en Belgique et dans trois autres pays.

Ce rapport ne formule pas encore de proposition par rapport à l'organisation de ces soins en Belgique. Pour ce processus nous ferons appel aux parties prenantes (stakeholders) belges. Le résultat de leur travail sera décrit dans un autre rapport.

REVUE DE LA LITTERATURE

Tant pour la revue de littérature que pour la description internationale, nous avons exploré les publications évaluées par les pairs (peer-reviewed) et la littérature grise. Outre des études comparatives, des études descriptives et des recherches qualitatives ont également été incluses dans l'étude. En ce qui concerne la description internationale, la littérature disponible a été complétée par des données d'informateurs locaux.

MODELES D'ORGANISATION DES SOINS

Le rapport se concentre sur les modèles les plus courants ainsi que sur les modèles pour lesquels on dispose d'une étude comparative.

Les deux principaux modèles qui ressortent de la littérature sont le modèle de l'OMS et le modèle Systems of care. Tous deux sont des modèles généraux qui demandent d'être affinés par le pays ou la région qui veut mettre en place un SSM pour enfants et adolescents.

La plupart des études comparatives se distinguent par de nombreuses limitations méthodologiques telles que des critères d'inclusion ou des mesures de résultats peu clairs ainsi que de petits échantillons.

Le modèle de l'OMS

L'OMS conseille fortement d'élaborer une politique nationale en matière de SSM pour enfants et adolescents. En outre, l'OMS a publié en 2005 un modèle d'organisation des SSM pour enfants et adolescents qui compte 4 niveaux :

- autonomie et soins informels dispensés dans un environnement personnel ;
- soins en santé mentale dispensés via les soins de première ligne ;
- soins psychiatriques dispensés via les hôpitaux généraux et l'ambulatoire ;
- soins hautement spécialisés et prolongés.

Ce modèle n'est pas complet (il ne couvre par exemple pas les secteurs connexes), et il n'est pas validé scientifiquement.

L'OMS met également en garde contre un transfert trop abrupt du budget des SSM du secteur hospitalier vers le secteur ambulant, et du secteur des soins de santé vers d'autres secteurs.

Systems of care

Le modèle Systems of care a été élaboré aux EU il y a 25 ans. Ce modèle est avant tout destiné aux enfants et aux adolescents souffrant de troubles comportementaux et émotionnels sévères ainsi qu'à leur famille.

Le modèle Systems of care n'est pas, par nature, un modèle organisationnel prêt à l'emploi mais plutôt un **cadre ("framework")** ou une **philosophie** destinée à offrir un **fil conducteur** dans l'élaboration d'un système de soins. Il en existe plusieurs définitions: une des plus récentes est celle de Stroul (2010) (voir encadré 1).

Encadré 1: Définition du Systems of care (Stroul 2010)

"Ensemble de services et de formes de soutien efficaces organisés à domicile ou à proximité pour les enfants et les adolescents souffrant de problèmes de santé mentale ou d'autres problèmes ou pour les enfants et les adolescents à risque et leur famille. Cet ensemble de services est organisé dans un réseau coordonné doté d'une infrastructure de soutien dans lequel les familles et les jeunes travaillent en partenariat et qui répond à leurs besoins culturels et linguistiques dans le but de les aider à mieux fonctionner à la maison, à l'école, au sein de la communauté et dans la vie."

L'implémentation d'un modèle Systems of care se déroule à trois niveaux:

- l'État (politique, financement, etc.);
- les organisations de soins locales (planification, management, infrastructure, etc.) ;
- et les soins factuels (diversité des formes de soins, coordination, etc.).

Dans les années 1990, le modèle Systems of care a été évalué aux EU dans le cadre d'une série d'études à grande échelle de bonne qualité. Il semble conduire à une meilleure accessibilité des soins, une meilleure coordination des soins et une meilleure satisfaction des patients. Malgré cela, les paramètres cliniques et fonctionnels ne s'améliorent pas. On en a donc conclu que les réformes ne peuvent pas se limiter à la seule organisation des soins mais que le contenu spécifique des soins doit lui aussi être amélioré.

Autres modèles

Les écoles s'avèrent une porte d'accès potentielle pour les soins de santé mentale dans le cadre de la prévention des troubles de l'anxiété et du développement de la confiance en soi. Des études de qualité modérée montrent que la mise sur pied de programmes préventifs ou d'intervention précoce dans les écoles a un effet positif dans ce domaine. En ce qui concerne les modèles sur les soins intensifs à domicile ou à proximité, la

littérature montre que dans les meilleurs des cas, les résultats obtenus sont prometteurs mais demandent d'être confirmés par des recherches supplémentaires. La majorité des études effectuées sont des études américaines.

APERCU INTERNATIONAL

Pour des raisons de faisabilité, on a choisi de limiter cette partie de l'étude à la Belgique, aux Pays-Bas, au Canada, (Colombie-Britannique) et à l'Angleterre. La sélection est partie d'une longue liste sur laquelle une série de critères de sélection a été appliquée.

Le rapport comprend un aperçu, sous la forme d'un tableau, pour les 4 pays inclus dans l'étude (Tableau 6.1 dans le paragraphe 6.6). Nous avons repris ci-dessous, par pays, quelques points saillants.

Les réformes menées dans les pays décrits reposent toutes sur leur contexte local et ne sont donc pas transposables, telles quelles, à d'autres pays. Il n'est pas simple non plus de comparer différents pays entre eux, ceci d'autant plus qu'on ne dispose que de très peu d'informations sur les résultats de la politique menée pour le patient.

Belgique

En Belgique, la compétence en matière de SSM est divisée entre les autorités fédérales et les communautés et les régions. Au cours de ces dernières années, plusieurs initiatives conjointes ont été prises, notamment la mise sur pied de projets pour promouvoir les circuits et réseaux de soins.

Contrairement à d'autres pays, le rôle des prestataires de soins de première ligne dans les SSM n'a jusqu'ici fait l'objet d'aucune reconnaissance formelle et n'est pas non plus soutenu par le pouvoir politique, alors que ces services et notamment les médecins généralistes proposent souvent des SSM.

En ce qui concerne les SSM spécialisés pour enfants et adolescents, l'offre est variée et les services proposés reposent sur différents mécanismes de financement. Il n'est cependant pas clairement établi dans quelle mesure le système ne présente pas certains chevauchements ou certaines lacunes. Au cours de la dernière décennie, une série de projets ciblés ont été lancés pour garantir une offre en soins plus spécifique à une série de groupes cible, mais sans financement structurel jusqu'à présent.

On a peu étudié si les mesures existantes destinées à promouvoir la collaboration au sein des et entre les secteurs ont donné l'effet souhaité ou si des mesures supplémentaires sont encore nécessaires.

Depuis quelques années, la Flandre travaille à la mise en place d'un système d'aide intégrale à la jeunesse (Integrale Jeugdhulp) : une politique commune dans tous les secteurs impliqués dans l'aide aux enfants et aux adolescents (action sociale, services aux personnes handicapées, enseignement, soins préventifs et centres de santé mentale ambulatoires). Le modèle d'intégration des différents secteurs est moins explicitement présent dans l'organisation des soins en Wallonie.

Pays-Bas

Pour permettre une coordination des soins plus efficiente entre les différents secteurs impliqués dans le bien-être des enfants et des adolescents, le Bureau Jeugdzorg (Bureau d'aide à la Jeunesse) a été créé en 2005. Cette instance se veut une porte d'accès commune pour les SSM pour enfants et adolescents, pour l'aide sociale à la jeunesse et pour les soins pour enfants et adolescents souffrant d'un léger handicap mental. Le Bureau Jeugdzorg a pour mission d'orienter toutes les demandes vers l'aide nécessaire. Pour l'instant ce système est fortement remis en question. Une évaluation récente a montré de nombreuses pierres d'achoppement, notamment des différences fondamentales de principe de financement entre le système des soins de santé (modèle de marché) et le système de l'aide sociale (subventionnement complet). On suggère aujourd'hui de transférer l'intégralité des SSM pour enfants et adolescents vers le secteur social mais ces plans sont fortement contestés par le secteur des SSM.

Une autre évolution récente concerne la demande croissante d'une aide spécialisée pour les enfants et les adolescents, surtout dans les SSM et l'aide à la jeunesse. Pour répondre à cette demande, l'accent a été fortement mis ces dernières années sur la prévention et les soins de première ligne.

Canada

La province de Colombie-Britannique (British Columbia - BC) a établi en 2003 son propre plan d'action pour les SSM pour enfants et adolescents, avec de grands principes de base tels que traitement basé sur les preuves (evidence-based), monitoring des résultats, collaboration entre les secteurs, etc. Le financement existant a été doublé en 5 ans, avec un grand investissement dans la prévention.

La BC accorde un rôle central aux SSM ambulatoires dispensés dans des centres multidisciplinaires spécialisés, traitant exclusivement des enfants et des adolescents. Le patient doit être référé par un de ces centres pour pouvoir être admis dans un centre de troisième ligne hautement spécialisé. La prise en charge d'urgence se fait via les hôpitaux généraux.

Angleterre

Pour permettre une meilleure collaboration entre les divers services aux enfants et adolescents, l'Angleterre a mis en place en 2004 les “Children’s trusts” qui ont rassemblé les agences locales pour qu'elles planifient et organisent, ensemble, les services régionaux nécessaires pour les enfants et les adolescents avec un budget commun. Ces services comprenaient les soins de santé, les SSM, l'action sociale, la justice, les soins aux personnes handicapées et l'enseignement. Le nouveau gouvernement a supprimé récemment les Children’s trusts pour des raisons peu claires, et le contenu concret de la nouvelle politique à mettre en œuvre n’est pas encore clairement défini.

Plusieurs instruments pratiques ont déjà été développés en Angleterre qui soutiennent la collaboration entre les différents services et secteurs. Parmi ces instruments, on trouve notamment un dossier standardisé pour les SSM pour enfants et adolescents destiné à faciliter l'échange des informations et des instruments de mesure standard des résultats cliniques. Enfin, l'Angleterre dispose de standards pour la formation du personnel qui travaille avec des enfants et des adolescents présentant des problèmes SSM.

CONCLUSION

L'importance de concrétiser la politique nationale/régionale dans le domaine des SSM pour enfants et adolescents est connue depuis longtemps. La littérature relative aux modèles organisationnels au sein des SSM pour enfants offre cependant peu d'informations utiles et de repères aux décideurs politiques. Les deux principaux modèles qu'on trouve dans la littérature se limitent en effet à énoncer quelques grandes lignes de conduite de nature générale.

Les études scientifiques disponibles dans ce domaine sont d'une qualité limitée et un grand nombre de questions de nature politique n'ont pas été étudiées ou ne l'ont pas été suffisamment. Suite à l’étude du modèle Systems of care il a été démontré que les autorités doivent non seulement promouvoir une meilleure organisation et coordinations des soins, mais également le développement et la diffusion de concepts thérapeutiques efficaces.

L'étude sur la prévention et le traitement des troubles de l'anxiété par le biais des écoles a montré qu'il faut oser chercher des solutions en collaboration avec d’autres secteurs en dehors des soins de santé.

Dans les pays étudiés, les réformes partent de cadres de pensée théoriques basés sur les grands principes et les grandes valeurs éthiques; ceux-ci sont partagés largement par les différents pays. Toutefois, la mise en place pratique de ce cadre de pensée se heurte à de nombreux écueils et les objectifs visés ne sont pas toujours réalisés. En ce qui concerne les résultats réels des réformes entreprises, on dispose généralement de peu de données solides.

Pour arriver à un résultat positif il faut peut-être aborder en même temps aussi bien les aspects cliniques et organisationnels que les aspects financiers et cela sans perdre de vue la spécificité de chaque secteur impliqué.

Dans la phase suivante de cette étude des propositions de réformes serons formulées avec les parties prenantes (stakeholders) belges. Les résultats de cette phase de l'étude seront publiés séparément.

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
ADHD	Attention deficit hyperactivity disorder
ALD	Affection de longue durée (long term medical condition)
APR-DRG	All Patient Refined Diagnosis Related Groups
ARC	Autism reference centres
ASD	Autistic spectrum disorders
ASS	Autismespectrum stoornis (Autistic spectrum disorder)
AWBZ	Algemene wet bijzondere ziektekosten (Exceptional medical expenses act)
AWIPH	Agence wallonne pour l'intégration des personnes handicapées (French agency for integration of disabled persons)
BC	British Columbia
BESD	Behavioural, emotional and social difficulties
BFM	Budget van financiële middelen (Budget of financial means)
BJB	Bijzondere jeugdbijstand (Flemish youth care)
BMA	British Medical Association
BOPZ	Wet bijzondere opnemingen in psychiatrische ziekenhuizen (Act on special admission in psychiatric hospitals)
CADTH	Canadian Agency for Drugs and Technologies in Health
CAF	The Common assessment framework
Camhs	Child and adolescent mental health care services
CAPA	Choice and partnership approach
CAR, CRA	Centra voor ambulante revalidatie - Centres de rééducation ambulatoire (The ambulatory rehabilitation centres)
CATTP	Centre d'accueil thérapeutique à temps partiel (Part time therapeutic reception centres)
CAW	Centra voor algemeen welzijnswerk (Social service centres)
CBJ	Comités voor bijzondere jeugdzorg, (Youth care office)
CCQI	The College centre for quality improvement

CGG-SMM	Centra voor geestelijke gezondheidszorg - Centres de santé mentale (Specialist ambulatory mental health care centres)
ChiMat	The Child and maternal health observatory
CIG	Centra voor integrale gezinszorg (Integrated family support service)
CiZ	Centrum indicatiestelling zorg (Care indication service)
CJG	Centrum voor jeugd en gezin (Child ad family centre)
CKG	Centrum voor kinderzorg en gezinsondersteuning (Child and family support centre)
CLB	Centrum voor leerlingbegeleiding (Education support team)
CMI	Cellules Mobiles d'intervention (Mobile intervention unit, assertive outreach)
CMP	Centres médico-psychologiques (Medico-psychological centres)
CMPP	Centres Médico-Psycho-Pédagogiques (Medico-psycho-pedagogical centres)
COCOF	Commission communautaire française (French community commission)
COCOM	Commission communautaire commune (Common Community Commission
CORC	Camhs Outcome Research Consortium
COS	Centra voor ontwikkelingsstoornissen (Centres for developmental disorders)
CPMS	Centres Psycho Médico Sociaux (Psycho-Medico-Social Centres)
CSM	Centres de santé mentale (Mental health centres)
CvI	Commissie voor indicatiestelling (Commission for indication of care)
CYPP	The development of the Children's and young people's plan
DBC	Diagnosebehandelingcombinatie (Diagnosis Treatment Combinations)
DfE	Department for Education
DH	Department of Health
DPB	Dienstelle für Personen mit Behinderung (Agency for disabled persons of the German speaking community)
DSM	Diagnostic and statistical manual of mental disorders
DTO	Detention and training order
ECM	Every Child Matters, UK policy of children's social care
EPSM	Etablissement Public de Santé Mentale (Public mental health care)
FFS	Fee-for Service

FIA	Flemish inter-sector agreement
OBC	Observation and treatment centres
FOBA	Forensic observation and guidance
FOR-K	Forensic K-beds (Child and adolescent psychiatric beds for youth offenders)
FPS	Federal public service
FTE	Full-time equivalents
GDT/SISD	Geïntegreerde dienst voor thuiszorg - Service intégré de soins à domicile (Integrative home care service)
GON	Geïntegreerd Onderwijs (Integrated education)
GON-ASS	Geïntegreerd Onderwijs - Autisme spectrum stoornissen
GP	General practitioner
HJ	Hospitalisation de jour (Day hospitalization)
HONOSCA	Health of the nation outcome scales for children and adolescents
HSR	Health Services Research
IBE	Intensieve behandel eenheid (Care circuit for youngsters with aggressive behaviour or conduct disorder)
ICD-10	International Classification of Diseases, 10th Edition
ION	Inclusief onderwijs (Inclusive education)
IPPJ	Institutions publiques de protection de la jeunesse (Public service for youth protection)
ITA	Intensive treatment for young people in need of individual guidance
IWSM	Institut Wallon pour la Santé Mentale (Walloon Institute for Mental Health)
JAC	Jongeren advies centrum (Young people's advice centres)
JSNA	Joint strategic Needs Assessment
KB/AR	Koninglijk besluit - Arrêté Royal (Royal decree)
Las	Local authorities
LVG-jongeren	Licht Verstandelijk Gehandicapte jongeren (Children with Light mental retardation)
MPD/MPG/RPM	Minimal psychiatric data / Minimale psychiatrische gegevens / Résumé psychiatrique minimum

MPIs/IMEs	Medical pedagogical institutes/Instituts Médico-éducatifs
MST	Multisystemic therapy
NGOs	Non-governmental organizations
NHS	National Health Service
NIHDI-RIZIV-INAMI	National institute for health and disability insurance / Rijksinstituut voor Ziekte- en Invaliditeitsverzekering / Institut national d'assurance maladie-invalidité
NICE	National institute for health and clinical excellence
NJI	Netherlands Youth Institute
NRZV/CNEH	Nationale Raad voor Ziekenhuisvoorzieningen - Conseil National des Etablissements Hospitaliers (National council of hospital facilities)
NSFCYMS	The NHS National service framework for children, young people and maternity services
OBC	Observation and treatment centres
ONE	L'Office de la naissance et de l'enfance (Child and maternity centre)
PAB/BAP/PGB	Personal assistance budget/ Budget d'assistance personnelle/ Persoonsgebonden budget
PbR	Payment by results
PCTs	Primary care trusts
PMS-Zentrums	Psycho-Medizinisch-Soziales Zentrum (Psycho-medico-social centre)
PRUs	Pupil referral units
RAI	Resident Assessment Instrument
RC	Reference centres for mental disorders
RCT	Randomized Controlled Trial
RECs	Regional expertise centres
SAI	Services d'aide à l'intégration (Integration support centre)
SAJ	Service d'aide à la jeunesse (Social care office)
SAJJNS	Services d'accueil de jour pour jeunes non scolarisables (Day centres for youngsters, unable to attendschool)
SAP	Services d'aide précoce (Early care centres)
SAS	Services d'Accrochage Scolaire

SASPE	Services d'accueil spécialisés de la petite enfance (Specialised maternity centres)
SEN	Steunpunt expertise netwerken / Centres for expertise networks
SENCO	The Special educational needs coordinator
SHI	The Statutory Health Insurance
SOC	Systems of care
SOS	Equipes SOS Enfants (Confidential centres on child abuse and neglect)
SPJ	Service de protection judiciaire (Judicial protection centres)
SPZ	Sozial-Psychologische Zentrum (Socio-psychological centre)
SRJ	Services résidentiels pour jeunes (Residential youth centres)
SSM	Services de santé mentale (Mental health centre) Or Soins de santé mentale (mental healthcare)
STCs	Secure training centres
TAC	Team around the child
TAF	Team-around-the family
TaMHS	Targeted Mental Health in Schools
TAS	Teams around the school
UK	United Kingdom
US	United States of America
VAPH	Vlaams agentschap voor personen met een handicap (Flemish agency for disabled persons)
VDIP-projects	Vroege Detectie en Interventie Psychose-projecten (Early detection and intervention for psychosis)
VGC	Vlaamse gemeenschapscommissie (The Flemish community commission)
VIC	Very intensive care service
VIR	Verwijsindex Risicojongeren (the "Reference index for youth at risk)
VK	Vertrouwenscentra Kindermishandeling (Confidential centres on child abuse and neglect)
VVGG	Vlaamse vereniging geestelijke gezondheid (Flemish association for mental

	health)
WHO	World Health Organization
YOIs	Young offender institutions
YOT	Youth offending teams
ZATs	Zorg- en adviesteams (Teams for care and advise)
ZVW	Zorgverzekeringswet (Care insurance act)

1. INTRODUCTION AND SCOPE

Mental and behavioural problems during childhood and adolescence are a serious public concern.[1] Indeed, it has been estimated that about 20% of the children and adolescents in Western countries are suffering from overt mental health problems or disorders, and that 5% are in need of a clinical intervention.[2, 3] A review (2002) of large population-based studies including interview-based diagnostic and functional evaluations, points to an overall prevalence rate for all clinically important child and adolescent mental health disorders of 14%, while the prevalence of co-morbidity of two or more mental disorders varies from 47 to 68%.[4]

Care for children and adolescents with mental health problems is often intersectoral in nature (e.g. health care, juvenile justice, welfare). Different agencies risk to address pieces of the service system puzzle, with little to no coordination with other agencies often serving the same children and adolescents.[5] Policymakers should give incentives and guidance for intersectoral collaboration that, otherwise, would not exist.[6] Therefore, over the past 20 years new organizational concepts emerged around the globe with the aim to strengthen collaboration between different types of services and sectors. These new models are mainly based on the principles "treatment in the least restrictive environment possible", "families as partners in the planning and delivery of care", "access to a comprehensive array of services".[5]

Also in Belgium, policymakers are reflecting on how to reorganize mental health care for children and adolescents. In the next paragraphs, the historical context of the present report, the scope and the definitions used in this report will be described.

1.1. Historical context of this report

1.1.1. The Western world: de-institutionalization, the balanced care model

In the last decennia of the 20th century, the mental health care policy in the Western world has been characterized by a strong de-institutionalization movement. This movement, predominantly related to care for adults, emphasized the need to reintegrate mentally disordered persons in the society by downsizing large psychiatric asylums and establishing alternative services in the community. Since the beginning of the 21st century, the "balanced care" model[7] is gradually gaining influence on mental health care organization. This model implies that a diversity of services should be established: community services should be offered whenever possible, but hospital services should be available if ambulatory care cannot provide a good answer to the patient's needs. At the same time, the importance of a smooth and seamless transition from one service to another has been acknowledged, and many countries currently experiment on how to develop integrated care, care coordination and continuity of care.[8]

1.1.2. The reforms in Belgium

1.1.2.1. Three waves of reforms

The organization of (predominantly adult) mental health care in Belgium has been re-shaped over the last decennia by three reform waves.[8] Like elsewhere in Europe, in the early nineties a **first wave** tried to transfer care for persons with a mental disorder out of the large psychiatric institutions and hospitals. Hospital beds were substituted by alternatives in residential or ambulatory care (i.e. sheltered living, psychiatric home nursing, psychiatric nursing homes). In 1999, a **second reform wave** further promoted reconversions of hospital beds (psychiatric and other hospital beds).

In 2002, **a third reformation** introduced the concepts of "care circuits" and "networks of care" in the Belgian law[a], now known as "article 11 of the Hospital Law". The following definitions are used in the Belgian law:

- A 'care network' is a whole (i.e. an aggregate) of caregivers, care organizations and services depending on the federal authority, which proposes to a 'target group' one or several care circuits.
- A 'care circuit' is a whole of care programs and services depending on the federal authority, organized by a network of care organizations, and dedicated to one 'target group' or a 'sub target-group'.

In addition, the Ministers responsible for Health at the federal, regional and community level all signed a common declaration about the future mental health care policy.[b] Although the definitions of "care circuit" and "care network" only include services under federal authority, the declaration specifically aimed to enhance collaboration between all the authority levels. The declaration is based on international principles articulated by the WHO (e.g. least restrictive environment, patient- and family centered)[2], and specifies that policy development should distinguish three target groups (i.e. children and adolescents; adults; elderly).

1.1.2.2. Three waves of Projects

To start the implementation of the new policy, several "**Pilot projects"** were initiated in 2002.[8] In 2007, new initiatives, the "**Therapeutic projects**", were launched to create care circuits and care networks for persons with a chronic and complex mental disorder for the three different target groups (i.e. children and adolescents; adults; elderly)[c]. Each therapeutic project had to include at least one partner organization of the first- (e.g. General practitioner), second- (e.g. Mental health center) and third line (e.g. Psychiatric hospital). On 23 December 2009 a Royal Decree (article 107 of the Hospital Law) was concluded, allowing a temporary and experimental financing of "care networks". This allows the Federal public service for health, food chain safety and environment (FPS) to develop "**Exploration projects"** as a temporary step to realize care circuits and care networks within the structures of the hospital financing budget. At the same time, this Royal Decree heralded the end of the Therapeutic Projects.

1.1.3. Context of the current report

1.1.3.1. Position of child and adolescent mental health care

Whereas the previous initiatives mainly (although not exclusively) focused on adult mental health care, the Belgian mental health care sector is now trying to make a similar turn to reorganize the provision of child and adolescent mental health care services ("camhs"). On 28/09/2009 the interministerial conference for Public Health[d] decided to realize article 11 of the hospital law (in first instance with exploration projects via article 107). In a first step, adults and adolescents from the age of 16 onwards would be involved in the development of care networks and care circuits.

At the same meeting, it was decided that in a second step, the development of exploration projects for the cluster of children and adolescents should be made possible. Indeed, although it seemed important to introduce care networks and care circuits for this age group as well, it was realized that reforms of child and adolescent mental health care might require a different approach. After all this is a field that only recently started developing, and hence it has a different historical background as compared to the adult mental health care sector. For instance, large psychiatric asylums for children did never exist and it lasted until 1971 before the first child psychiatric wards in Belgium were recognized as autonomous hospital services (see 5.1 for a more detailed

[a] See the article 9ter of the hospital law introduced by the Law of 14th January 2002; see article 11 of the Hospital Law coordinated on 10 juli 2008 ("Wet betreffende de ziekenhuizen en andere verzorgingsinrichtingen/ Loi relative aux hôpitaux et à d'autres établissements de soins" coordinated on 10 July 2008)

[b] MB 23rd May 2005

[c] For evaluation of these projects, see KCE reports n° 103, 123 and 146 (www.kce.fgov.be)

[d] Meeting of the federal, regional and community ministers in charge of health or public health issues

historical background of child and adolescent mental health care in Belgium).

In the literature, other specificities of child and adolescent mental health care have been described, that might be important when service reorganization is considered. Children and adolescents go through consecutive developmental stages, each associated with specific mental health problems; and children at different ages can respond differently to a certain treatment. Therefore a developmental framework should underpin service organization.[6, 9] Also, the creation of a treatment for a child is rarely undertaken without consideration of the family context, and moreover, several different systems of care (e.g. health care, education, welfare) may need to be involved to ensure that services are effective. This requires organizational structures allowing for these specificities.[6, 9, 10]

1.1.3.2. Preparation of child and adolescent mental health care reorganization

In order to prepare this reorganization, two initiatives were launched. The **first initiative** concerns an advice by the National council of hospital facilities (NRZV/CNEH) to the Minister of Social affairs and Public Health. This advice, published on June 9th 2011, points out the actual problems and the future needs in the sector of child and adolescent mental health care in Belgium[e]. It is based on a broad consultation of experts working in the domain of camhs (child and adolescent mental health services). A **second initiative** is the present KCE-study which was commissioned by the Federal public service for health, food chain safety and environment. The study includes two parts. The first part, which is the subject of this report, aims at an evaluation of existing scientific knowledge in the area of organization of camhs. The second part, will build on this evidence base to develop a policy scenario for the reform in a participatory approach, involving key stakeholders along the way. The results of this second part (i.e. policy scenarios) will be published in a separate report.

[e] http://www.health.fgov.be ; http://www.overlegplatformsggz.be/Adviezen_NRZV/284/ggz

1.2. Scope of study and research questions

1.2.1. Scope

This report is about the organizational aspects of child and adolescent mental health services (camhs). Given the, above mentioned, (inter-) national trend to focus reforms on integrated care models, this will be a special focus in this report as well. Further, special attention will be given to information on reform processes in camhs.

To elaborate these topics, the report consists of two parts:

- a literature review;
- an international overview of child and adolescent mental health care organization.

Since in Belgium 18 years is the age of legal responsibility, the age range 0-18 years will be used in this report to define children and adolescents.

1.2.1.1. Camhs and its neighbouring sectors

Often, specialized mental health care providers such as child psychiatrists and psychologists, are expected to assume the lead role in the provision of mental health services.[11] However, a review (2002) of six large population-based studies including each at least 1000 children, demonstrated that only 16 to 27% of children with mental health needs as defined by interview-based diagnostic and functional evaluation, received mental health care by the specialized mental health care sector.[4] Between 40 en 59% of these children received care in the primary health care sector and between 24 and 50% in the educational system. Other involved sectors could be child welfare and juvenile justice. One study reported on the subgroup of seriously emotionally disturbed children, of which 29% used services in multiple sectors.[11] The review did not comment on the number of children that received no care at all.

The countries included in this review were the US, Canada, Australia, New Zealand and the UK. Although the health and social care context of these countries probably show several differences compared to the Belgian situation, they are all Western high-income countries. Therefore, it is not unlikely that the same basic trend in care supply can be found in Belgium.

This would imply that many children in need of mental health care receive care in other sectors than the specialized child and adolescent mental health care sector.

In line with this, it has been recognized by many authors that not only mental health care providers, but also other organizations charged with health, welfare and education of children have to play a role in the provision of mental health care.[1, 3, 9, 11, 12] Indeed, all children function within multiple systems, usually involving their families, schools, communities, and primary health care. Their mental health needs may first come to the attention of professionals in schools, primary care offices, welfare systems, or even detention facilities. As pointed out before, care for these children is often intersectoral and may require services from several systems such as mental health care, special education, developmental disabilities services, child welfare and youth social care, and juvenile justice.

In this report, a broad approach is used, to acknowledge that supporting children and adolescents with mental health problems is not the responsibility of specialist mental health services alone. Mental health services delivered at the primary care level, by health care providers not specialized in child and adolescent mental health care, will also be included. Neighbouring sectors that contribute to children's and adolescent mental health such as education, child welfare and youth social care, services for disabled children and juvenile justice are also within the scope of this study. However, for feasibility reasons, these neighbouring sectors will not be discussed with the same profundity as specialist camhs which will be the main focus in this report (definition: see 1.3.3).

1.2.1.2. Prevention and treatment of mental disorders

When addressing service supply in mental health care, several aspects can be included. The WHO states that achieving mental health and maintaining it, consists of two functions.[3, 10] One is about preventing and treating mental disorders, and the other is about fostering or promoting mental health and wellbeing.

In this report, only the first aspect, prevention and treatment, will be included. Prevention as such is a broad topic, ranging from specific large-scale actions on the population level, to individualized advices provided by many caregivers at all tiers of care. In this report "prevention" will be mainly discussed in the international comparison. We will focus on the relative importance of "prevention", and its position in the overall mental health care policy for children and adolescents in the selected countries.

1.2.2. Research questions

The main research questions to be answered in this report are:

1. What evidence is available on the organization of child and adolescent mental health care services (camhs) and (different variants of) integrated care services?

- Which are the main models that ground the (re-) design of mental health services for children and adolescents?
- What is known on the efficacy and effectiveness of integrated camhs compared with non-integrated systems?
- What is known on the efficacy and effectiveness of different types of camhs?

2. What is the current provision of camhs in Belgium, taking into account regional specificities?

- What is the range of services and support in place to meet the needs of children and adolescents across Belgium?
- How are different services in different sectors coordinated?
- How are these services financed?

3. What can be learned from practices in other countries in the organization and financing of camhs?

- How is camhs organized and financed in other countries? What models are developed to encompass the broad array of different services in different sectors?
- What is known on recent camhs reforms in these countries?
- What is known on the policies and underpinning ideologies?

- To what extent can these experiences be translated to a Belgian health services context, taking into account the social insurances model, the complex political competencies, the geographical organisation?

4. What are relevant financing mechanisms for (reforms and integration of) camhs?

- What are possible financing mechanisms that could support an adapted organizational model?
- What are the advantages and disadvantages of these financing mechanisms?

1.3. Definitions

Terminology referring to (child and adolescent) mental health and mental disorder in literature and mental health policy papers is often ambiguous and not clearly defined. Terms are used in different ways or referring to different concepts. It is beyond the scope of this report to give a comprehensive theoretical background on these concepts. Rather, the following paragraph aims at giving an overview of the interpretation used throughout this report for: mental health; mental disorders and mental health problems; camhs and specialist camhs; children and adolescents. A more extensive list of definitions can be found in the Appendix 1.

1.3.1. Definition: mental health

According to several authors, mental health refers to the presence of psychological strengths[13] such as adaptive behaviour and personal coping skills[14], a sense of self-efficacy[15, 16] or resilience[17].

A broad view on mental health for children and adolescents, is adopted in the WHO Atlas of Child and Adolescent Mental Health Resources[3]; this definition will be used in this report.

According to the WHO, mental health can be defined as:

"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well being. It is directly related to the level reached and competence achieved in psychological and social functioning".

While this definition might be considered as too broad or unspecific, it has the advantage of referring to the holistic character of mental health and addressing positive psychological mechanisms in relation to environmental conditions. This holistic approach is confirmed in WHO's definition of health stating that: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[f].

1.3.2. Definition: mental disorders, mental health problems

Often the term "mental disorder" relates to any emotional, behavioral, or brain-related condition that causes significant impairment in functioning as defined in the standard diagnostic protocols of the Diagnostic and statistical manual of mental disorders (DSM), published by the American psychiatric association[g]. Also the criteria defined in the fifth chapter of the ICD-10, the International classification of mental and behavioural disorders by the WHO[h] are often adopted as a reference. These two definitions will be used in this report. It is recognized that many caregivers conceptualize mental disorders based on other models, but it is beyond the scope of this report to discuss in depth this subject.

Many authors use the terms "mental illness" or "mental disorder" interchangeably; in this report, the term "mental disorder" will be used preferably. On the other hand, a distinction will be made between "mental

f WHO constitution 1946
g http://www.psych.org/MainMenu/Research/DSMIV.aspx
h http://www.who.int/classifications/apps/icd/icd10online/

disorders" and "mental health problems", based on two documents in the domain of child and adolescent mental health care, one published by the UK Department of health[18], and one published by the British Columbia Government in Canada (2003)[19]. The difference is defined as follows:

"Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behavior. They are relatively common, and may or may not be persistent. When these problems conform to the ICD-10 criteria, and when they are persistent, severe and affect functioning on a day-to-day basis, they are defined as mental disorders."

1.3.3. Definition: camhs and specialist camhs

A detailed and useful definition of camhs and specialist camhs, has been provided by the UK Department of health[18]. This definition makes a difference between "camhs" and "specialist camhs", and will be used in this report:

- **Camhs** is used in a broad sense and refers to all services that contribute to the mental health care of children and adolescents, whether provided by health, education, social services or other agencies. Hence it includes those services whose primary function is not mental health care such as general practice, schools.
- **Specialist camhs** are camhs whose primary function is the provision of mental health care to children and adolescents.

Likewise, the British Columbia Government in Canada (2003)[19] makes a difference between "broad children's mental health system" and "formal children's mental health system".

1.3.4. Definition: children and adolescents

The WHO makes a distinction between children and adolescents[3]:

- Child: a person below the age of 10 years.
- Adolescent: a person aged 10 to 19 years.

Sometimes the term Children refers to all those under the age of nineteen years, as a generic term, e.g. in the Convention on the Rights of the Child art. 1[i]. In this interpretation it refers to minors, as opposite to adults.

In some countries, including Belgium, child refers to a person below 12 years and adolescent to a person between 12 and 18 years. This goes along with organization of educational levels and differentiation in gradually evolving legal rights and duties.

1.3.5. Definition: "Integrated care"

During the last few decades, the concepts "integrated care" or "service integration" have been used broadly in the field of service organization for people with complex needs. These concepts are also widely considered to be important elements of contemporary care for mentally disordered persons. So far no uniformly accepted definition of "integrated care" exists in the literature of mental health care, but it is clear that it is a complex concept with many different aspects. Throughout the literature on mental health care organization, it becomes clear that the following aspects of the **integrated care** concept should be clearly defined, to avoid confusion[8]:

- The *service system level* toward which activities are directed. This can be the "patient level" (e.g. case management: integration of care for individual patients) or the "service system" level (integration for a defined population as a whole: e.g. program integration)
- The *intensity of integrated care* can range from loosely organised alliances to highly integrated organizations. In addition, the formality of integrated care governance can range from verbal agreements to formal procedures and rules.

[i] The Convention on the Rights of the Child art. 1: http://www2.ohchr.org/english/law/crc.htm viewed at 10/06/2011

2. METHODS

The report consists of two parts:

- a literature review, highlighting:
  - organizational aspects of child and adolescent mental health care;
  - funding and financing mechanisms.
- an international overview of child and adolescent mental health care organization, including:
  - a detailed analysis of the provision of mental health care services for children and adolescents in Belgium;
  - a description of child and adolescent mental health care organization in a selection of countries.

2.1. Literature review

2.1.1. Search strategy

An in-depth literature review was conducted between December 2010 and February 2011 using electronic peer-reviewed bibliographic databases as well as other sources of information (grey literature). All databases were searched starting from 1995 onwards. The search strategy included four steps.

Search strategy step 1:

In Step 1 search algorithms for organization of services and policy reforms for child and adolescent mental health care were developed. The following databases were searched:

- MEDLINE (OVID);
- EMBASE;
- PsychINFO;

Medline (OVID) was considered as the core database. For each of the other databases, a search algorithm was developed starting from the Medline (OVID) algorithm, adapted to the specific requirements or features of the database. Detailed descriptions of the search algorithms for all the databases are presented in Appendix 2. In addition the Cochrane Database of Systematic Reviews (Cochrane DSR) was searched for systematic reviews within the study field using the key word “Child and Adolescent Mental Health Care Services”.

Search strategy step 2:

We searched Google and OAIster using a selection of key words (Appendix 2) to identify grey literature and other publications not identified in step 1. In addition, we searched for additional unpublished reports by searching the sites of specialized institutions (Appendix 2).

Search strategy step 3:

In the third step of the literature review we used a set of free text key words (Appendix 2) that evolved from step 1 to identify additional studies on the efficacy and effectiveness of integrated systems for child and adolescent mental health care. Given the broad scope of search strategies used in steps 1 and 2 additional key-words were used to limit the search to studies with the following designs: randomized clinical trial; (quasi-) experimental studies, comparative studies; pre-test post test studies. The same data sources used in step 1 were searched.

Search strategy step 4:

This step included a search of three databases (Medline OVID/Pubmed; Econlit; CRD, Centre for Review and Dissemination) and focused on financing systems. Medline (OVID/Pubmed) was considered as the core database. First, financing-related MeSH terms and keywords were identified. Secondly, the target population was limited to child and adolescent populations and MeSH terms of mental health care services were included to limit the target population on mental health care (Appendix 2). For the other databases, a search algorithm was developed starting from the Medline algorithm, adapted to the specific requirements or features of the database (Appendix 2).

2.1.2. In- and exclusion criteria

A different set of in- and exclusion rules (Focus & design) is used for literature resulting from search strategy steps 1 to 3 compared to literature that was found by applying search step 4.

- **Inclusion criteria:**
  - Population: child or adolescent (age 0 to 18 years) psychiatry and mental health care;
  - Focus:

    -Steps 1-3: Innovative policies (policy perspective); organization types of services; organization models; organizational approaches;

    -Step 4: Studies examining or describing financing systems/models of child and adolescent mental health care. Reviews targeting the financing of adult mental health care were also be considered as appropriate for analysis;
  - Design/publication types:

    -Steps 1-3: Meta-analyses, (systematic and narrative) reviews, randomized controlled trials, controlled clinical trials, cohort studies, case-control studies, descriptive studies;

    -Step 4: Meta-analyses, (systematic) reviews, conceptual papers, descriptive studies, qualitative research, randomized controlled trials, controlled clinical trials, cohort studies;
  - Language: English, French, Dutch.
  - Geography: High Income Western countries or European countries.
- **Exclusion criteria:**
  - Population: less than 75% of the study population includes children or adolescents;
  - Focus: epidemiological aspects of mental health care and needs assessment; therapeutic treatments/ clinical approaches;
  - Design/publication types:

    -Step 4: case-control studies, case studies, letters to the editor;
  - Language: other than above;
  - Geography: other than above.

2.1.3. Selecting studies

The results of search strategies 1 to 3 were downloaded in one endnote file removing all duplicate studies. In a first step publications that appeared to meet the inclusion criteria were identified. One third of the search results were assessed by two reviewers. In case of disagreement, the publication was discussed (referring back to the review protocol) to reach consensus. In case of substantial discrepancies, a third reviewer was consulted. The same two reviewers evaluated each 50% of the selected full publications. Those papers, which the respective researcher could not clearly in- or exclude, were also reviewed by a second reviewer for selection.

The publications resulting from search strategy 4 were kept in a separate endnote file. However, the same selection procedure was used. A first selection of the studies was performed by one of the researchers based on the title of the papers. Validation of this selection was performed by two other researchers.

2.1.4. Quality appraisal and data extraction

The full text articles, retained for this (narrative) review were classified as descriptive/background articles (i.e. narrative reviews of models, single descriptive studies about models) and articles contributing to the evidence (i.e. evaluation component present) base. Only for the latter category of studies a full data extraction and quality appraisal was done. Two researchers extracted details of organizational intervention (e.g. sectors involved, healthcare workers involved, settings involved, financing mechanisms), study design, control and outcome data using a self-developed data extraction instrument (see Evidence tables Appendix 3). The quality of the included studies was assessed according to a modified version of the Dutch Cochrane checklists[j]. The quality of descriptive studies was assessed for some key methodological characteristics. (i.e. a

[j] http://dcc.cochrane.org/beoordelingsformulieren-en-andere-downloads

high-quality descriptive study had to have: a clear theoretical framework; address a focused research question; a good description of context; appropriate method of sampling, data collection and data analysis; a complete and precise description of study results; study results that are relevant for policy or further research.) In addition, a general appraisal of the risk of bias for each study was scored as 'high'; 'moderate' or 'low'. In addition, concerning step 4 'What are relevant financing mechanisms for (reforms and integration of) camhs?', a general appraisal about the relevance of the studies on financing and budget issues of camhs for the Belgian context applied a 'high', 'moderate' or 'low' scoring.

2.2. International overview

2.2.1. Selection of countries

Besides Belgium, a sample of countries had to be selected. This selection was based on a long-list of countries for which information was gathered via a grey literature search and expert consultation (Appendix 2).

For feasibility reasons it was decided to limit the study to an in-depth analysis of Belgium and three other countries (or regions within a country).

The criteria used to select the foreign countries were:

- Type of healthcare system: Bismarck/Beveridge;
  - In the Beveridge- or National Health Services model, health care is provided and financed by the government though tax payments. Hospitals are state owned and many physicians are employees of the government. Access to specialized care is dependent on a referral from a GP (the gate-keeping system);
  - In the Bismarck- or Social Security Health Care system the funding occurs by means of premiums, mainly from salaried employees. There is less state influence and physicians and hospitals tend to be private. There is often parallel access to primary and specialised care.
- Existence of a clear policy for child and adolescent mental health care;
- History of reforms, resulting in models with attention on organization of community services, integration of services and intersectoral collaboration;
- Information availability in Dutch, English, French or German;
- Scientific evaluations of reforms available, systems auditing information available;
- Information on whether reform processes are imposed by government or if developed bottom up.

It was strived for that the selection of countries would meet the criteria above as good as possible. The foreign countries from the longlist (Appendix 2) meeting the above criteria sufficiently, include the UK (England), the Netherlands, Canada, Australia, New Zealand and the USA. Other country profiles did not meet one or more of the postulated criteria (Norway, Sweden, Switzerland, Germany, Austria, France, Italy, Ireland, Iceland). To further select countries, a next criterion was used: probable compatibility with the Belgian situation. Because of major differences in the way the (mental) health system is organized, the USA was not selected for further comparison. Nevertheless many interesting USA-based concepts and experiments will be discussed in the literature review. Similar reasons applied for the non-selection of Australia and New Zealand. Therefore, besides Belgium, the following countries are selected for evaluation:

- England (UK);
- The Netherlands;
- Canada.

Since there are some ongoing evolutions in other countries that might be of interest for the scope of the study, the in-depth review of these 4 countries was expanded by a limited description of some recent experiments in:

- France (EPSM Lille-Métropole).

2.2.2. Methodology of data collection

2.2.2.1. Part 1

Data collection was based on a specific search per country and on expert consultation. The search focused on general information on care organization, but also on research evaluating performance of the country's system, on models for organizing integrated camhs, and on reforms including their guiding principles. Grey literature was obtained by searching the internet (e.g. Oaister, Google), starting from references found in the peer reviewed literature, from reports of the WHO and European Union, and references obtained by contacting experts in the selected countries (Appendix 2) and in Belgium (see colophon). Also governmental websites were searched for legislation, policies and plans on child and adolescent mental health care and mental health care reform.

Based on the information from this review, drafts of country reports were made.

2.2.2.2. Part 2

For the foreign countries (England, the Netherlands, Canada), experts were contacted (Appendix 2) to verify these drafts and to provide information on the missing links. They were also explicitly invited to describe the strengths and weaknesses of camhs organization in their country. After the first, written round, experts were given the option to discuss more in detail the written comments by phone. For each country four experts were contacted. In selecting the experts it was aimed at to have a representation of different stakeholder levels including the following: policymakers, service providers, scientists and patients' advocates.

For Belgium, a separate KCE project will deal with stakeholder involvement in the development of a camh policy; results will be published in 2012.

2.2.3. General framework

To initiate the searching on different aspects of care organization in foreign countries, and to start reflecting in a systematic way, we used a methodological framework consisting of seven (five + two) dimensions, each with several items (for more extensive description, see Appendix 2). This framework is based on several WHO documents[3, 10, 20], on a document released by the British Medical Association (BMA)[21] and on several expert reports.[12, 22-25]

The first five dimensions (A1 to A5) deal with

- Population characteristics and geo/demographical characteristics
- Involved stakeholders in organizing mental health
- Organizational models for camhs
- Financing models for camhs
- Processes of change in reorganizing camhs

The last two dimensions should initiate reflections on the transfer to the Belgian context:

- Systems efficacy, evaluation and monitoring, feedback
- Applicability and adaptability to the Belgian context

3. LITERATURE RESULTS: A NARRATIVE REVIEW ON ORGANIZATIONAL ASPECTS OF CAMHS

3.1. Introduction

This review aimed to provide an overview and evaluation of dominant models and principles regarding the organization and policy of camhs. With such a broad topic, it was not possible for searching to be comprehensive. Therefore, this review of the literature should be considered as a narrative rather than as a systematic review.

This chapter describes concepts and organizational aspects emerging from the literature. First, the **WHO-model** (as a result of the grey-literature search focusing on reports from international organizations) for child and adolescent mental health care is described. Second, **country level policies resulting from the peer-reviewed literature search** (i.e. Canada, Norway, US) are described. It was beyond the scope of this study to perform a broad grey literature search on reports of national or regional reforms or to perform a content analysis on the numerous published discussion papers and editorials about this topic. We opted to analyze and describe the camhs-policies of a selection of countries (i.e. Canada, England, The Netherlands and Nord-Pas-de-Calais, France) in chapter 6. Third, special attention is given to **system-of-care**, a US-based model dominantly present in the peer reviewed literature. Fourth, **organization models/aspects at the service and patient level** are described.

We focus only on models and organizational aspects that are empirically evaluated in more than 2 studies that were selected during our literature search: intensive community based interventions (including intensive case management, wraparound, therapeutic foster care, multisystemic therapy, community care as an alternative for specialized inpatient mental health care) and school-based services. Fifth, **other initiatives regarding the organization of camhs**, for which our literature search yielded no or very limited empirical evidence, are listed without trying to be exhaustive. We conclude this paragraph with a short discussion highlighting the main limitations of this review.

3.2. Search Results & Quality appraisal

The primary search targeting the literature on organizational aspects of child and adolescent mental health services in Medline (Ovid), Embase and Psychinfo (Ovid) yielded 2907 citations (search strategy step 1). The additional search on the efficacy and effectiveness of integrated systems for child and adolescent mental health care (search strategy step 3) yielded 175 extra publications. Following screening of title and abstract against the predefined selection criteria, 170 citations were selected for more detailed evaluation. Full-text evaluation resulted in 75 relevant citations. In addition, 7 and 14 citations were retrieved by the grey literature search and hand searching reference lists, respectively. Fifty-seven of all the 96 included papers were classified as papers that only described models and approaches, whereas 39 papers (7 review articles[26-32] and 29 individual studies, 32 citations[9, 33-64] were considered to contribute to the evidence base (i.e. studies that evaluated models and/or organizational aspects of camhs empirically). Only the quality of the studies from this latter group of papers was critically appraised. For the **reviews**, the risk of bias (table 3.5) is assessed to be "low" in four[27, 28, 31, 32], "moderate" in two[26, 29] and "high" in another review[30].

The risk of bias in the **RCT's** (table 3.6) is judged to be "moderate"[45, 46, 54, 58, 59, 63] or "high"[11, 34, 39, 41, 49]. Frequently problems with the RCT's are the lack of power calculation, absence of a primary outcome measure, multiple testing, small sample sizes, absence of double blinding and no intention-to-treat analyses (Appendix 3: evidence tables).

For almost all **quasi-experimental** and **"non-experimental evaluation"** studies (i.e. non-experimental studies with comparison element) (table 3.6)[33, 40, 47, 50, 52, 53, 57, 61, 64] and **descriptive studies**[48, 55, 56, 60, 62] (table 3.7) the risk of bias has been scored as "high". The risk-of-bias was judged to be moderate in three quasi-experimental studies.[35, 37, 38, 42, 44]

The majority of primary studies (n=21) included in this reviews are **carried out in the US**.

3.3. The WHO model

The importance of national plans for child and adolescent mental health care was already stressed in 1977 by the WHO.[65] A national child and adolescent mental health policy refers to a specifically written document of the government or Ministry of Health containing the goals for improving the mental health situation of the country, the priorities among those goals and the main directions attaining them.[10] Policy needs to offer guidance for the development of child and adolescent mental health, for the identification of those who are accountable and to support funding mechanisms.[66, 67] To help nations in establishing child and adolescent mental health policies, the WHO published "Child and adolescent mental health policies and plans".[10]

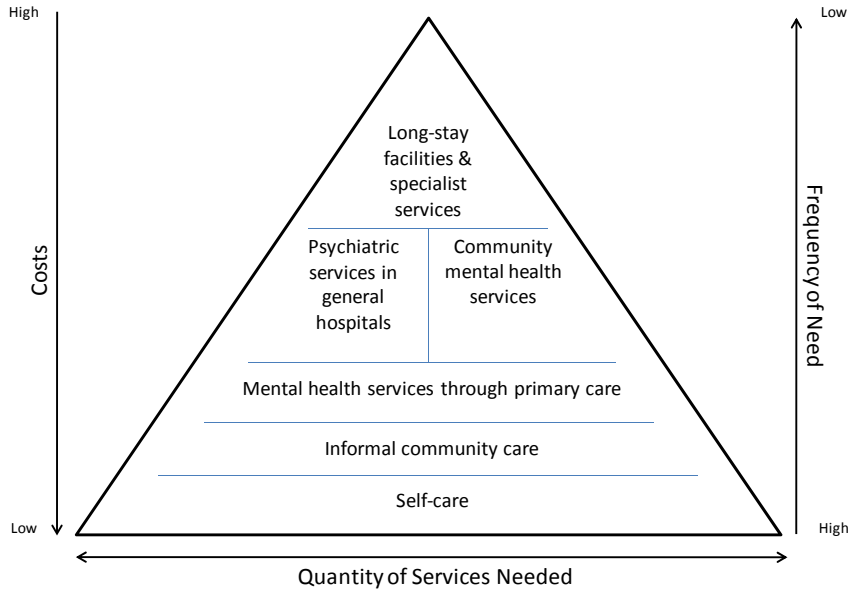
3.3.1. WHO guidance on Policy development

The WHO describes the different steps to undertake when developing a country level mental health care policy.[10] The first step of the framework describes the importance of **gathering data and information** to determine the most pressing child and adolescent mental health problems, the locus of need, and the available resources for care and advocacy. Once the needs and resources are determined, it is necessary to **evaluate the available evidence** for effective strategies in the peer reviewed literature. **Involving crucial stakeholders** is important at every stage of the process to create support for the policy but also to increase the insight into the potential contributions of their sector (e.g. education) to the mental health of children and adolescents. Next, it is recommended to **study policy development in several other countries** with a similar economic development, health system organization and/or governmental arrangements. Based on information gathered in the previous steps policy-makers develop the core of the policy which includes the **vision, values, principles and objectives of the policy**. Lastly, it is important to determine the **specific areas of action** that are linked to the established policy. The policy needs to be translated in a concrete implementation plan including a timeline, budget, funding mechanisms. Despite this recognized need of national camhs policies and plans Rosenblatt et al. (1998)[68] warn that reforms are subject to swirling political, social and economic winds. Changes in the political climate, in elected officials and their staffs, and in funding agency priorities can rapidly create, and disband reforms in human service delivery.[68]

3.3.2. WHO Model components

Within the same WHO-report[10] a model (Figure 3.1), in which the organization of services for child and adolescent mental health are classified, is presented. The model is not comprehensive (e.g. it does not include all neighbouring sectors) nor is it validated. It also includes some normative elements: it presents the "ought-to-be" situation and is not merely an analysis of existing organizational structures. It attempts to present an optimal mix of services. The largest portion of mental health ought to be **self-management and informal community care** with a focus on promotion of mental health and primary prevention of mental disorders. These services are mainly delivered by volunteers and non-health workers in settings like, for example, schools, families, prisons and children's homes.

Figure 3.1. WHO-recommended optimal mix of services[10]



The next level of the WHO-model includes the **primary care level** where usually non-specialist health workers (e.g. doctors, nurses) deliver the basic preventive and curative mental health care at the first point of entry into the health system. This level is followed by **community mental health services** (i.e. any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community) and **psychiatric services in general hospitals**. The care at this level is mainly carried out by general mental health specialists, child and adolescent mental health specialists and multidisciplinary teams with additional training in child and adolescent mental health care. The care at the **most specialized level** (i.e. long-stay and specialized services) is provided by child and adolescent mental health specialists.

3.4. Country level policies

In this paragraph country-level policies are discussed in two ways. First, a general status of global child and adolescent mental health policies is given based on a WHO-study.[67] Next, policy aspects from three countries (i.e. Canada, Norway, US) are discussed based on publications that were retrieved through the peer-reviewed literature search.

It lasted until 2004 before the first objective study was published about **the status of child and adolescent mental health policies around the world**.[67] Based on a systematic review of the literature and the use of key informants it appeared that only 7% of countries worldwide (14 of 191, of which 11 are European countries) had a clearly articulated specific (stand-alone) child and adolescent mental health policy.[67] The WHO atlas on child and adolescent mental health resources supplemented these data with more detailed information about the presence of child and adolescent mental health policy at the regional, country and local level.[3] In Europe 95.8% of countries identified some form of child and adolescent mental health policy. But only 66.7% of these countries have also a national child and adolescent mental health programming. The latter is a national action plan including the broad and specific lines (e.g. who has to do what in which time frame) of action required in all sectors involved. The report illustrated also that child and adolescent mental health services funding is rarely identifiable in country budgets. Funding comes from largely temporary and vulnerable sources rather than by more stable government allocations.[1] Even in countries with an identifiable budget it is considerable lower than the budgets provided for adult mental health services.[1] A major limitation of the WHO-ATLAS study[3, 67] is the low response rate. Meaningful information could only be obtained for 66 of 192 countries possible causing selection bias.

3.4.1. Policy aspects on countries (or regions) resulting from the peer-reviewed literature: Canada, Norway, the US

Publications[4, 22, 24, 69-73] evaluating or assessing policies in three countries (or part of these countries) were selected.

In Canada, a policy analysis was performed to examine whether Canadian provinces and territories are addressing child and adolescent mental health through the development of child and adolescent mental health plans.[22] Policy documents were obtained via a web search and by contacting key persons in the field. The obtained information was analyzed using the criteria stipulated in the WHO framework (i.e. financing, intersectoral collaboration, legislative and human rights, advocacy, information systems, research and evaluation of policies and services, quality improvement, organization of services, promotion-prevention-treatment-rehabilitation, improving access to and use of psychotropic medicines, human resources development and training) outlined in the module on child and adolescent mental health policies and plans.[10] It appeared that only 4 (i.e. Ontario, Saskatchewan, Alberta, and British Columbia) out of 13 provinces (n=10) & territories (n=3) have an identified child and adolescent mental health policy or plan. Most other do have programs that address one or more specific issues of concern for youth such as suicide, substance abuse, or eating disorders. Among the policies and plans that exist, there is substantial variability regarding content as well as degree of adherence to the WHO template. Special areas of attention are information systems (failing in all 4 provinces) – databases that allow the monitoring of camhs policies - and quality improvement (poor in 3 provinces, excellent in British Columbia).[22]

In Norway, it was estimated that as much as 60 percent of those in need of specialized mental health care (i.e. around 5% of all youth under 18 years) did not receive such care. As a consequence, a government white paper introduced a major policy change aiming to increase capacity (i.e. increasing number of therapists by more than 50%) and productivity (i.e. 50% increase in consultations per full-time-equivalent) of specialized camhs.[70] A secondary data analysis including data from 37 outpatient clinics showed that increased productivity was estimated at 25 per cent between 1996 and 2001. The increased productivity seems to be more related to strong public focus on increased productivity rather than to the increase of available resources. In fact, an increase in number of available staff was related with decrease in productivity (potentially due to larger non-productive time because of educational needs).[70] In addition a secondary data analysis performed by the same authors illustrated that treatment intensity (i.e. number of consultations per patient) increased between 1998 and 2006. This increase was even more pronounced after 2002. In 2002 hospital ownership was transferred from 19 counties to five regional health enterprises. Together with this reform new professional management issues and performance management (including a new target of 30% productivity increase) were installed.[69]

On the other hand, the evaluation of the impact of doubling the capacity for specialized mental health care in a specific region (i.e. southern and central parts of the county of Rogaland) was less positive. By creating 3 new outpatient clinics, 1.8% instead of 0.9% of the population of children aged 0-13 years in the region could be treated with specialized camhs. It was expected to find a reduction in wait times and the age of children at time of referral (with the aim to achieve early intervention). In addition it was expected to find less increase in referrals for heaviest burden of impairment and to find an increase in referrals for lesser degree of impairment. However, a secondary data analysis on routinely collected data, did not illustrate any significant changes on one of these variables comparing 505 patients admitted in the 6 months prior to this capacity increase with the 1194 patients admitted in the 18 months after the capacity was increased.

A possible explanation for this finding is that the capacity of the services is still not sufficient to meet the fully needs of the population.[71]

In the US the survey, in the spring of 1995, among opinion leaders in each state aimed to identify camhs state reforms in the US. In nearly all states (43 out of 50) camhs-reforms were reported. In 34 states these reforms were, at the time of the study, in its early stages. In 31 states these reforms involved a “carve out of mental health”. This means that the reforms only involved mental health or that they involved also physical care

but that mental health administration & financing were handled through separate arrangements. Important to note is that in 90% of the reforms, case management was used as a mechanism.[24] Despite these reforms, epidemiological surveys in the US (and the UK and Canada) illustrate that fewer than 25% of children with mental health disorders receive specialized mental health services, although some receive primary care or school-based services for their mental health problems.[4, 73] This split between many reform initiatives and the largely unmet needs of children in need of special mental health treatment can be partially explained, by the lack of a policy that creates a meaningful, comprehensive mandate for mental health services for children in the US.[72] The delivery of child mental health services has been driven by a series of inferred policies that grew out of a number of programs (e.g. System-of-care), often outside the mental health field (e.g. juvenile justice: multisystemic therapy).[72]

3.5. Systems of care

3.5.1. Historical context, definition and principles

To understand Systems of care, it is helpful to describe the context in which it originated.[74] After all, over the past 25 to 30 years there has been a major paradigm shift in the philosophy and organization of services for children and adolescents with mental health problems.

In the 1970's the **"medicalization" of psychiatry**, served to move child and adolescent mental health services towards the more hospital-based, tertiary care model.[5] Pumariega indicates that the publication of Jane Knitzer's (1982)[75] groundbreaking book "Unclaimed Children", documented (together with other reports) a disorganized and fragmented system, serving only a fraction of children in need for receiving mental health services.[62] These reports illustrated the consequences of neglecting the provision of community-based mental health services for children and their families.[5]

In response, the National Institutes of Mental Health US launched the **"Child and Adolescent Service System Program"** with the objective of helping states and communities to build capacity to develop "systems of care" targeted for children with serious and complex needs.[5, 76]

The underlying concept (i.e. systems of care) was first published in 1986[77]. The Systems of care concept aims to serve as a framework and philosophy to guide service systems and service delivery in order to improve the lives of children with mental health challenges. It was **originally defined** as "a comprehensive spectrum of mental health and other necessary services and supports which are organized into a coordinated network to meet the multiple and changing needs of children with serious emotional disturbances and their families.[77]"

Also the **key principles** were articulated as: access to a comprehensive array of services, treatment individualized to the child's needs, treatment in the least restrictive environment possible (with full utilization of the resources of the family and the community), full participation of families as partners in services planning and delivery, interagency coordination, the use of case management for services coordination, early identification and intervention, smooth transition of youth into the adult service system, effective advocacy efforts, and non-discriminating, culturally sensitive services.[76, 77]

In first instance, **demonstration projects across the US** emerged, based on this conceptual work.[5, 77] The impact of the Systems of care concept is probably evidenced most significantly by a funding program launched in 1992 by the Center for Mental Health Services. It concerned, the **largest investment to date** in children's mental health services when they funded over 100 "Systems of care" demonstration projects (duration: 6 years) in diverse communities in all 50 states.

A recent special issue[78] of 'Evaluation and Program Planning', provoked by a recent review[79], is devoted to the Systems of care definitions[79]. The authors of this review indicate that the original definition changed over time.[79] In table 3.1 a comparison (i.e. population, system response, mode of system response) of Systems of care definitions currently in use is made.

The originators of the concept, for instance, introduced in a follow-up monograph person- and family-first language in the core definition and added cultural competence to the core values.[80] This special attention to cultural minorities is needed because of the disparities in mental health

services for minority youth. Lack of access, for example, caused by suspiciousness towards mental health services resulted in increasing numbers of minority youth entering juvenile justice and child welfare.[81]

Table 3.1. Core values and principles Systems of care[82]

Core values Systems of care are: (1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided (2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level (3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve
Guiding principles systems of care are designed to: (1) Ensure availability and access to a broad, flexible array of effective community-based services and supports for children and their families that address their physical, emotional, social, and educational needs, including both traditional and non-traditional services, as well as informal and natural supports (2) Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family (3) Deliver services and supports within the least restrictive, most normative environment that is clinically appropriate (4) Ensure that families/other caregivers/ youth are full partners in all aspects of the planning & delivery of their services; in the policies & procedures in their community, state, territory, and nation (5) Ensure that services are integrated, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management (6) Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs (7) Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes (8) Provide the services and supports needed to facilitate the transition of youth to adulthood and ensure smooth transitions to the adult service system (9) Protect the rights of children and families and promote effective advocacy efforts (10) Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences (11) Continuous accountability mechanisms to track/monitor/manage the achievement of goals, fidelity to philosophy, and quality and outcomes at the system, practice, and child and family level

It is also shown that some authors do not include a reference to serious emotional disturbance in their definition to enhance the applicability of the concept to other populations.[23, 83]

Hodges et al.[79] added many (e.g. “access” and “availability” of services) specifications to the systems of care definition. Access refers to a child’s/family ability to enter, navigate and exit appropriate services and supports as needed. Availability includes services and supports in sufficient range and capacity to serve these needs. According to the authors, access and availability cannot be achieved unless there are no administrative and funding restrictions for the person who needs help. Therefore, this was also added to their definition. [79]

The originators of systems of care stresses that it is not a “model” to be “replicated” or to be implemented in a “model-adherent manner” similar to a discrete, manualized treatment.[82] It can be better described as a **“paradigm shift”, an “ideal”** to describe how child-serving systems

should function or as a framework for systems reform based on a clear philosophy and value base.[82] Therefore, it is possible that different communities, despite using a same philosophy, have implemented systems of care in very different ways.[82] In addition, these authors point on the multiple levels and complexity inherent in the systems of care concept. Systems of care implementation involves a multifaceted, multilevel process that involves:

- Making changes at the *state/territorial system level* in policies, financing mechanisms, workforce development and other structures and processes to support systems of care;
- Making changes at the *local system level* needed to plan, implement, develop an infrastructure, manage and evaluate the system;
- Making changes at *the service delivery or practice level* to provide a broad array of effective, state-of-the-art treatment services and supports to children and families.[82]

The authors underline the importance of flexibility and the possibility to respond to unique needs of culturally diverse populations. Therefore, the authors caution for definitions that are too prescriptive[82] and suggest the following **update of the definition**:

> "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network with a supportive infrastructure, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life."

In addition, they indicate that that the underlying principles and values are at least as important as the definition. In table 3.2 an updated version of the core values and principles of systems of care is shown.

3.5.2. Systems of care: observational studies

Four of the included **observational studies**[48, 55, 56, 62] investigated aspects of implementation of Systems of care principles in practice. One observational study could not illustrate that caseload segregation (children served by a variety of organizations, which is an essential component that Systems of care tries to avoid) is a predictor for residential treatment, hospitalization & incarceration rates.[55] Hernandez et al.[48] found that, in general, the principles of systems of care (e.g. individualization, case managements, integration and coordination, informal support) are more represented in daily practice in organizations, known to have adopted the system-of-care principles, compared to traditional services. In addition, the findings of Rivard and Morrisey (2003)[56] suggest that agencies are becoming interdependent, and were beginning to shift from individual goal attainment to systemic goal attainment two years after the start of system-of-care projects. However, in a study about the ability of Federal funded sites in the US to sustain their systems of care beyond the federal grant period the results are inconclusive.[62] After all, both positive and negative changes are demonstrated with respect to maintaining the availability of each service included in the broad service array, the implementation of Systems of care principles, the Systems of care infrastructure, and the achievement of Systems of care goals.[62]

Table 3.2. Comparison of Systems of care definitions currently in use (adapted from Hodges, 2010)[79]

	Stroul and Friedman (1986)[77]	Stroul and Friedman (1994)[80]	Pires (2002)83 and Stroul (2002)[23]	Center for Mental Health Services (2006)[84]	Hodges (2010)79
Population [describes individuals affected by Systems of Care]	[The multiple and changing needs of] severely emotionally disturbed children and adolescents	[The multiple and changing needs of] children and adolescents with severe emotional disturbances and their families	[The multiple and changing needs of] children and their families	[The challenges of] children and youth with serious mental health needs and their families	Children and youth with serious emotional disturbance and their families
System Response [describes activities of system response]	Comprehensive spectrum of mental health and other necessary services	Comprehensive spectrum of mental health and other necessary services	Comprehensive spectrum of mental health and other necessary services	Community-based services and supports [that] build on strengths of individuals and address each person's cultural and linguistic needs	Access to and availability of necessary services and supports across administrative and funding jurisdictions
Mode of System Response [describes organization of system response]	A coordinated network	A coordinated network	A coordinated network	A coordinated network [in which] families and youth work in partnership with public and private organizations	An adaptive network of structures, processes, and relationships grounded in Systems of care values and principles

3.5.3. Systems of care: Fort Bragg and Stark County studies

Systems of care has also been evaluated using **(quasi-)experimental study designs**. Two (quasi-) experimental studies (i.e. the Fort Bragg Evaluation and the Stark County project) are landmark studies within this area of research. The Fort Bragg Evaluation was designed to examine one of the key elements of the original Systems of care model[77]: the provision of a full continuum of services to children and adolescents with mental health and substance abuse problems, including residential, intermediate and nonresidential services. The study included a sample of 984 families, of which 547 at the Demonstration site (military personnel) and 410 at the comparison site. Significantly lower restrictiveness of care, higher family and consumer satisfaction, greatly increased access to services, and greater funding spent in less restrictive services were illustrated.

However, the continuum-of-care groups showed clinical and functional outcomes similar to those of the traditional services group, while costs were higher for the continuum of care group. The notion that costs can be controlled by clinicians and their managers by placing children in what they believe to be the most appropriate level of care for the most appropriate length of time was not supported by the evaluation.[35, 36, 77] It is argumented that focusing on systems reform not necessary will lead to improved clinical or functional outcomes unless services delivered themselves will be reformed.

Possible explanations for the lack of difference in clinical outcome between the experimental and control populations have been formulated. The Fort Bragg Demonstration only implemented a continuum of care and was not preceded by interagency coordination and pooling of funds, elements

necessary to develop a Systems of care.[35, 36, 77] The population of Children and adolescents in the Fort Bragg Demonstration were children of military dependent parents. This population is comparable to middle and lower-middle class children and adolescents treated in the civilian sector, mostly from two-parent families with good education and middle to lower incomes. This is in contrast with the original model that was conceptualized for children and adolescents with the most severe level of disorders.[9] Hoagwood further states that there is some evidence to assume that the services at the comparison sites were as coordinated as those in the Fort Bragg area.[9]

The Stark County Systems of care longitudinal experimental study[37, 38] addressed those remarks in order to examine whether system-level reforms were sufficient to alter client-level outcomes. The Stark County Systems of care included 288 subjects in the implementation and 336 in the control group. The study showed that well organized Systems of care produce positive effects, such as increasing access to care and better coordination of services. Despite these improvements, no effect on clinical outcomes could be illustrated. The study concludes that clinical outcomes will not improve, if the services, regardless of the system in which they are delivered are not effective. Reform should occur not only on the systems level but also on the service level or treatment level.[37] Mental health services for youth are unlikely to improve without a system of measurement that is administered frequently, is concurrent with treatment and provides feedback.[85]

In addition to these landmark studies a number of **single papers** studied **interventions inspired by the system-of-care model**. These studies were smaller in scale and have variable results.[42, 49, 50, 52, 64] The interested reader can find more information about these studies in the evidence tables (Appendix 3).

3.6. Patient and Service level models

The studies empirically evaluating patient and service level models can be grouped into “intensive community-based interventions” and “school-based mental health services”.

3.6.1. Intensive community-based interventions

Serving children and adolescents in the community and allowing them to maintain their relationships with families, schools and neighbours is a central goal of most recent camhs reforms (including reforms that are based on systems of care) cited in the literature. Therefore, community-based treatment and support are provided, often in the home, to enable children and adolescents to stay at home. In this review only the intensive community-based interventions (i.e. intensive case management, wraparound, therapeutic foster care, Multisystemic therapy) that have found to be empirically evaluated are included. This is only a fraction of the models that are described in the literature, but not extensively evaluated.[74]

3.6.1.1. (Intensive) Case Management

Case management in child and adolescent mental health care can be defined as “a mechanism for linking and coordinating segments of a service delivery system, within a single agency or involving several providers, to ensure the most comprehensive program for meeting an individual client’s needs for care”.[86] Despite the general consensus about this definition, case management remains an ill-specified and variously implemented concept.[86] Since the introduction of case management to camhs, several different styles have evolved including assertive outreach and intensive case management.

Intensive case management has been differentiated from other forms of case management through factors such as caseload size, team (rather than clinician) management, outreach emphasis.[87]

Importantly, all types and styles of case management place a responsibility for the care of an individual or caseload of individuals on clinicians and/or team of clinicians.

The evidence about intensive case-management is, in contrast with adult mental health care, limited within the field of child and adolescent mental health care. The literature search yielded only two RCT's.[39, 86] The results of Burns et al.[86] show some improvements on process (e.g. more time spent on typical case management aspects like outreach, service planning, linking/referrals) and service utilization measures (e.g. intervention group used more outpatient services) whereas the clinical and functional outcome measures were inconclusive.[86] In the study of Cheng[39] there were no significant differences between the intervention (i.e. case management program for re-injury among assault-injured youth presenting to the emergency department) and control group (i.e. usual care, receiving a list of community services) regarding service utilization or outcome (e.g. fighting incidents) measures.

3.6.1.2. Wraparound planning process

Wraparound is an individualized, family-driven, team-based service planning and care coordination process intended to improve outcomes for youth with complex behavioural health challenges and their families.[88] Despite divergent use in the literature, there is growing consensus that "wraparound" refers to the planning process and not to the services themselves. Services are "wrapped around" the child and family in their natural environments.[74]

Wraparound is underpinned by a strong value base (see table 3.3) that dictates the manner in which services for youth with complex needs should be delivered. Wraparound has been described as the most direct practice-level representation of Systems of care.[88] It can be articulated as a mechanism through which care planning and coordination can be provided to children and adolescents with the most serious complex needs in a way that is consistent with the Systems of care principles.[88] Wraparound is delivered at an individual basis.

However, it is more likely to be faithfully implemented within a hospitable system (e.g. flexible funding mechanisms, community partnerships, human resource development, service array).[74, 88]

This review includes **two individual studies**[53, 61] and one meta-analysis about the effectiveness of the wraparound planning process. Mears et al. (2006)[53] compared the wraparound planning process with traditional foster care. Despite a lower number of placements ($p<0.05$) in the intervention group, no effect was found on a number of other outcomes (e.g. law enforcement rates, disciplinary actions at school).[53] Solhkhah et al. (2007)[61] found positive effects (i.e. lower inpatient psychiatric hospitalization rates and higher maintenance within the community) after implementation of the wraparound planning process.

Table 3.3. The ten principles of the wraparound process[32]

Principle	Description
Family voice and choice	Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences
Team based	The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships
Natural supports	The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support
Collaboration	Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work toward meeting the team's goals
Community based	The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote child and family integration into home and community life
Culturally competent	The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community
Individualized	To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services
Strengths based	The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members
Unconditional	A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working toward meeting the needs of the youth and family and toward achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary
Outcome based	The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators and revises the plan accordingly

A comprehensive review[32] bundling seven published controlled wraparound studies found that mean treatment effects ($p<0.05$) across outcome domains ranged from medium for adolescents living situation (0.44) to small for mental health outcomes (0.31) and juvenile justice related outcomes (0.21). The overall mean effect size (i.e. 0.33) across studies and outcome domains, falls within the range of small to medium effects. **On average children receiving wraparound were better off than 63% of those receiving conventional services** ($p<0.05$). These results indicate that wraparound can potentially yield better outcomes for children and adolescents with severe and emotional behavioural disorders. However, given the small number of studies and the lack of methodological robustness (e.g. high attrition, heterogeneity target populations) of studies included in the meta-analysis these results can at best be described as promising.

3.6.1.3. Treatment Foster Care

Treatment foster care differs from mainstream foster care by providing carers with the skills and support services needed to manage challenging behaviour of their foster children. A variety of terminology is used (e.g. specialized foster care; multidimensional treatment foster care, wraparound foster care) in the literature to describe placements with caregivers that are specifically designed and delivered to provide tailored support to young people, their caregivers and families.[28, 74] The basic ingredients are listed in table 3.4. Treatment foster care targets children and adolescents at risk of multiple placements and/ or more restrictive placements such as hospitals or secure residential settings. Besides children and adolescents with mental health problems it also targets children and adolescents who have experienced a trauma, neglect or abandonment; with problems of antisocial behaviour and offending.[28]

The evidence base for therapeutic foster care in this review is based on a single RCT [41] and one systematic review.[28] The **single RCT**[41] (with a high risk of bias) compared an early intervention foster care program with regular foster care for pre-school foster children who, research indicates, are at increased risk of developmental delay. This risk appears to increase with the number of placements experienced. The results of the RCT show that this treatment foster care program has the potential to improve the success rates for permanent placements following foster care.[41]

The systematic review included five RCT's (RCT of Fisher not included) in which the effect of therapeutic foster care was evaluated.[28] Only one of these 5 studies targeted children with mental health problems stricto sensu. The other studies targeted delinquent adolescents and abused or neglected children.[28] The results of the individual studies included in the review of MacDonald, like the study of Fisher[41], illustrate that therapeutic foster care is a promising intervention for these target groups. However, the evidence-base is not robust.

Table 3.4. Basic ingredients treatment foster care[28]

Treatment foster care basic ingredients
Programme for children and adolescents that otherwise would be treated in more restrictive non-family settings (usually institutions), or are at risk to be admitted in those settings.
Philosophy with strong community links and individually designed treatment plans
Foster caregivers are selected and trained to provide therapeutic care
Care is provided within a family setting, in a home owned or under the control of the foster carers
The number of children placed in the home is limited to no more than two
Foster caregivers receive support, consultation, and supervision from professionals who carry a small caseload with crisis intervention services available around the clock
Foster caregivers are regarded as professional members of the service and treated as such
Foster caregivers receive payments above those provided for regular foster care
The programme is administered by specialist agencies

3.6.1.4. Multi-systemic therapy

Multisystemic Therapy, developed by Henggeler[46, 89] is a multi-faceted, short-term, intensive home- and community-based intervention for children and adolescents at risk of out-of-home placement because of serious emotional and behavioral problems.[27, 74] Originally sponsored by and developed for juvenile offenders[90], multisystemic therapy has been applied to youth in the child welfare system[63], youth at risk for psychiatric hospitalization[58], and violent sex offenders.[74]

Multisystemic Therapy is consistent with social ecology theory, in which behaviour is viewed as a product of reciprocal interactions between individuals and their social environments.[27, 74] These interconnected social systems encompass individual, family and extra familial (peer, school, neighbourhood) factors.[91]To understand the problem of children and adolescents multisystemic therapists should, therefore, systematically asses the influences of a variety of these individual, family, school, peer, neighbourhood, and community characteristics.[27, 30]

Since problems are multi-determined, it follows that effective interventions should be relatively complex, considering adolescent characteristics as well as aspects of the key systems in which adolescents are embedded.[27, 90] The goal of multisystemic therapy is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer school and neighbourhood problems[91] Multisystemic treatment interventions are individualized to address specific needs of adolescents and families, and includes work with other social systems including schools and peer groups. Therapists work in the natural environment of the children and adolescents, in collaboration with their primary care givers. However, if psychiatric hospitalization is required then therapists continue to provide services in these clinical settings. Treatment requires active efforts from the family to reach treatment goals.[30, 90]

Multisystemic therapists work with small caseloads (about 3 families) during a period that lasts 3 to 5 months.[74] The multisystemic service is available 24 hours a day, seven days per week. The intensity of treatment is determined by the needs of the youth and their family.[47] Multisystemic therapists are mental health professionals with masters or doctoral

degrees who are supervised by a child psychiatrist. Multisystemic programs are licensed by MST Services, Inc. (see www.mstservices.com).[27]

Multisystemic therapy has been evaluated in **individual US-based RCT's**, targeting adolescents at risk for psychiatric hospitalization[47, 58, 59]; delinquent youth[43] or substance dependent adolescents[46]. Multisystemic therapy achieved significant ($p<0.05$) lower out-of-home placements compared to psychiatric hospitalization[58] or usual care[43]. Although, the results for drug use were inconclusive, also in this study lower rates ($p<0.05$) of out-of-home placements were shown.[46] Henggler[47], nevertheless, mentioned that savings in hospitalization days for youth in the multisystemic therapy partially was offset by a higher than expected use of other out-of-home placements, such as juvenile detention.

Two Scandinavian studies, one in Sweden[63] and one in Norway[54] evaluated the effect of Multisystemic therapy in treating adolescents with problematic behaviour in child welfare. In the Norwegian study, multisystemic therapy achieved better results (i.e. out of home placements, parent and adolescent self-reported behavioural problems) compared to usual child welfare services. In Sweden, no significant differences with usual child welfare services were found on a number of outcomes (e.g. self-reported delinquency; alcohol and drug consumption). One important difference between both studies is that in Norway multisystemic therapy is implemented by the Ministry of Child and Family Welfare, whereas in Sweden it is up to local initiatives. Although the Scandinavian results[54, 63] are informative, they cannot easily be compared with the results of the US. Norway and Sweden do, for example, not have a juvenile justice system. Therefore, adolescents cannot be arrested. What's more compared to the US, in Scandinavian countries in-home services are quite frequent in usual child welfare services.

A **recent systematic review** evaluated the effectiveness of multisystemic therapy by pooling the results of 8 RCT's carried out in 3 different countries (6 USA; 1 Norway; 1 Canada), representing 3 different target groups (i.e. 6 juvenile offenders; 1 problem behaviours; 1 psychiatric emergencies).[27] Despite the promising results shown in individual studies, the pooled results indicated trends for lower rates of incarceration, less arrest and conviction rates that were statistically not significant. Given the high heterogeneity of the included studies, it is not appropriate to conclude that multisystemic therapy has no effects. Evidence is promising but, at present, inconclusive. It should be noted that all individual studies and 7 out of 8 RCT's included in the systematic review were conducted by researchers who are not independent of the multisystemic therapy program developers. It is their merit that they investigated the effectiveness of a program within the field of camhs. However, the fact that they are not independent from MST Services, Inc. (see www.mstservices.com) could have introduced bias.

3.6.2. Specialized outpatient care as alternative to inpatient mental health

Four individual studies (5 citations)[40, 44, 57-59] and one systematic review[31] are studying the effect of community-based alternatives (redundancy exist with models discussed above: e.g. multisystemic therapy) to specialist inpatient mental health services. In addition, Ahrens et al.[33] studied mental health services providing specialist care, beyond the capacity of generic outpatient provision (i.e. program of assertive community treatment) without using inpatient treatment as a control group.[33]

Despite some positive effects illustrated in individual studies[57-59], a recent systematic review[31] concluded that there **is too few evidence to draw conclusions about the effectiveness of community-based alternatives compared to in-patient services**. The latter review included 7 RCT's studying three different community-based alternatives (i.e. multisystemic therapy, intensive home based crisis intervention, intensive specialist outpatient treatment). [31]

3.6.3. School-based services

3.6.3.1. General description

School-based programs offer the promise of improving access to diagnosis of and treatment for the mental health problems of children and adolescents.[92-94] For many children and adolescents the school system provides the only form of mental health treatment.[9] School-based mental health services in mainstream schools offer the potential for preventive efforts (e.g. programs that decrease risk factors and build resilience) as well as intervention strategies (e.g. group or individual therapy).[93-95] School-based mental health services range from minimal support services

provided by a school counselor to a comprehensive, integrated program of prevention, identification and treatment within a school.[94] Many schools offer components of more than one of the following models: **school-supported mental health models** (e.g. separate mental health unit exist within the school system: Social workers, guidance counselors, and school psychologists are employed directly by the school system); **community connections models** (e.g. a mental health agency or individual delivers direct services in the school); **comprehensive-integrated models** (e.g. A comprehensive and integrated mental health program addresses prevention strategies, school environment, screening, referral, special education, and family and community issues and delivers direct mental health services).[94]

3.6.3.2. Evaluation school-based services

A US-based study using secondary data analyses illustrated that the probability of using mental health counseling services increased when schools offered on site counseling without impacting the services used outside schools.[60] The **high accessibility** of school-based mental health centers is confirmed by Jusczak et al. (2003).[50] The authors found, in their retrospective cohort study, that adolescents were 21 (95% CI: 15-29) times more likely to come for mental health visits at school based mental health centers than at community networks. Atkins[34] also found that parents of children from Kindergarten through 4th grade of schools in high poverty communities, receiving a school-based mental health intervention, were significantly more likely to enroll their child in services, compared to those who were referred to outpatient clinics.

A single quasi-experimental pre-post test study in Norway evaluated the impact of **school-based early intervention programs** on 8 behavioural and learning outcomes. Significant but small changes ($p<0.05$) were found 9 months after implementation of the programs on 4 of these outcomes (i.e. less problem behaviour, learning inhibition, aggression incidents and increased student relationships).[51]

Browne et al.[26] conducted **a systematic review** (assessed to have a moderate risk of bias) including 23 reviews of (quasi-) experimental studies studying the effectiveness of mental health-services programs for school-aged children. Almost every included review dealt with services that were all or, in part, within a school venue. Despite the many methodological shortcomings of the included studies, the cumulative evidence resulting from the high number of studies is in favor of:

- universal programs that focus on protective factors rather than to change negative behaviour;
- Tailored (cultural and gender adapted), long-term timely interventions for high-risk children;
- Programs who address the whole child and his family instead of focusing on a single problem behaviour;

Another more recent review of 27 RCT's shows a positive effect of structured universal, selective and indicated school-based programs that aim to prevent anxiety symptoms and to build resilience. Twenty-one of the 27 included studies reported a significant ($p<0.05$) improvement in participants' symptoms of anxiety either immediately post-test, at follow-up or both.[29]

3.7. Other initiatives regarding the organization of camhs

Without aiming to be exhaustive, the literature search yielded many other models or organizational aspects, such as:

- **Transition from adolescent mental health services to adult mental health care**[96, 97]. Young people in late adolescence and early adulthood have specific mental health needs, which are often related to their transitions in different aspects of their life. Service provision, however, is fragmented, and there are different philosophies and priorities for agencies working with children/adolescents as opposed to adults, with resulting service gaps and disengagement of young people from services during the transitional period of high level need. Therefore, recent policies (e.g. UK, Australia) targeting youth in transition to adulthood emerged in the domain of mental health.[73, 98, 99]
- Special educators to support transition between inpatient care and school environment[100, 101];
- **Interagency collaboration child-welfare and mental health-services**. According to Prince and Austin[102], three collaborative elements are typically included when agencies work together: (1) interagency structures, or mechanisms that address shared needs

(e.g. pooled funding); (2) ongoing relationship process designed to address environmental constraints such as insufficient resources or fragmentation of services (e.g. multi-agency task forces); (3) use of a central authority (e.g. legislation) to manage networks of systems that actively negotiate with each other.

- **Telepsychiatry models.**[103];
- **Community outreach clinics**.[104]
- **Functional Family Therapy** is an outcome driven home-based prevention/intervention program, based on Family Systems theory. It is mainly intended for treatment of externalizing adolescent behaviour disorders. Functional Family Therapy was developed in the late 1960s by Alexander and Parsons.[105] It is called to be evidence-based and culturally sensitive. The Functional Family Therapy program is a short-term intervention program with an average of 12 sessions over a 3-4 month period. Services can be delivered at home, or clinic- or school based, or other settings (child centres, probation offices, aftercare services).
- **Mental health services in primary care**[106] and **the role of primary mental health workers**[107]; Delivering mental health care services for children and adolescents in primary care has been considered useful for several reasons: early detection and early intervention of psychosocial problems, treatment for less severe problems, and health promotion and prevention.

  Several approaches are identified: increased management by the general practitioner and community professionals; management by specialist mental health care professionals working in primary care; consultation-liaison methods to support management by primary care rather than take responsibility for individual patients. Despite some promising effects of treatments in primary care carried out by specialized staff as well as educational interventions that aim to increase skills and competence of primary care staff, the authors of a systematic review about this subject conclude that a significant programme of research is needed to support evidence-based policy in this area.[108]
- A model for **infant mental health care** is proposed in an article reviewing the social commitment to infants and their families in Canada and the USA. The model is build up (like the WHO-model depicted in figure 3.1) as a pyramid of services covering prevention (all families, families needing some extra support); treatment (families needing specialized treatment, families in crisis) and ongoing follow-up (families whose children cannot be protected or treated home). The authors conclude that the Canadian policy targets all families, whereas the policy in the US only targets troubled families.[109]This study is in line with the ambition of the World Association for Infant Mental Health[k] to promote the mental wellbeing and mental health of infants.
- **Psychiatric liaison-services for adolescents in residential group homes**. Child and adolescent psychiatrists provide regular outpatient treatment in residential group homes, working closely with the group caregivers to integrate them into the therapeutic process.[110]

These models will not be discussed in detail in this report, since the number of publications found during our literature search that evaluated the effectiveness (≤2) of these models was too low. A **more specific targeted literature search is needed to describe and assess these models more in-depth**.

3.8. Restrictions of this review

Given the wide scope of this review it should be considered as a narrative rather than as a systematic review. Some additional limitations should be taken into account when interpreting the results presented in this chapter.

First, the research questions stated at the onset of this study were only partially answered because of the **limited availability** of evidence. The literature search yielded two (i.e. WHO; Systems of care) highly cited *frameworks* that ground international camhs-reforms. The WHO describes the need for a country level camhs-policy/plan and the different steps to undertake when developing such a policy/plan. In addition, the organization of services for child and adolescent mental health are classified in a model[10]. However, the number of countries (or regions) with

[k] http://www.waimh.org

a sound national policy and/or plan for camhs is limited. Moreover, few (if any) countries followed the steps suggested by the WHO rigourously.[67] Systems of care served in the US as a framework and philosophy to reform the mental health services for children and adolescents with serious emotional disturbances[77]. It was aimed to evolve from a fragmented disorganized system into an integrated and coordinated system that includes a wide array of services to meet the multiple and changing needs of children with serious emotional disturbances and their families.[77]

Secondly, the evidence on the *efficacy and effectiveness* of the different types of camhs and integrated versus non-integrated camhs is limited. Many different models are described[74] but few are evaluated empirically. The retrieved studies were chiefly carried out in the US, which limits the generalization of the findings (because of their specific context). In addition, the reasons why some models are studied and others not, are not always clearly articulated and warrant some caution.

Multisystemic therapy, for instance, is studied extensively but almost exclusively by researchers who are not independent of the multisystemic therapy program developers. Potential publication bias can therefore not be excluded.

Next, the critical appraisal of the included studies shows that **a number of caveats** should be noted about the nature of the evidence reviewed in this chapter. Many evaluations are underpowered and studies about the effectiveness of camhs are hampered by a lack of appropriate and pre-defined outcome measures (e.g. multiple measurement), and by the fact that many interventions are multifaceted (like the problems they seek to solve). Furthermore, it is often difficult to disentangle what aspect of a service might be making a difference.

A system change requires **actions at three levels**: country/regional level; local system level; service delivery or practice level.[77] Researchers often neglect one or more of these three levels or mix up levels when designing their studies. As a result, findings are sometimes hard to interprete. Bickman et al.,[85] for example, state as a reaction to the null finding (i.e. no significant changes in clinical and functional outcomes) in the Fort Bragg study that clinical outcomes will not improve if policy changes only include changes on the organizational level. They stress the importance to put efforts in monitoring and improving the therapeutical content in parallel.

Finally, it should be noted that **therapeutical models and choices** were not included within the scope of the study. Nevertheless, the interplay between therapeutical programs and organization of camhs is important in two directions. The different therapeutic schools can, on one hand, have a large influence on how camhs are organized.

On the other hand, the organizational context restricts or facilitates the development of certain therapeutic programs at the treatment program level.



Table 3.5. Systematic reviews including intervention studies

Study	Time-frame	Risk of bias	Patients	Interventions
Browne et al., (2004)[26]	1990-2000	Low	School-age children with mental health problems	Mental health-services programs (non-clinical) for school-aged children
Litell et al., (2009)[27]	1985-2003	Low	Children and adolescents (10-17 years) with social, emotional, and behavioural problems, at risk of out-of-home placement	Multisystemic Therapy
Macdonald et al., (2008)[28]	1966-2007	Low	Children and adolescent (0-18 years) with severe medical, social, psychological and behavioural problems at risk of or being placed in out of home care in restrictive settings	Therapeutic foster care programmes
Neil et al., (2009)[29]	1987-2008	Moderate	Children and adolescents (5-19 years)	Structured school-based program that aims to prevent the symptoms or incidence of anxiety or to build resilience
Painter et al., (2010)[30]	Not specified	High	Adolescents with serious clinical problems	Multisystemic Therapy
Shepperd et al., (2009)[31]	1966-2007	Low	Children and adolescents Aged 5-18 years with a serious mental health condition or non-specific emotional or behavioral disorders.	Mental health services providing specialist care, beyond the capacity of generic outpatient provision, which provide an alternative to inpatient mental health
Suter et al., (2009)[32]	1986-2008	Low	Children and adolescents (3-21 years) with severe emotional and behavioural disorders and/or significant functional impairment	wraparound

Table 3.6. (Quasi-) experimental studies and non-experimental evaluation studies

Study	Risk of bias	Target Population	Design	Intervention/ control	Country	Mean age	Post-test (distal point)
Ahrens et al., (2007)[33]	High	Adolescents with severe and persistent mental illness 15-21 years	Quasi-experimental pre-post-test design	Program of Assertive community treatment (n-15) comparison of hospitalization days before and after the program	US	16.8	12 months
Atkins et al., (2006)[34]	High	Children from Kindergarten through 4th grade in high poverty communities	RCT	School-based mental health service model (n=60) vs. referral to neighbourhood mental health clinic (n=30)	US	?	1 school year
Bickman et al., (1996)[35]	Moderate	Children and adolescents with mental health problems	Quasi-experimental design	Continuum of care (n=574) vs. usual care in community (n=410)	US		12 months
Bickman et al., (1997)[38]	Low/Moderate	Severe emotional disturbed children	Randomized longitudinal experimental design	Systems of care (n= 171) vs. usual care in community (n=179)	US	11.1	6 months
Bickman et al., (1999)[37]	Low/Moderate	Severe emotional disturbed children	Randomized longitudinal experimental design	Systems of care (n= 171) vs. usual care in community (n=179)	US	11.1	12, 18 and 24 months
Burns et al., (1996)[86]	High	Severe emotional disturbed children	RCT	Intensive case management (n=82) vs. regular care (n=85)	US	13.3	12 months
Cheng et al., (2008)[39]	High	Adolescents presenting to Hospital Emergency Department after peer assault injury	RCT	Intensive case management (n=43) vs. usual care in emergency department and referral to community resources (n=45)	US	14.5	6 months
Evans et al., (1997)[40]	High	Children and adolescents with serious emotional and behaviour problems	Randomized design, not controlled	Intensive in-home Crisis Services (n=296), 3 conditions	US	12.3	6 months

Fisher et al., (2005)[41]	High	Foster children 3-6 years of age	RCT	Early Intervention Foster Care Program (n=47) vs. regular foster care (n=43)	US	4.5	24 months
Garner et al., (2010)[42]	Moderate	Adolescents, alcohol or drug dependent, with an episode of residential treatment	Quasi-experiment	Assertive continuum of care (3 conditions) (n=234) vs. standard continuing care (n=86)	US	15/16	3 months
Glisson, (2010)[43]	Moderate	Delinquent Youth in rural counties	2X2 RT	Multisystemic therapy (n=349) vs. usual services (control)(n=325), crossed with ARC organizational intervention	US	14.9	18 months
Harrington et al., (2000)[44]	Moderate	Children 3-10 years behavioural disorders	Quasi-experiment	Parent education groups in community treatment (n=72) vs. parent education groups in hospital treatment (n=69)	UK	6.9	12 months
Henggler et al., (1997)[47]	High	Adolescents, referred to Emergency psychiatric hospital	Pilot study of randomized field trial	Multi-systemic therapy (n=13) vs. hospitalization (n=13)	US	14	4 months
Henggeler et al., (1999)[46]; **Henggeler et al., (2002)**[45]	Moderate	Juvenile justice – substance abuse	RCT	Multi-systemic therapy (n=58) vs. Community based substance abuse treatment (n=60)	US	15.7	4 years
Holden et al., (2007)[49]	High	Moderate mental health problems, authorized for residential care	RCT	Flexible funded community agencies (n=78) vs state services as usual (n=79)	US	I:12.3; C:11.8	12 months
Juszczak et al., (2003)[50]	High	School based mental health centers	Retrospective cohort study	School-based mental health center (n=667) vs. Community health networks (n=165)	US	/	/
Kjobli et al., (2008)[51]	High	School-based early intervention	Quasi-experimental pre-post test design	School-based early intervention (n=128) vs. Regular school services	Norway	7.7	9 months
Magiati et al., (2007)[52]	High	Children with autism	Prospective outcome study	Home-based early intensive behavioural therapy (n=28) versus nursery at school (n=16)	UK	I:3.2; C:3.5	32 months
Mears et al., (2009)[53]	High	Severe emotional disturbed children	Quasi-experimental pre-post test design	Wraparound (n=96) vs. regular foster care (n=30)	US	12.3	6 months
Ogden et	Moderate	Adolescents with	RCT	Multi-systemic therapy (n=46) vs. regular	Norway	15	6 months

al., (2006)[54]		problematic behaviour		child welfare (n=29)			
Schmidt et al., (2006)[57]	High	Children requiring psychiatric hospitali-zation	Quasi-experimental	Home treatment (n=76) vs. Inpatient treatment (n=35)	Germany	10.9	12 months
Schoenwald et al.,(2000)[58]; Sheidow et al., (2004)[59]	Moderate	Adolescents approved for emergency psychiatric hospitalization	RCT	Multi-systemic therapy (n=57) vs. hospitali-zation (n=56)	US	13	15-16 months
Solhkhah et al., (2007)[61]	High	Severe emotional disorder	Within-group design (retrospective data)	Wraparound (n=169) vs. Wait list (n=169)	US	11.98	12 months
Sundell et al., (2008)[63]	Moderate	Adolescents with conduct disorders Child welfare	RCT	Multi-systemic therapy (n=79) vs. regular child welfare (n=77)	Sweden	15	7 months
Vostanis et al., (2006)[64]	High	Family support service	Non-randomized (clustered) case-control	Family support service (n=93) vs. GP with direct referral to specialist camhs (n=40)	UK	I:5.6-7.2;C: 8.8	5 months

Table 3.7 Descriptive studies

Study	Risk of Bias	Subject	Design	Country
Hernandez et al., (2001)48	High	Implementation system-of-care principles in practice	Mixed method	US
Pandiani et al., (2001)55	High	Systems of care	Descriptive study, secondary data analysis	US
Stroul et al., (2007)62	High	Sustainability Systems of care	Mixed Method	US
Rivard et al., (2003)56	High	Interagency collaboration	Descriptive study, survey data	US
Slade et al., (2002)60	High	School-based mental health	Descriptive study, Secondary data analysis	US

Key-points

- **This is a narrative review providing a broad overview on dominant models and organizational aspects within the field of camhs. Specific targeted literature searches are needed to assess these models and organisational aspects more in-depth.**
- **The WHO recommends identifiable national policies and plans for child and adolescent mental health care containing goals for improvement, priorities and main directions for achieving these goals.**
- **In Europe most countries have some form of child and adolescent mental health policy. However, national action plans including the broad and specific lines (who have to do what in which time frame) and the identification of available funding are generally absent.**
- **Most Western-countries report that available resources for specialized mental health care for children and adolescents are insufficient to meet the needs. To address this issue many countries initiated camhs-reforms during the last two decades.**
- **US-based research dominates the peer-reviewed literature. Research conducted in countries with a health system that can be compared with the Belgian system is virtually absent.**
- **Most peer-reviewed articles focus on models of specialized mental health services to deal with severly emotional or behavioural disturbed children. Models focusing on the continuum of services (from self-management and informal care to specialized tertiary care services) or at the lower end of this continuum (informal care, mental health services through primary care) are less prominent.**
- **Systems of care is a highly referenced framework. It is based on a clear philosophy that introduced a paradigm shift in the delivery of child mental health services in US during the last 25 years. Reforms aimed to move away from "medicalized", hospital-based, tertiary care psychiatry towards integrated**

organizational forms that offer a comprehensive array of services offering individualized treatment in the least restrictive environment possible.

- Systems of care implementation involves a multifaceted, multilevel process that involves changes at the territorial system level (e.g. financing, workforce), the local system (e.g. infrastructure) level, service delivery or practice level (e.g. array of effective treatment services). Research fails to evaluate the effects of changes on all three levels simultaniously.
- The Fort-Bragg and Stark County studies are US-based large experimental studies with a low to moderate risk of bias, set up to evaluate the Systems of care approach, by introducing systems-level reforms e.g. changing payment, range of services, coordination.
- These reforms produced positive effects, such as increasing access to care, better service coordination, more patient satisfaction. However, clinical outcomes did not improve. It is concluded that reform should occur not only on the systems level but also on the service or treatment level, to improve clinical outcome.
- Models that are inspired by the Systems of care philosophy have also been evaluated. Examples are intensive community-based interventions like intensive case management (mechanism to coordinate segments of the service delivery system to meet the individual client's need), wraparound (planning process at the practice level, services are wrapped around the child and family in their natural environment), therapeutic foster care (carers are provided with skills and support services needed to manage challenging behaviour of their foster children), and multisystemic therapy (intervention originally developed within the juvenile justice system).

- Results of single studies show often favourable results on one or more process or outcome measures. Many methodological shortcomings (e.g. multiple testing, no clear and pre-defined outcome measures, insufficient control for contextual influences, underpowered studies), however, hamper internal and external validity of these results.
- High-quality systematic reviews studying these organisational aspects and models conclude that the current evidence is inconclusive or at best promising.
- A variety of school-based mental health services programs ranging from minimal support services provided by a school counsellor to integrated programs of prevention, identification and treatment are evaluated. For these interventions, enough evidence of moderate quality is available to make conclusions. This evidence supports positive effects on the prevention of anxiety and the development of resilience of structured, universal, selective and indicated school based programs.

4. LITERATURE RESULTS: A NARRATIVE REVIEW ON FUNDING AND FINANCING MECHANISMS OF CAMHS

4.1. Introduction

Child and adolescent health services frequently suffer because of lack of specialty providers due to low reimbursement rates, a fragmented service system, and lack of continuity and integration of services and/or funding streams.[111] This chapter describes what the – limited – peer reviewed literature has found with regard to the impact of different financing systems in dealing with these issues. Before describing the results of the literature study, it appears to be relevant to provide a short overview of the different financing mechanisms:

- **Capitation**. In capitation the budget is based on a fixed fee for each enrolled person. A specified level of health care is covered, regardless of the amount of services provided. Fully capitated payment arrangements are like fixed-budget arrangements in providing a strong incentive to control costs and improve efficiency.
- **Fee-for-Service.** The providers are paid each time a patient accesses or uses the system. There is a financial incentive for health care providers to provide more units of care because payments to providers increase with the amount of services provided. There is no incentive to contain costs.
- **Global budget.** A global budget arrangement consists of a budget for some defined set of services for a specified period. The budgetary approach provides strong incentives to control costs and produce care efficiently. Salaries represent a variant of the budget approach when applied to the payment of clinicians.

Case rate. Under the case-rate model of payment the purchaser pays a fixed rate for each case, i.e. each designated individual who enters the system and uses services. The case rate is calculated by estimating the expected average expenditures for service users only. A case rate is typically higher than a full capitation rate, because a pure capitation rate is calculated as an average of expected expenditures over a population that includes both users and non-users of services.

4.2. Search results

The primary search targeting the literature on financing mechanisms of camhs in Medline (Pubmed) including the financing-related MeSH terms and keywords, the child and adolescent population MeSH terms and MeSH terms of mental health care services resulted in 124 references. Based on this rather small number of references it was decided to renew the search excluding the MeSH terms for child and adolescent populations (see Appendix 4). This second search in Medline (Pubmed), Econlit and CRD yielded 651 references, including studies in camhs, which were not identified in the first search. All the citations found in Econlit and CRD were also found through the search in Medline (Pubmed); duplicates were removed. After the selection based on title, 595 records were excluded based on the exclusion criteria as described in 2.1.2., leaving 20 references eligible for full-text evaluation, of which 2 reviews. Eight citations were excluded after the full-text evaluation and quality appraisal. One additional review and one report of the World Health Organization about mental health financing were identified via hand search.

This resulted in ten peer reviewed studies on funding and financing mechanisms of child and adolescent mental health care (camhs) considered eligible for this review. Next to these studies, three reviews[111-113] and one report of the World Health Organization[114], all dealing with financing issues of mental health care in general, were also considered appropriate for this review.

4.3. Children and adolescent mental health care: peer reviewed studies

4.3.1. Peer reviewed studies camhs: Introduction

This part of the review includes the ten peer reviewed papers of funding and financing issues of camhs. In seven of these, the target group consisted of children and adolescents, while the study population of one study consisted of only children and two studies included only adolescents. Six studies were aimed at both in- and outpatients, three at outpatients and no studies at inpatients alone. The full text evaluation of one study[115]

provided no clear answer if the study population comprised in- or outpatients. Nine studies were conducted in the US and one in Australia.

4.3.2. Peer reviewed studies camhs: focus and funding environment

In three studies[116-118], the focus is put on financial issues related to the accessibility of (mental) health care for children and adolescents. Financing and budget issues of community-based or multidisciplinary care were assessed in two studies.[115, 119] In four studies, a comparison between the financing mechanisms capitation (under Managed Care) and Fee-for Service (FFS) was performed[120-123]. In a capitation system the budget is based on a fixed fee for each enrolled person. A specific level of health care is covered, regardless of the amount of services provided. In FFS systems, the providers are paid each time a patient accesses or uses the system. In the latter case, there is a financial incentive for health care providers to provide more units of care because payments to providers increase with the amount of services provided.[114]

4.3.3. Peer reviewed studies camhs: evidence

Scott et al.[115] made a comparison between two service models in Australia. The first service-type consisted of a FFS model. The second service-type was developed to establish a specialized 'Youth Mental Health Clinic'. This initiative was developed through a partnership between the Brain and Mind Research Institute of the Faculty of Medicine at the University of Sydney. The Brain and Mind Research Institute includes, among other services, a clinical centre providing mental health services for people with a range of disorders affecting the brain and the mind[l]. Significant differences between the two services types in the pattern of services delivered to young people were identified. The FFS model was associated with a strong reliance on a single provider providing most of the care. These patients had less contact with other providers. This pattern occurred despite the fact that access to the other complementary services were available free of charge to these patients. Young people who entered the 'Youth Mental Health Clinic' received interventions from a much wider range of practitioners.

In the study by Lever et al.[117], the partnership between a school mental health program (SMPH) and an outpatient mental health center in Maryland (US) was assessed. For the SMHP, the relationship with an outpatient mental health center allowed for billing, providing more intensive services, improved interdisciplinary collaboration with greater referral options, and adding child psychiatry fellows to the staff. Prior to the year 2000, the school mental health program received its budget with 80% of revenue from local and state grants and contracts, and the remaining 20% from FFS billing. Financial realities of the school mental health program prompted the decision to implement more FFS billing as a secondary revenue stream. Several concerns of including the FFS billing were identified. The clinicians were concerned that additional administrative duties would reduce their ability to meet the needs of the school population and reduce their overall volume of service. Next to these concerns, also some benefits were described.

Similar results about concerns of FFS billing were found by Weist et al.[124] in their review of issues related to different funding mechanisms (e.g. FFS, state and local funding) of school-based mental health care programs. Important identified obstacles of FFS funding are again the bureaucratic and administrative requirements necessary for reimbursement. These are often quite intensive, placing a considerable burden on clinicians that competes with their time and ability to provide more preventive services.

Snowden et al.[118] evaluated whether an expansion of the Medicaid's Early Periodic Screening, Diagnosis, and Treatment program resulted in greater mental health treatment access. This program serves children and adolescents from birth to 21 who meet Medicaid income eligibility requirements and age-specific medical necessity criteria. In 1995, the State Government of California broadened the criteria for what constituted 'medically necessary' mental health treatment (e.g. prevention of deterioration in functioning). New categories of clinicians (like social workers, family therapists) were permitted to bill for Medical 'Early Periodic Screening, Diagnosis, and Treatment' services. After the expansion of the 'Early Periodic Screening, Diagnosis, and Treatment' mental health program, mental health care access increased especially in rural county mental health systems and in counties historically receiving the least state funding.

l http://sydney.edu.au/bmri/

The 'Kids Oneida' project (Oneida County, New York) was developed to provide integrated services (e.g. nursing services, family therapy, crisis care, service coordination) and supports to children and adolescents aged 6-18 years with serious emotional, behavioral, and mental health disturbances. For this, the Integrated Community Alternatives Workgroup, Inc. was created as a local not-for-profit entity to operate Kids Oneida, as a cooperative initiative with Oneida County and the New York State Office of Mental Health. The 'Kids Oneida' project contracted with the County and the State Medicaid offices to manage services for these children and adolescents. 'Kids Oneida' received case payments (per child per month) and, in return, accepted financial risk for all enrollees. The findings of this study indicated a relatively low use of specialized medical/psychiatric care and other mental health services. The unit costs (= contracted rates for one unit of service delivered) declined over time as 'Kids Oneida' developed a provider network and negotiated lower, uniform rates for services provided.[119]

The risk for underuse and primary cost focus with fixed payments is confirmed in other studies as well. Behavioral health service utilization patterns were examined in two studies[120, 123] among Medicaid-enrolled children who were being served under managed care, with capitation, in Tennessee or a FFS system in Mississippi. Children in the FFS system were significantly more likely to receive any formal behavioral health service than children in the managed care system (capitation). The managed behavioral health care led to a reduction in access to behavioral services overall and inpatient and specialty outpatient services particularly.

No matter how services are financed, the content and the quality of the financing decisions is of importance. Indeed, Cook et al.[121, 122] examined whether plan satisfaction among caregivers predicted later service utilization of children with severe emotional disturbance aged 4-17 in Medicaid-funded behavioral health care plans. The results indicated that plan satisfaction (e.g. the willingness of the insurance plan to provide or pay for prescription medications, the availability of information about what services and providers are covered by the plan, the willingness of the plan to pay for inpatient hospital or residential care) was associated with greater likelihood of service use regardless of the type of financing (FFS or capitation under managed care). No evidence was found regarding the influence of the financing mechanisms on the time of treatment or the level of evidence based working.

4.4. Financing issues of (integrated) mental health care: reviews

The report of the World Health Organization about 'Mental Health Financing: Mental Health Policy and Service Guidance Package'[114] describes that the financing of (mental) health care is not an isolated independent activity and should be aligned with policy and planning priorities and with opportunities for quality improvement. Financing mechanisms can be used to facilitate change and introduce innovations in systems. The WHO also comments on one approach, proposed for building community-based systems and involving transferring resources from hospital-based systems. However, this needs careful evaluation and should be based on an assessment of the number of hospital beds needed as community systems grow. According to the WHO, double funding may be needed initially in order to assure that a community system can accommodate people discharged from hospital.

In the case of integration of mental health services with other health services, it is however important to insure an adequate funding for mental health services to minimize the risk that mental health funding remains static or even diminishes. At the same time, the WHO warns that individuals with mental disorders are commonly poorer than the rest of the population, which makes out-of-pocket payments more of an obstacle to care compared to payment for acute physical health problems.

Several barriers regarding integration of care were identified in the review about 'Financial integration across health and social care: Evidence Review'.[123] These barriers can include the costs of setting up and implementing services, perverse incentives (e.g. encouraging oversupply, discouraging prevention) associated with paying for particular services and meeting particular objectives associated with the service. Pooling of budgets (each partner makes contributions to a common fund to be spent on agreed health or health-related services under the management of a host partner) can be a complex process involving alignment of legal and financial frameworks. It is noteworthy that such pooling of budget in camhs has not been the topic of scientific research to our knowledge.

Yet, it is believed that joint working and funding can facilitate a coordinated network of health and social care services, hence narrowing gaps in provision. Second, it could enhance efficiency, by reducing duplication and achieving greater economies of scale. Third, it can improve the quality of care by adopting a more holistic approach to provision, making services more responsive to users' needs and views.[123]

Although financial integration of different types of health care may be desirable, there are however very few successful models. In the US, effective care integration between physical and behavioral health providers has been difficult to achieve regardless of how it is funded. According to Coleman et al.[111] managed care can impact the formation of behavioral health policy, leading to the creation of systems of care for specific eligible populations rather than effective systems for all state citizens.[111]

Considering the limited evidence we may conclude, together with Weatherly & Goddard[113] that assessing the effectiveness and cost-effectiveness of financial (integration) systems across health and social care poses substantial methodological challenges, particularly in terms of obtaining unbiased estimates of effect. In practice, few of the approaches fall neatly within a specific type of financing and there is a lot of heterogeneity.

Problems with both FFS and capitation have been reported. Studies on providing incentives for coordination and obtaining quality standards have not been conducted which is a clear evidence gap.

Key Points

- **The type of financing influences the provision of mental care to children and adolescents. Fee for service may compromise a multidisciplinary approach and increases the administrative burden. Capitation, on the other hand may lead to underuse of services.**
- **Financial integration of care may be desirable to narrow gaps in provision of care. However, several barriers regarding integrative care were reported. Further research on incentives for integrative systems of care is required.**
- **Assessment of the effectiveness and cost-effectiveness of financial (integration) systems of health and social care poses however substantial methodological challenges.**
- **Nine of ten studies included in the review were conducted in the US resulting in a low relevance of the studies about financing and budget issues of camhs for the Belgian context.**

5. BELGIUM

5.1. Historical context of child and adolescent mental health care in Belgium

Child (mental health) care is a recently developing field, as is the science of child psychopathology and the discipline of child psychiatry. It generally took until the 20th century, mostly after World War II, before child psychiatry began to develop in Europe.[125] The first child psychiatric wards in Belgium were recognized as autonomous hospital services in 1971 by the Federal Public Health Service, when these "K-services" were established by law. At the same time some treatment centres for children with severe psychiatric deficits agreed with the NIHDI specific treatment conventions and were recognized in 1991 by the NIHDI as re-educational centres (known as 7.74 and 7.75 conventions). In 1975 outpatient mental health services (now known as CGG & SSM) knew a first legal regulation.[m] However, at that time there were only few services that specialized in child and adolescent mental health problems.

Broad reforms in the field of psychiatric services for adults in the nineties of the previous century focused on a shift from inpatient treatment facilities to more community based care. These reforms had little effect on child and adolescent mental health care, given the very limited number of in- or outpatient services for children and adolescents that were available at that time. However, subsequent waves of reforms, as from the beginning of the 21st century onwards, included child and adolescent psychiatry as a specific target group (see also paragraph 1.1.2). In addition to these general mental healthcare reforms, specific initiatives for camhs were launched. These included the creation of: additional capacity in general

[m] Royal Decree 20/03/1975

hospitals (K-services); For-K units (targeting youth with mental health problems in association with offending behaviour and juvenile justice problems); intensive treatment units for youth with aggressive behaviour or conduct disorders. These policies, and the most recent evolutions, will be discussed further in this chapter.

5.2. General considerations

The next section aims to describe the general organizational principles of health care supply for children and adolescents with mental disorders in Belgium. Given that other sectors providing services for children and adolescents, contribute as well to the provision of mental health care in its broad sense, these sectors are also dealt with.

This section is of a descriptive nature, and gives a global overview of the current situation. For in-depth information, the interested reader will be referred to relevant sources. In fact, the subject of this section is a vast domain, and many subtopics, including some methodological issues, might have been interesting to explore as well, but could not be dealt with given the time frame for this study. For the same reason, extensive detailing of all topics in this section was not possible.

The following topics will be worked out:

- Country profile and health care system;
- Target population;
- Health care: camh service organization & stakeholders:
- Health care: camh policies & policy stakeholders;
- Neighbouring sectors: Youth social care, Juvenile justice, Disability care, Education;
- Financing and funding;
- Intra- and inter-sector collaboration;
- Needs assessment, workforce training, knowledge development;
- Key-points.

Finally, at the end of the next chapter (see paragraph 6.6), an overview table of the most important items is given, comparing these items to the situation in the Netherlands, Canada (British Columbia) and England.

For this part of the report, no new information has been included after July 1st 2011.

5.3. Country profile and health care system

5.3.1. Country profile

Belgium is a federal state with a parliamentary democracy. There are three levels of government: the federal Government, the federated entities (three regions and three communities), and the local governments (provinces and municipalities). The regions are competent for territory matters: Brussels Capital region, Walloon region and Flemish region. The communities are competent for person-related matters, related to language and culture: French community, German speaking community and Flemish community. Person-related matters that are common to the two communities, in the Brussels capital region are regulated by the Common Community Commission (Cocom)[n]. This is the case for e.g. health related matters and social care like child protection, and special assistance for youth. French community matters in the Brussels region are due to the French community commission (COCOF)[o], Flemish community matters to the Flemish community commission (VGC).

Justice policy is mainly a responsibility of the federal Government. The federal Government is also responsible for a large part of health policy.[126] Education, welfare, some health related matters (e.g. prevention, community care, see further) and care for persons with disabilities is organized by the federated entities. In general, the allocation of competencies is a complex matter due to different policies and responsibilities of the federal state and the communities and regions.

Belgium has a population number[p] of 10.839.905 inhabitants; 1.089.538 inhabitants live in the Brussels Capital region, the Walloon region has a population number of 3.498.384 people and the Flanders region 6.251.983 (01.01.2010). By 01.01.2010 there were 2.214.156 minors (< 18 years of

n http://www.brussel.irisnet.be/about-the-region/the-communal-institutions-of-brussels/cocom?set_language=en

o http://www.cocof.irisnet.be/site/fr/organisation/competences_htm

p http://economie.fgov.be/nl/statistieken/cijfers/bevolking/structuur/; http://www.belgium.be/nl/over_belgie/land/belgie_in_een_notendop/fiche_belgie/

age) in Belgium. The territory of Belgium is about 30500 km²; it has 10 provinces (the Brussels capital region does not belong to any province) and 589 municipalities.

5.3.2. Health care system

5.3.2.1. Health policy

In Belgium, health policy is partly a responsibility of the federal Government and partly of the federated entities.[126] The federal Government, under the Minister of Social Affairs and Public Health, is accountable for the health care system as a whole, for the regulation and financing of the compulsory health insurance system, the determination of accreditation criteria for hospital services, the financing of hospital budgets and equipment of intensive medical care units, legislation of involved professions and the regulations on pharmaceuticals.[126]

The federated entities and their respective Ministers are responsible for health promotion and prevention, different actions of community care, coordination and collaboration in primary health care and palliative care, specific maternity or child health and social care services, the implementation of accreditation standards and the determination of additional standards and financing of (regular) hospital investments. To facilitate cooperation between the federal level and the Federated Entities, Inter-ministerial Conferences are organized.[126]

5.3.2.2. General health care organization and financing

Preventive care in Belgium is mainly provided by public health services, although in a broad sense it belongs to the tasks of every health care provider. Health care on the primary level or first tier is provided mainly by independent care professionals like General practitioners (GP), home visiting nurses, pharmacists, and others. Specialist or second tier health care is provided as well in a private ambulatory setting as in hospital facilities. Third tier health care is provided by university hospitals which at the same time have a teaching and research function.[126] Because there is no formal referral system between GPs and second or third tier specialists, every citizen has free access to medical specialists and hospital care, even as the first point of contact with the health care system.

The Belgian health system is based on the principle of social insurance (Bismarck-type of health care insurance) characterized by solidarity and with no selection of risk. Almost the whole population (> 99%) is covered by this compulsory insurance system for a very broad benefits package. The National institute for health and disability insurance (NIHDI-RIZIV-INAMI) organizes and supervises the correct application of the compulsory health insurance. It allocates budgets to the sickness funds, which are not-for-profit bodies that finance the health care costs of their members.[126]

5.4. Target population

5.4.1. Age limits

In Belgium as in many countries, the age of legal majority is set at 18 years of age. Adolescents and children under the age of 18 are considered minors.[q]

Youth social care services are involved up to 18 years of age. However, under certain circumstances, care can be expanded beyond the age limit of 18 years up to the age 21, either on a motivated request of the young person him/herself, either imposed by a judge of the youth court.

5.4.2. Epidemiologic data

For many types of care provision, figures on how many children are taken in care each year are not readily available, e.g. private consultations with child psychiatrists, outpatient clinics of K-services, NIHDI conventions, special education boarding schools (MPIs/IMPs, see § 5.7.3.1), ambulatory care support in the disability sector (e.g. for autism) etc.

In Flanders the minors in specialist ambulatory mental health care centres (CGG) represented 26% of the total population and accounted for 13099 children and adolescents (on a total of 52924 persons in care) in 2010[r]; 7180 children or adolescents started a treatment in 2010, whereas 5919 of them had already started in the years before; with the education sector as the most important sector making referrals[s]. In the Walloon region, in 2006, 11658 children and youngsters under the age of 18 years were offered

[q] http://www.kinderrechten.be/

[r] www.zorg-en-gezondheid.be/cijfers/zorgaanbod-en-verlening/Geestelijke-gezondheidszorg/leeftijd-en-geslacht-van-de-clienten, accessed 20/06/2011

[s] http://www.zorg-en-gezondheid.be/Cijfers/Zorgaanbod-en-verlening/Geestelijke-gezondheidszorg/Hoe-komen-jongeren-terecht-bij-een-CGG, download 15/04/2011

care by a mental health centre (SSM)[t], which is 40% of the persons offered care in the SSM. As in Flanders, schools have an important role in referring.

In 2007, 6575 treatment episodes for minors were registered in different types of Belgian psychiatric hospital facilities, for 5391 children and young people (A, K, T and partial hospitalization in a en k; see also further) (4133 or 77% in K-beds)[u]. The average duration of a stay in K-services was 40 days.

In youth social care services we can estimate that over 40.000 children and adolescents, along with their families receive some type of support (>23.000 in the Flemish community[v] in 2008 (see table 5.2 in Appendix 5); >17.000 in the French community in 2006, (see Milkay[w], increasing every year by approx. 3%). Not all children and adolescents in social care have mental health care needs, but international studies have consistently established high rates of mental health problems among this group. In Flanders, it has been demonstrated[127] that the prevalence of psychopathology among children in different types of social care settings (at home, day care, foster or residential care) is around 50%, and that the rate of children in need of additional care by the mental health care sector (according to the social care agency involved) can be estimated at 1/3. These figures are in line with international data.

In the Belgian juvenile justice sector, there were in 2008 over 50.000 cases referred as severely problematic educational situations and nearly 60.000 crime like acts[x]. Of these, 13.225 severely problematic educational situations were eventually dealt with by the youth court in 2008.

Educational sector[y]: 8895 children participated in type 3 special education for behavioural and emotional difficulties, together in the Flemish community (2008/2009) and the French community (2007/2008). This does not include children with behavioural disorders (e.g. autism, ADHD) in special schools of type 8, 1, 2, or 7 (see further), who are not registered separately. Part (but not all) of the children in type 3 special education also receive care in the special education boarding or semi-boarding schools (medical pedagogical institutes MPIs; services résidentiels pour jeunes IMPs), for which no figures were readily available.

5.5. Health care: camh service organization & stakeholders

Along with the different responsibilities of the different governments, mental health care is partly a responsibility of the federal government and partly of the federated entities. Camhs policy initiatives in Belgium are discussed further (see paragraph 5.6.2). In the different parts of the country, there are several points of differences in the provision of mental health care services. Nevertheless, there are also many resemblances. For this reason, there will be no separate description for each of the federated entities when describing the organization of camhs.

Usually, the Belgian health care system is divided in 3 tiers (see paragraph 5.3.2.2). Camh professionals often apply a different division: specialized ambulatory care is considered as second tier care, inpatient hospital care as third tier and university hospital care as third to fourth tier. Although unofficial, and maybe not universally adopted, the latter division will be used in this chapter.

In Belgium, with very few exceptions, all camhs at the different tiers are directly accessible by patients, in line with the general Belgian health care policy.

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t L' offre addressée aux enfants et aux adolescents dans les Services de Santé Mentale de la Région Wallonne,rapport IWSM, 10/2008, http://www.iwsl.be/institut-wallon-sante-mentale.php?idt=47

u FPS Health, food chain safety and environment; Minimal psychiatric data, accessed April 2011;

v http://www4.vlaanderen.be/dar/svr/Cijfers/Pages/Excel.aspx

w Nouvelles statistiquesd'aide à la jeunesse, F. Milkay, http://www.secgen.t3.cfwb.be/index.php?id=5218

x Justitie in cijfers 2010, Download from http://www.just.fgov.be/index_nl.htm

y www.ond.vlaanderen.be/onderwijsstatistieken/; document 2008-2009/0809_071-093_basisonderwijs.pdf; 0809_193-213_buitengewoon_secundair.pdf. Publics de l'enseignement spécialisé: importance relative et répartition par type d'enseignement. Indicateur n°08. http://www.enseignement.be/index.php?page=26157&navi=3018; Communauté française de Belgique, Administration générale de l'enseignement et de la recherche scientifique.

The following paragraphs will successively discuss: first tier mental health care; specialist camhs: second tier, generic services; specialist camhs: third and third-fourth tier, generic services; and specialist camhs: special target groups.

5.5.1. Camhs organization: services level

5.5.1.1. First tier mental health care

While there are several services and professions delivering primary mental health care including primary mental health care for children, there is no clear health policy recognizing, emphasizing and supporting that this is or should be their task and that people should use these service providers for first line help and support.

In practice, the General practitioner (GP) is the first health worker to whom people can address. He/she plays an important role as a first contact in (mental) health care.

Other important front line services that specifically can play a role in first tier mental health care for children and adolescents are Paediatricians, the Child and family agencies ("Kind en Gezin", ONE (L'Office de la naissance et de l'enfance), "Kind und Familie", see further), the School support teams (CLB's, CPMS, PMS-Zentrums, see further). General social care services providing first line help are e.g. CAW (Centra voor algemeen welzijnswerk), social service centres (centres de service social), other social services (e.g. mutualities) as well as the telephone services Tele-onthaal, Télé-acceuil, Telefonhilfe, centre for suicide-prevention, youth telephone.

Most of these services provide first line care and/or support in more than one domain, e.g. general health and well-being, mental health, healthy development and/or education. A specific service coordination system for some of these services is under development in Flanders (see paragraph 5.7.1.2).

5.5.1.2. Specialist camhs: second tier, generic services

In mental health care for children and adolescents in Belgium, there is a strong accent on secondary or tertiary level specialist services.

- Mental health care centres

Mental health care centres (centra voor geestelijke gezondheidszorg CGG; services de santé mentale SSM; Sozial-Psychologische Zentrum SPZ) are ambulatory specialist centres providing advice, diagnostic evaluation and psychological, psychotherapeutic and psychiatric treatment and support. The service provision mostly takes place in the centres, but outreach services are possible. They can also advice and support other care agencies and services.

The Mental health care centres are under the authority of and funded by the federated entities[z]. In Flanders[aa] there are 20 centres, each having a separate team for child and adolescent mental health care, along with teams for other target groups (adults, elderly, forensic care). In the French part of the country there are more and smaller services. Ten services[bb] have a recognized team for child and adolescent mental health care. For the German community, and for German speaking inhabitants of neighbour municipalities, there is one SPZ that directs its offer to children and adolescents, as well as to adults and elderly people[cc].

As of 01/01/2010, the French federated authorities approved the establishment of Reference centres for mental disorders (RC). These RC are held responsible for supporting the SSM, for care coordination between the SSM and other mental health care providers; and they can have research tasks. So far, these RC remain to be established.

Necessary professions involved in mental health care centres are psychiatrists, psychologists, socials workers, receptionist/administrative workers; and a general manager and therapeutic manager. For services restricted to children and adolescents in the French part of Belgium, staff has to include a child psychiatrist as well as paramedical personnel (speech therapist…).

- Private child psychiatrists and psychologists

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z For the Brussels region, the interested reader is referred to http://www.bruxelles.irisnet.be/vivre-a-bruxelles/sante-securite/

aa http://www.zorg-en-gezondheid.be/Zorgaanbod/Geestelijke-gezondheidszorg/Centra-voor-geestelijke-gezondheidszorg/

bb L'offre pédopsychiatrique en Wallonie et ses partenaires directs. Document de travail IWSM, 18-3-2011

cc www.dglive.be

Child psychiatrists working in a private practice are freely accessible in Belgium. When people consult child psychiatrists they pay on a fee for service base, and are reimbursed by the sickness fund (Federal authorities). For consultations with (clinical) psychologists there is no reimbursement, since psychologists in Belgium are not adopted as a health profession, although the professional title of psychologist is recognized and regulated by law. A side effect of this is that anyone can offer mental health services in a free market without guarantee of quality, training, as long as they do not interfere with legal medical activities.

- Outpatient services from K-services

Most inpatient K-services (Federal authorities, see further) also provide outpatient consultations for first contacts, follow-up, ambulatory support etc.

- Outreaching Teams

The Flemish government started outreach projects to provide mental health care for the youth social care sector, e.g. in closed youth institutions, for youngsters that came in youth social care because of a problematic educational situation. The Flemish ambulatory mental health care centres (CGG) host these outreach teams. The funding is still temporary.

- Ambulatory centres for rehabilitation (CAR,CRA)

The ambulatory rehabilitation centres (centra voor ambulante revalidatie CAR, centres de rééducation ambulatoire CRA) are centres for multidisciplinary rehabilitation of children with several types of complex developmental or psychological/psychiatric problems[dd]. They target children and adolescents with behaviour disorders (autism, ADHD, depressive or complex emotional disorders), but also with other problems such as complex developmental or learning disorders, hearing and speech disorders, etc. Referral by a physician is mandatory. The centres offer multidisciplinary diagnostic evaluation and medical, para-medical and psychosocial treatment and advice from a re-education or functional re-adaptation point of view[ee]. Close collaboration with the school of the child is mandatory. Outreach to schools can also be provided; i.e. general information and support sessions with teachers are reimbursed. The team is composed by medical specialists, speech therapists, physiotherapists, manual therapists, educational specialists, psychologists, and social workers.

The 81 CAR (48 Flanders, 23 Walloon region, 10 Brussels) are funded by a NIHDI-convention (see also paragraph 5.8.2.1), with the NIHDI (Federal authorities) setting out the conditions of the funding and therapeutic offer (e.g. duration). The recognition and programming of the centres is due to the federated entities (VAPH/AWIPH/DFB, see 5.7.3)[ff]. The CAR are funded per treatment (see also 5.8.2.1), and currently no information on the total Belgian number of patients treated is readily available.

5.5.1.3. Specialist camhs: third and third-fourth tier, generic services

As already pointed out, mental health care for children and adolescents in Belgium is dominantly provided by secondary or tertiary level specialist services.

- Hospital care

Inpatient mental health care in psychiatric wards of general hospitals or in psychiatric hospitals comes under the responsibility of the Federal health authorities. Specialized wards for children and adolescents are called K-services. They are restricted to children and adolescents up to 18 years. These services can provide full residential mental health care (K), or provide day/night care facilities (k1/k2) for general mental health problems. Usually adapted education is provided e.g. by hospital schools. In some cases, youngsters between the age of 15 and 18 years can be hospitalized in adult psychiatric wards of general hospitals or adult psychiatric hospitals (A, a1/a2, T services).

dd http://www.riziv.be/care/all/revalidatie/general-information/contacts/pdf/953965.pdf

ee http://www.revalidatie.be

ff For the Brussels region, the interested reader is referred to http://www.bruxelles.irisnet.be/vivre-a-bruxelles/sante-securite/handicap-et-invalidite; http://www.phare-irisnet.be/accueil/

Special emergency services for camh problems are not yet included in the standard service provision, and are scarce, although a few general hospital emergency services and/or K-services took initiatives to provide emergency camh services. For a detailed description, see KCE-report 135.[128]

A specific collaboration exists between some K-services that are part of general or university hospitals and the paediatric ward of the hospital where they are located: child psychiatrists come in consult and provide advice on children and youngsters staying at the paediatric ward: the "liaison function".

On 01/01/2010, a total of 716 K-beds and 224/63 k1/k2 places (including university hospital services, see further) were recognized, in 45 K-services. Per 10000 inhabitants<18 yrs, this corresponds to 3,2 K-beds and 1,3 k1/k2 beds. The redistribution among the different regions, and the difference with the theoretical maximum of beds programmed by the Government (ref: doc NRZV/CNEH), can be found in Table 5.1. The theoretical maximum of beds programmed by the Government is based on criteria stipulated in the KB/AR of 3/8/1976: 0,32 beds for K-services and 0,32 places for k1/k2-services per 1000 children; these numbers have not been updated since then. In the German speaking community[gg], specific measures have been taken to assure that children and adolescents can benefit from camhs in their own mother tongue. For an overview of the evolution of K-beds and k1/k2 places since 2000, see Table 5.3 in Appendix 5.

In 2007, there were 6575 treatment episodes registered in different types of hospital beds (K or k, A or a, T) for minors (<18 years) in Belgium, for 5391 children or adolescents (of which 4133 or 77% stayed in K- or k-services)[hh]. The average duration of a stay in K-services was 40 days[128].

Table 5.1: Programmed and realized K-k1-k2 beds in Belgium by 01/01/2010- Source: Advice NRZV/CNEH[ii] June 2011

01/01/2010	Programmed Beds		Realized Beds			
	K	k1+k2	K	k1	k2	k1+k2
Flanders	342	342	371	89	42	131
Walloon Region	210	210	225	57	20	77
Brussels	66	66	120	78	1	79
Total Belgium	618	618	716	224	63	287

- NIHDI-conventions

The psychotherapeutic centres or functional rehabilitation centres for children and adolescents with severe mental health problems are reimbursed through a convention with the NIHDI (Federal authorities), that stipulates the specific conditions for each centre. They are known as 7.74 institutions (3 in Brussels, 11 in the Walloon region and 2 in Flanders)[jj], and can provide residential and/or day care, as shown in Table 5.2. The 7.845 institutions (2 in the Walloon region) can provide care to the same target group, but also have other target groups (e.g. brain trauma). Five of the 7.74 institutions in the Walloon region work closely together with local K-services.

gg As of 2006, the government of the German speaking community of Belgium made an arrangement with the University Hospital of Aachen (Germany) on inpatient psychiatric care for children and adolescents. This care is covered by the NIHDI. Referrals are made in close cooperation with the liaison child psychiatrist of the local camhs for the German speaking community (SPZ) in Eupen. (www.dglive.be). Youngsters as of the age of 16 years can be admitted in the adult psychiatric ward (inpatient or day care) of the hospital in St. Vith.

hh FPS Health, food chain safety and environment; Minimal psychiatric data, accessed April 2011

ii Advies m.b.t. de uitbouw van een GGZ-programma voor kinderen en jongeren/ Avis relatif au développement d'un programme de soins de santé mentale pour enfants et adolescents. NRZV/CNEH 9 juni 2011. http://www.health.belgium.be/eportal/Healthcare/Consultativebodies/Nationalcouncilforhospitalfaciadviesprogramming2011/index.htm?fodnlang=fr;

jj personal communication NIHDI, Direction of Care providers and services, department rehabilitation, June 2011

Table 5.2: 7.74 NIHDI Conventions (June 2011) - Source: NIHDI department rehabilitation.

June 2011		Flanders	Walloon Region	Brussels	Total Belgium
7.74 Residential	N° providers	1	3	1	5
	N° beds	11	105	12	128
7.74 Day care	N° providers	1	5	1	7
	N° places	10	122	9	141
7.74 Mixed	N° providers	--	3	1	4
	N° beds-places	--	66	20	86

The Centres for functional re-education aim to stimulate the intellectual and emotional development of children with mental health problems, and preparing them to return to their natural living environment and regular or special education services. An average duration of the rehabilitation program, based on data from 1 Brussels and 8 Walloon centres, is 3 years; for most centres the maximal duration is put on 5 years. Involved professionals are medical doctors (mostly child psychiatrists), psychologists and educational specialists, para-medical professionals e.g. speech therapists, psychomotor therapists, and staff for general services (administration…).

- University hospital inpatient services

In Belgium, university hospitals provide third to fourth level inpatient camhs services, as well as outpatient services (see before). The clinical work in university hospitals mainly but not exclusively focuses on highly specialized services; it is combined with research and teaching tasks. The university hospital inpatient beds are included in the K-beds, day/night places in the k1/k2 places (see above).

- Outreaching Teams

As of 2002, the Federal authorities responded to an increasing need for youth mental health care, with the creation of outreaching teams in each province. The aim is to provide home-based treatment as a substitute or alternative for inpatient care. These outreaching teams facilitate treatment of the child or the adolescent in his/her own environment, which may include interventions within the educational setting, other services supporting the family etc. The intervention should be short (approximately 3 months) and should address persons that otherwise would not be able to access care. One of the compulsory conditions to establish an outreaching team is interagency collaboration between the hospital hosting the child psychiatric ward, one or more child- and adolescent mental health centres, and a homecare collaborative initiative[kk]. The caseload for each outreaching team is set at 44. Each team consists of a psychiatric nurse (1FTE), a psychologist (1FTE) and a child psychiatrist (0,25FTE)[ll]. There are 13 outreaching projects in the country. They continue to be financed as projects by temporary funds.

- Flemish OBC (Observation and treatment centres)

In Flanders, 7 centres can perform a comprehensive diagnostic observation for children and adolescents with severe behavioural or emotional problems. They can start treatment and then refer for further treatment; a stay can last from 3 months to 3 years. The centres are recognized and funded by the VAPH (see also 5.7.3.1).

5.5.1.4. Specialist camhs: special target groups

- Care circuit for youth offenders with mental health problems (FOR-K)

For youngsters as of the age of 12 years, having committed a fact that can be considered as criminal (Youth protection act of 1965) and suffering from mental disorder as defined by the DSM-IV or ICD-9 or ICD-10, special mental health care wards for intensive treatment were established, along with the judicial areas of the Appeal Courts (see 5.7.2). The currently existing 8 specialist services “For-K” (76 beds, see Advice NRZV/CNEH 2011) have been established in collaboration with the Federal Ministry of Justice, the Federal Ministry of Social Affairs and Public Health, and the

[kk] GDT Geïntegreerde dienst voor thuiszorg ; SISD Service intégré de soins à domicile;

[ll] www.health.belgium.be.

Ministries of the federated entities involved in Welfare, Public Health and Family. They are still financed as temporary projects under the Ministry of Social Affairs and Public Health. Admission of youngsters is only possible by a children's judges court order, that is grounded on an independent psychiatric evaluation. A care path-coordinator is assigned to each Appeal Court area, to bridge the gap between the camhs involved in the care for a young offender and between the camhs and juvenile justice services and other services involved.

FOR-K services also provide short time out possibilities and crisis care (max 2 weeks) after discharge. Outreaching modules connected to these services aim to prevent re-uptake in FOR-K units.

- Care circuit for youngsters with aggressive behaviour or conduct disorder (IBE)

In 2002, specialist intensive treatment services were established for youngsters with severe behavioural disorders or aggressive behaviour, but not having committed criminal like facts (IBE). However, referral by the judicial system is required. There are currently 6 services representing 48 beds (see Advice NRZV/CNEH 2011). They are still financed as temporary projects under the Ministry of Social Affairs and Public Health.

IBE services also provide short time out possibilities and crisis care (max 2 weeks) after discharge, as well as outreaching modules to prevent re-uptake.

- Addiction problems

One specific residential service for adolescents with addictive behaviour exists, situated in Flandres. Ambulatory aftercare is provided. It is reimbursed under a NIHDI convention (Federal authorities) with additional funding from the Flemish youth social care. In one of the other 29 NIHDI addiction conventions, adolescents can be accepted as well, but they remain a minority as compared to the adults[mm].

- Care for children with mental disabilities

Officially recognized services for children with mental retardation and co-occurring severe behavioural problems so far don't exist. Nevertheless, one K-service in Flanders (Fioretti)[nn] took the initiative to develop a specific inpatient service supply, within their temporary IBE-financing (see before). In Flanders, there are initiatives to finance in the future in the ambulatory mental health care centres 0.5 FTE per province for this target group.

- Early parent-child interaction problems

Specific NIHDI-conventions (Federal authorities) exist for treatment of early parent-child interaction problems. Parents of infants (up to 1.5 yrs) that suffer from severe socio-emotional or psychological problems, so that the early interaction with their infants is endangered, are looked after together with their child, in close collaboration with the Child and family agencies (see further)[oo]. There are 2 of these conventions in the Flemish speaking part of the country and 1 in Brussels[pp].

- Autism reference centres

The Autism reference centres (ARC), under a special NIHDI convention (Federal authorities), are specialized in multi-disciplinary diagnostics and treatment coordination for people with autism spectrum disorders. There are 8 ARCs: 3 in Brussels, 2 in the French speaking and 3 in the Flemish speaking part of the country. They are attached to University child psychiatry services.

- Other

The above list sketches the most important initiatives, but does not aim to be exhaustive. Other initiatives exist, e.g. a pilot project has been established for day care treatment for adolescents with anorexia nervosa and boulemia, in the French part of the country. In the Flemish part of the country, early intervention projects for young people (14-35 years of age) suffering from psychosis, established by local initiatives, received additional governmental funds (VDIP-projects, see also further (bottom-up initiatives)).

mm personal communication NIHDI, Direction of Care providers and services, department rehabilitation, June 2011; according to doc NRZV/CNEH: 13% adolescents in adult services.

nn http://www.guislain.be/zorgaanbod/zorgaanbod.htm

oo In some countries, e.g. in England, this type of care is considered to be part of maternity health care.

pp http://www.riziv.fgov.be/care/nl/revalidatie/general-information/contacts/index.htm; accessed June 2011

5.5.2. Stakeholders: health services level

5.5.2.1. Involved professionals

Many professions are involved in providing camhs. Most prominent professions are child- and adolescent psychiatrists, clinical psychologists, nurses, social workers, paramedical professions such as speech therapists, physiotherapists, creative therapists, educational staff, paediatricians, family doctors and other medical specialists (e.g. ear-nose-throat specialists for autistic disorders), as well as staff from supporting services such as administrative personnel.

Specific training in child psychiatric pathology or child and adolescent mental health problems however is only provided for child psychiatrists. For the other professions, it is mainly a part of their general training.

5.5.2.2. Patient involvement: patient advocacy organizations

The legal position of children and their families in mental health care is regulated by general laws on patient's rights and by decrees of the communities on participation. This includes access to medical records, information, consent for treatment (as of the age of twelve years). Child commissioners defend the rights of children[qq].

Several patient associations, self-help or advocacy groups for mental health care patients in Belgium exist[rr]; some of them develop specific services for children, adolescents and their parents within targeted diagnostic categories (e.g. Zit Stil[ss], Vlaamse Vereniging Autisme[tt], etc.). To enhance the visibility of patient advocacy for minors, a symposium has been organized by the coalition for the children's rights (June 15th 2011).

5.6. Health care: camh policies and policy stakeholders

5.6.1. Health care: Policy stakeholders

As already mentioned above, it is clear that several governments are involved in the organization of camhs, each with own competencies and advice bodies (see 5.3.2). Cooperation between those levels is very complex, as well on fine tuning the policies and competencies as on the financing matters.

- Federal ministry of social affairs and public health

The Federal ministry of social affairs public health[uu] holds the main responsibility for a large part of the health care system. It is supported in its administrative and organizational tasks by, among other, the FPS (Federal public service) Health, food chain safety and environment[vv]. The FPS took many initiatives in the mental health care reforms of the last decennia. It currently hosts the "Exploration projects" (see paragraph 1.1.2.2). Moreover, the FPS has a specific role in controlling the prospective hospital budgets, and oversees the financing of innovative projects with the B4 component of the hospital budget (see further).

- The respective Governments of the federated entities;
- The inter-ministerial conferences, gathering all involved ministers, accountable for health matters, and hosted by the FPS Health, food chain safety and environment.
- Regional consultations platforms for mental health services (provincially organized)

The "Consultation platforms" (Plates-formes de concertation psychiatrique - Overlegplatformen), financed by the federal Government, are active in all the regions: five in the Flemish region[ww], one in the Brussels region, seven in the Walloon en German regions. These platforms aim at consulting with the different specialized mental health care organizations in their region to optimize the diversity and complementarily of the care supply, and to promote collaboration. One federal umbrella platform (connected with the Federal public service health, food chain safety and environment) is in charge of the contacts between the 13 platforms and the policy makers.

qq http://www.dgde.cfwb.be/, http://www.kinderrechtencommissariaat.be/

rr For more details, see KCE report n°144 paragraph 7.5.5.5

ss http://www.zitstil.be/

tt http://www.autismevlaanderen.be/

uu Federaal Minister van Sociale Zaken en Volksgezondheid- Ministre Fédérale des Affaires sociales et de la Santé publique

vv FOD Volksgezondheid veiligheid van de voedselketen en leefmilieu - SPF Santé publique, sécurité de la chaîne alimentaire et environnement- http://www.health.belgium.be/eportal;

ww http://www.overlegplatformsggz.be/Home/60/ggz; http://www.fnams.be/LOGINONE/levelone/santé_mentale/smpcso.html;

5.6.2. Health care: camh policies

5.6.2.1. Policy level initiatives by the Federal Government

As already mentioned before (see 1.1.2 and 5.1), several initiatives in camh care have been taken as part of global mental health care policy initiatives. In the last decade, “care networks” and “care circuits”, aiming to realize an integrated and well-coordinated service supply, have been at the centre of these reforms. Besides this, the federal government allocated additional funding for the development of child and adolescent mental health care, and took several new initiatives.

1. The capacity for general hospital care (K-services) has increased over the years (see before). Autism reference centres have been created.

2. In 2002 outreaching projects for home based mental health care were initiated (see also 5.5.1.3).

3. In her public health policy notes 2008 (www.laurette-onkelinx.be), the Minister of Social Security and Public Health states that mental health care policy is to be based on the needs of the patient and his family. The Government agreement states that extra efforts are necessary for underdeveloped domains within the specific target groups (children, adults, and elderly people). For the child and adolescent target group, this includes provision of more money to augment the facilities for intensive treatment for children under the juvenile justice act of 2006 (art 37, §2). Specific projects have been developed in order to deal with mental health problems in association with youth offending behaviour and juvenile justice problems (FOR-K). Besides this, specific projects have also been developed for youngsters with aggressive behaviour or conduct disorder (intensive treatment unit or IBE (see also 5.5.1.4).

4. Therapeutic projects: temporary experiments to stimulate integrated care and care circuits, in line with adult mental health reforms (2007-2010).

To stimulate interagency collaboration through care circuits and care networks, the “therapeutic projects” were launched in 2007 by the NIHDI and the FPS Health, food chain safety and environment. They took an end in 2010. Separate therapeutic projects were initiated for children and adolescents, adults and elderly people.

The therapeutic projects promoted interagency consultation models, regardless of the funding government. The aim was to improve continuity of care, needs based care, coordination between services on the patient level. Efforts were made to link services on different levels of care by including at least a primary care service, a specialist camhs (secondary level) and a psychiatric hospital (third level care).

They were evaluated by the KCE[xx]. Important conclusions seem to be the lack of a framework to deal with information sharing between different partners, and the difficulties in setting up interagency collaboration, while a bottom-up approach was appreciated.

- 5. Studies and advice papers to assist in policy making

In 2003, the NRZV/CNEH (Nationale raad voor ziekenhuisvoorzieningen/ Conseil national des établissements hospitaliers) proposed a definition for geographic regions for the experimental projects that were starting up at that time. It was proposed to include between 165.000 and 220.000 children and young people (0 -18 years) in one region. The advice stipulated that the partnerships would have the responsibility to define the boundaries of the area. Also the creation of networks or partnerships should definitely be bottom up, without any negative consequence for those services not engaging in the experiment.[yy]

To prepare an appropriate policy on emergency child and adolescent mental health care and acute crisis intervention, the Minister ordered a study by the KCE, published in 2010[128].

The Superior Health Council (Hoge gezondheidsraad/Conseil supérieur de la santé) was asked to evaluate the treatment of conduct disorders. They proposed a Bio-psycho-social treatment model representing an integrated model of camhs along a “stepped care model”[zz] (2011).

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xx http://www.kce.fgov.be/index_nl.aspx?SGREF=5265; KCE-reports 103 (2009); 123 (2010), and 146 (2011).

yy NRZV/D/PSY/225-1, 13/3/2003

zz http://www.health.belgium.be/eportal/Aboutus/relatedinstitutions/SuperiorHealthCouncil/publications/index.htm; advice n°8325

In June 2011, the Working group psychiatry of the NRZV/CNEH, on request of the Federal Minister of Social Affairs and Public Health, concluded an advice on the future camhs organization[aaa].

5.6.2.2. Policy level initiatives by the Flemish Government

- Integrated Youth Care

The organization of ambulatory specialist mental health care services in Flanders is a responsibility of the Minister of Welfare, Public Health and Family, along with youth social care, disability care and education. In 2001, an ambitious plan was set up to integrate all the different youth sectors accountable to the Flemish Government, in order to make different types of services more accessible, and strengthen the overall organization. This comprehensive youth care plan is still under construction. Seven partners are involved, among which one specialist mental health care partner: the children and adolescent divisions of the mental health care centres (CGG). The plan implies the organization of one central management, the development of regional networks of free accessible services, the development of a comprehensive data bank on all services that can be delivered by the service providers of the different partners, and the creation of a single central entrance to allocate intensive, non-free accessible services (see further 5.7.1.2).

- Primary health care and camhs

On 11 December 2010, a primary health care conference was held in the Flemish community. A task force for mental health care prepared a final report on the position of general mental health care services within primary health care, including important recommendations[bbb]. There was no specific focus on access to primary (mental) health care for children and adolescents (as a more vulnerable group). Nevertheless the task force concluded that especially School Support Teams and School Medical Teams (CLB and MST) are important actors in camhs on the primary care level along with the Centres for general wellbeing. The report also argues for primary care psychologists to work along with other primary care workers.

5.6.2.3. Bottom-up initiatives and Good practices in Flanders

Several bottom-up initiatives and good-practices gradually developed or were implemented in Flanders, among others: Stent[ccc] and Bijpass model;Network tables[ddd] Capa[eee]; registration models e.g. RAI; Positive Parenting Program® (Triple P)[fff]; Friends program[ggg]; Flemish early psychosis projects (for young people between the age of 14 and 35 years) in cooperation with the Flemish government (VDIP), and initiatives for infant mental health. More details can be found in the Appendix to chapter 5, Belgium.

5.6.2.4. Policy level initiatives in the French federated entities

The decree of the Walloon Region government (03/04/2009), applicable as of 01/01/2010, defines the legal modalities and agreements for the organization of the ambulatory mental health care services.

The decree considers mental health services as general outpatient centres, addressing their offer to the whole population. Some centres however can be permitted to address their offer uniquely to children and adolescents. If this is the case a child psychiatrist and additional professionals like a speech therapist or a physiotherapist are necessary part of the team of professionals. At the same time, Reference centres for mental disorders are created, responsible for education and support of the ambulatory mental health care centres and for care coordination between these centres and other mental health care providers.

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aaa Advies m.b.t. de uitbouw van een GGZ-programma voor kinderen en jongeren/ Avis relatif au développement d'un programme de soins de santé mentale pour enfants et adolescents. NRZV/CNEH 9 juni 2011. http://www.health.belgium.be/eportal/Healthcare/Consultativebodies/Nationalcouncilforhospitalfaciadviesprogramming2011/index.htm?fodnlang=fr;

bbb Van Audenhove,C. Et al; 2010, Eindrapport Werkgroep 6 Geestelijike Gezondheidszorg, download from www.zorg-en-gezondheid.be/Beleid/Vlaamse-bevoegdheden/Beleid-eerstelijnsgezondheidszorg/

ccc http://www.stentproject.be/

ddd Van Dongen & Deboutte, 2009

eee http://www.camhsnetwork.co.uk/

fff http://www.triplep.net/

ggg http://www.friendsinfo.net/

5.6.2.5. *Bottom up initiatives and Projects in Brussels and the Walloon region*

Several bottom-up initiatives and good-practices gradually developed in the Walloon region and Brussels, among others:

Clinique Fond'Roy (Brussels) ; collaboration between youth care and camhs[hhh] ; le Toboggan ; L' entretemps; [iii]S'Acc'Ados et Passado[jjj] ; initiatives of the Centre Chapelle-aux-Champs ; Collaboration between AWIPH and camhs : les cellules Mobiles d'intervention CMI[kkk]. More details can be found in the Appendix to chapter5, Belgium.

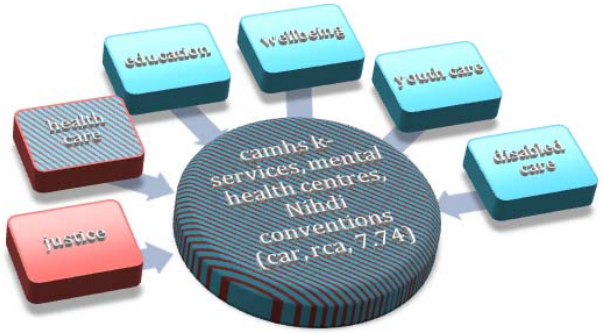
5.6.2.6. *Policy level initiatives in the German speaking community*

The German speaking community took several initiatives to assure camh services in their mother tongue for German speaking children and adolescents (see also 5.5.1.3).

5.7. Neighbouring sectors

Several sectors providing services for children and adolescents, contribute to the provision of mental health care in its broad sense (see 1.3.3). Those sectors are situated among different levels of governmental competencies. This is graphically illustrated in figure 5.1.

Figure 5.1: Federal competence: red; competence of regions and communities: blue.



In the next paragraphs, the global organization of these sectors will be shortly presented. Aspects that are relevant for camhs, or for collaboration with camhs, are presented in italics.

5.7.1. *Social care and youth welfare*

5.7.1.1. *Political responsibility in (youth) social care*

Social security is a responsibility of the Federal Government[lll]. The aim is to provide the social security, along with the health insurance, in case of illness and disability, and the retirement pension of the working people but also to assure a minimum standard of living by providing social support and allowances for the unemployed and the poor. Welfare and social care on the other hand, including youth welfare, are person-related matters that are organized under the authority of the federated entities, especially the communities. Action domains are, among many other, general measures to fight poverty, psycho-social support and counseling for vulnerable people, support to detainees etc.

In practice, in both the Flemish and the French speaking community the responsibility for these matters is shared or divided between the communities and the regional authorities (Flemish region, Walloon region). In the Flemish federated entities, welfare and social care belong to the responsibility of the Flemish Minister of Welfare, Public Health and Family.

hhh http://www.aidealajeunesse.cfwb.be/ajss_pro/jaaj/sante_mentale_et_aide_a_la_jeunesse/

iii (www.lentretemps.be)

jjj (www.passado.be)

kkk http://www.awiph.be/AWIPH/projets_nationaux/cellules_mobiles_intervention/cellules+mobiles+intervention.html

lll http://www.socialsecurity.fgov.be/nl/over-de-fod/organisatie/ministers.htm

In the French federated entities, welfare and social care belong to the responsibility of the Minister of Health, Social action and Equal chances (Ministre de la Santé, de l'Action Sociale et de l'Egalité des chances, Région wallonne), of the Minister of Childhood, Research and Public functions (Ministre de l'Enfance, de la Recherche et de la Fonction Publique, French community) and of the Minister of Youth and Youth care (Ministre de la Jeunesse et de l'Aide à la jeunesse, French community).

The German speaking community will be discussed separately in the Appendix 5. Given the complex situation of the bilingual community of Brussels, and given the scope of this report, interested persons are referred for some further reading[mmm].

5.7.1.2. Service supply in youth social care

A diversity of services is available in youth social care and will be discussed in the next paragraphs. General social care can be found in frontline social care services for all vulnerable people; and in Flanders in centres for integrated family care address socially vulnerable families with severe educational problems. The Child and Family Agencies (Kind&Gezin/ ONE (L'Office de la Naissance et de l'Enfance)) are independent agencies active in the field of preventive (mental) health care and social care for young children. These agencies also supervise the Confidential centres on child abuse and neglect. Specialized youth social care is structured in a different way in the Flemish and the French federated entities, respectively, and will be discussed separately.

All these services can, if necessary, refer to camhs, or start ad-hoc collaboration at the patient's level. For at least some of these services, e.g. youth social care in Flanders[127], it has been demonstrated that this collaboration is poorly structured, although many children are in need of mental health care (see also paragraph 5.4.2). Also, the service supply of several services active in this domain overlaps to a certain degree. To address these and other problems, the Flemish Integrated youth care policy was launched in 2001 and is still under construction; it will also be briefly discussed below.

General social care and Centres for integrated family care

First line support in the domain of welfare, accessible for everybody, can in Flanders be found in one of the 26 CAW, the centres for general social work (centra voor algemeen welzijnswerk), or at other social services[nnn]. *Young people's advice centres (JAC) are a part of the CAW's, addressing themselves to young people from 12 to 25 years of age. They offer free information, advice and counseling.* Another type of first line help is offered by several Tele-services and on-line services.

In the Walloon region, some examples of freely accessible first line support services in the domain of welfare[ooo], are the centres for social services (centres de service social), the centres for family planning and consultation for families and spouses (centres de planning et consultation familial et conjugal) etc. Teleservices exist as well (Télé-Acceuil, Ecoute-enfants etc.)

The Flemish centres for integrated family care (Centra voor integrale gezinszorg CIG)[ppp] provide ambulatory or residential support to socially vulnerable families in case of severe educational problems, always on a voluntary basis. The problems are put in a broad perspective, all contributing factors are addressed (financial problems, housing…)

Child and family Agencies

The Child and family agencies (Kind&Gezin[qqq], ONE[rrr]) are independent agencies aiming at improving the wellbeing of young children and their

mmm http://www.bruxelles.irisnet.be/vivre-a-bruxelles/famille-et-vie-privee/aide-aux-personnes-et-aux-familles; http://www.bruxelles.irisnet.be/vivre-a-bruxelles/sante-securite/soins-prenatals-et-des-enfants; http://www.bruxelles.irisnet.be/vivre-a-bruxelles/famille-et-vie-privee/aide-aux-personnes-et-aux-familles/aide-psychologique; http://www.bruxelles.irisnet.be/a-propos-de-la-region/les-institutions-communautaires-a-bruxelles/cocom; http://www.bruxelles.irisnet.be/a-propos-de-la-region/les-institutions-communautaires-a-bruxelles/cocof; http://www.bruxelles.irisnet.be/a-propos-de-la-region/les-institutions-communautaires-a-bruxelles/vgc

nnn http://www4.vlaanderen.be/wvg/welzijnensamenleving/Pages/default.aspx

ooo http://socialsante.mrw.wallonie.be/pages/4100.php

ppp http://www4.vlaanderen.be/wvg/welzijnensamenleving/gezinszorg/pages/inhoud.aspx

qqq http://www.kindengezin.be

rrr http://www.one.be/index.php?id=9

families with services in the field of preventive health care (including preventive mental health care), as well as social care. The agencies are responsible for the policies, funding and supervision of services related to preventive family support, professional child nursery and crèches for children under the age of 12 years, and child adoption.

Preventive family support covers support for maternity and education by offering general advice and information on healthy child raising, child development, and child mental health up to the age of 3 years (Flanders) or 6 years (the Walloon region). Preventive family support also includes several specific services: services for temporary educational support or sheltering in case of family crisis, services in case of (suspicion of) child abuse, or (in Flanders) foster care services:

- Centres for child care and family support

These services (Centrum voor kinderzorg en gezinsondersteuning CKG, Services d'accueil spécialisés de la petite enfance SASPE) have several tasks. They can deliver educational support at home (Flanders). They can provide temporally sheltering for children up to the age of 12 years (Flanders) or 7 years (Walloon region) in case of family crisis.

- Confidential centres on child abuse and neglect

These multi-disciplinary services (Vertrouwenscentra Kindermishandeling VK, Equipes SOS Enfants)[sss] act as reference point to report (suspicion of) child abuse, violence on children or child neglect. Reporting to the centre results in investigation, and setting up guidance and care. When the child's safety is jeopardized, protection is guaranteed.

- Service for Foster care

This Flemish service provides short-term foster care in foster families, supporting the own family as well as the foster family at the same time.

Youth social care in the Flemish federated entities

In Flanders, there is an independent agency specifically responsible for specialized youth welfare and social care, the Youth care agency ("Jongerenwelzijn"). The mission of the Youth care agency[ttt] is to implement the youth welfare policy, to commission youth social care services and to supervise all the services involved in youth social care, also called "youth care" (Bijzondere jeugdbijstand BJB).

Youth social care traditionally has been active in the field of socio-educational support for socially vulnerable families, protection for children or youth in danger and resettlement of youth after crime like acts.

- Referral to youth social care services

Youth social care is only accessible on referral. In case of voluntary, non-compulsory help referral is done by the Youth care committees (Comités voor bijzondere jeugdzorg CBJ). In case of compulsory protection measures imposed by the Children's judge, or resettlement after a youth crime like act, referral is done by the social services of the Youth court (belonging to the Federal Ministry of Justice, see further). *The CBJ's and Youth court social services can also work together with services beyond the youth care agency, as e.g., mental health care services, if required*.

- Youth social care services

Youth social care is delivered by not-for-profit private institutions or by Public institutions. Different types of care can be delivered by the private institutions, ranging from short term crisis intervention, through home based and day care interventions up to out of home placement in foster homes or foster families and support to living independently. This offer is either on request of the CBJ's or imposed by the court.

When a youngster has severe unwilling behaviour that needs securing or when he committed a crime like act, the court can decide to refer the youngster to a closed, semi-closed or open education program that is delivered by the Public Institutions. There are 2 such institutes in Flanders: one in Mol, and one in Ruiselede/Beernem; they are both under the responsibility of the Flemish Minister of Welfare, Public Health and Family. Additionally there are two Federal closed Public institutes (Everberg and Saint-Hubert), where there is a joint responsibility between the Federal Minister of Justice and the federated entities; these are meant for the most severe cases.

sss http://www.kindermishandeling.be/startsite/3-www.html
ttt http://wvg.vlaanderen.be/jongerenwelzijn/

A new Flemish policy: Integrated youth care

The organization of ambulatory specialist mental health care services in Flanders is a responsibility of the Minister of Welfare, Public Health and Family, along with youth social care, disability care and education. In order to make different types of services more accessible, and strengthen the overall organization, an ambitious plan was set up to integrate all the different youth sectors accountable to the Flemish Government. This comprehensive youth care plan, applicable to children and adolescents 0-18 years, is still under construction and implies a process of change that still is going on. Core elements of the plan[uuu] are discussed briefly. A first scientific analysis of the practical implementation of the Plan has already been published[vvv].

Seven different partners, accountable to the government of the Flemish community are brought together[www]:

- General social care;
- Centres for integrated family care (Centra integrale gezinszorg);
- Youth care agency (Bijzondere Jeugdbijstand);
- Child and family Agency (Kind&Gezin);
- Mental health care centres (CGG) as far as it concerns the services offered to children and adolescents;
- Educational support centres (CLB, centra voor leerlingenbegeleiding);
- Flemish agency for disabled persons (VAPH, Vlaams agentschap voor personen met een handicap).

One central management:

The aim of the "Integrated youth care" policy, launched in 2001, is to facilitate service delivery by eliminating as much as possible obstacles of care delivery such as the differences in organization, regulations, and funding of the involved sectors, by bringing them together in one central management.

Regional council:

At the regional level (provinces and the Brussels region), regional councils are responsible for developing crisis networks and collaborative networks with all participating partners. These networks consist of all service providers in a region, which offer free accessible care. The aim of the networks is that a client receives the most appropriate care he needs or asks, and that different services are well coordinated. To assist with referral within the network, a signaling list is developed to stimulate awareness of children at risk, or other threatening situations.

Services data bank:

A data bank is available containing the different services, delivered by all of the service providers connected to one of the seven sectors, for each region. These services are defined in a uniform format and are called "modules". A module is every single service, or set of interventions that can be offered. It is the aim that modules of one or different service providers could be combined to meet the needs of the client in the most appropriate way.

Central gate to intensive youth care:

A next step to organize within the integrated youth policy is the creation of *a single central entrance to allocate intensive youth care services*. The function of this entrance system is assessment and assignment of necessary but not free accessible services. A definitive concept note on the inter-sectorial entrance gate was released[xxx] on January 17, 2011. In this document attention also is given to collaboration with juvenile justice, the collaboration with care providers not due to the integrated youth care regulations, and to assertive non-juridical care.

uuu http://wvg.vlaanderen.be/jeugdhulp/

vvv Nele Van Tomme, Joris Voets, Koen Verhoest (2010). K.U.Leuven; Instituut voor de Overheid K.U. Leuven; Steunpunt voor Welzijn, Volksgezondheid en Gezin. Werknota: De netwerken van Integrale Jeugdhulp geanalyseerd vanuit een keten- en netwerkmanagementperspectief.

xxx wvg.vlaanderen.be/jeugdhulp/05_publicaties/index.htm

Youth social care in the French federated entities

Several services for Youth social care ("Youth care") are available in the French community; an operational plan 2009-2013 defines the youth care policy.[yyy]

- Referral to Youth social care

Youth social care is only accessible on referral.

"Youth care services" (Service d'aide à la jeunesse SAJ) are the French community counterparts of the Youth care committees in Flanders. They are the commissioners for the voluntary care for socially vulnerable families.

"Judicial youth protection services" (Service de protection judiciaire SPJ) are the French community's social services for youth care when the youth court is involved and the children's judge imposes measures to protect the child or adolescent, or in case of resettlement after a youth crime like act. The SPJ carries out the decisions of the court by commissioning the imposed services.

- Youth social care service providers

Youth social care is delivered by not-for-profit private institutions or by Public institutions.

Private non-for-profit youth care service providers offer 14 different types of youth social care[zzz] on request of the SAJ or the SPJ, e.g. crisis care, home-based care, foster care, day care etc. Five Walloon Public institutions for youth protection (Institutions publiques de protection de la jeunesse IPPJ)[aaaa] deliver educational care by means of secured or open programs, for adolescents referred by the court because of severe youth offending behaviour that needs securing, or when he committed a crime like act for which the Children's judge imposed educational measures (Jumet, Wauthier-Braine, Braine-le-Château, Fraipont, St-Servais).

Additionally there two Federal closed Public institutes (Everberg and Saint-Hubert), where there is a joint responsibility between the Federal Minister of Justice and the federated entities; these are meant for the most severe cases.

5.7.2. Juvenile justice

Justice is a Federal matter under the authority of the Minister of Justice. There are 5 judicial areas, each with an Appeal Court, and 27 judicial districts.

Juvenile justice in Belgium is still importantly grounded in the Youth Protection Act of 1965, stipulating that minors (< 18 years) need to be protected in any circumstance, and cannot be charged of having committed crimes. Criminal behaviour that would be punished when committed by an adult is called a "crime like act" in the case of minors. Adaptations in 2006 incorporate new practices, such as repair measures and even detention, to eliminate any perception of staying unpunished.[bbbb]

The Youth courts and Children's judges have two main responsibilities.

Their first task is to impose compulsory youth protection, for children and adolescents in an endangering or threatening educational situation, if non-compulsory care is not sufficient or not accepted by the family. This can be when parents or responsible adults neglect their educational duty or in case of child abuse; but it can also be that the behaviour of the youngster potentially would endanger himself or his environment. Measures for the parents could be supervision, deprivation of their parenting rights, or penalizing them. Compulsory care can be imposed, e.g. home care, day care interventions or foster care. If it is necessary to ensure safety for the children or for the environment, they can be sent to an open, semi-closed or closed Public institution[cccc].

The second task of the Children's judges is to take measures for youngsters that committed crime like acts. Measures might be a warning,

yyyyyy Le plan opérationel de la DGAJ de 18.02.11, download from http://www.aidealajeunesse.cfwb.be

zzz http://www.aidealajeunesse.cfwb.be/ajss_pro/servicespro/

aaaa http://www.aidealajeunesse.cfwb.be/ajss_pro/servicespro/

bbbb Ministeriële omzendbrief nr 1/2006 van 28 september 2006 betreffende de wetten van 15 mei 2006 en 13 juni 2006 tot wijziging van de wetgeving betreffende de jeugdbescherming en het ten laste nemen van minderjarigen die een als misdrijf omschreven feit hebben gepleegd (B.S.29.IX.2006)

cccc http://wvg.vlaanderen.be/jongerenwelzijn/instellingen/inleiding.htm

compulsory ambulatory treatment; or compulsory treatment in the open, semi-closed or closed Public institutions. Measures might even be correctional like repair measures, community service or even detention.

As already mentioned before (see 5.7.1.2), most service-providers in charge of Youth court measures belong to the Youth care sector and are under a federated responsibility. Only the two Federal closed Public institutions (Everberg, Saint-Hubert) come under a joint responsibility of the Federal Minister of Justice and the federated Ministries of Welfare, Public Health and Family.

Youngsters that committed a crime like act but who at the same time suffer from a mental disorder, can be treated in FOR-K units (see paragraph 5.5.1.4). These FOR-K units are established in collaboration with the Federal minister of Justice, the Federal Minister of Social Affairs and Public Health, and the ministries of the federated entities involved in Welfare, Public Health and Family; they are still financed as temporary projects through the Federal health care budget.

5.7.3. Disability care

The federated entities are responsible for the provision and financing of long term care for disabled persons: the VAPH (Flemish agency for disabled persons; Vlaams agentschap voor personen met een handicap[dddd]); the AWIPH (French agency for integration of disabled persons; l'Agence wallonne pour l'intégration des personnes handicapées[eeee]); the DPB (agency for disabled persons of the German speaking community; Dienstelle für Personen mit Behinderung DPB[ffff]); for the specific situation of Brussels the interested reader is referred for further reading[gggg].

These agencies help disabled persons to integrate in school, education, work and social life. To benefit from one of their services, an indication by an independent multidisciplinary team or another service recognized by the VAPH/AWIPH/DPB is necessary. A limited part of the VAPH and AWIPH budgets is available for PAB/BAP (personal assistance budget), which means that disabled persons receive money themselves that they can spend to the assistance services of their choice (e.g. household tasks, pedagogical support).

For further information on the service supply by the DPB, see Appendix 5.

5.7.3.1. Flemish federated entities

- VAPH Services[hhhh] related to child and adolescent mental health care

-MPI's or medical pedagogical institutions provide special education boarding schools (24/24h, 5/7 or 7/7 days, internaat, MPI) and semi-boarding schools (8-18h, 5/7 days, semi-internaat) for children and adolescents with mild, moderate or severe mental retardation with or without behavioural problems; for children and adolescents with severe behavioural, or emotional problems (MPI cat 11 and MPI cat 14); and for motor or sensory disabilities. These MPI's are usually linked to a special education school. Besides educational staff, para-medical personnel (psychiatric nurses, speech therapists…) and medical doctors are involved. In the semi-boarding schools, a limited number of day care places is available for children not able to participate in regular or special education schools.

-Observation and treatment centres (OBC) for children and adolescents with severe behavioural, or emotional problems: these centres perform a comprehensive diagnostic observation, start treatment and refer to appropriate services for further treatment; a stay can last from a 3 months till 3 years (see also 5.5.1.3). There are seven OBC in Flanders; staff is as for MPIs.

-Short stay host centres (Kortverblijf) for all types of disability: they provide temporary relief for the family caregivers.

-Support services for parents (Thuisbegeleiding): professionals come at home, on a weekly or monthly basis, to support parents in all their educational and practical questions in relation to their child's handicap. *Target groups are autism spectrum disorders (5 services) and mental retardation with or without behavioural problems (5 services in Flanders),*

dddd http://www.vaph.be

eeee http://www.awiph.be/

ffff http://www.dpb.be/ ; http://www.dpb.be/images/2011/11051-JB2010_def.pdf

gggg http://www.bruxelles.irisnet.be/vivre-a-bruxelles/sante-securite/handicap-et-invalidite; http://www.phare-irisnet.be/accueil/

hhhh www.vaph.be

besides motor and sensory disabilities. Staff is para-medical or educational personnel.

- Centres for developmental disorders (COS)

Centres for developmental disorders (Centra voor ontwikkelingsstoornissen, COS) have a diagnostic and care coordinating role for young children (0-7 years) who are suspected to have a cognitive, motor, sensory *or psycho-emotional developmental disorder*. COS are free accessible; for therapeutic interventions they refer to appropriate service providers. There are four COS in Flanders. They operate as independent services recognized and financed by the VAPH.

- Centres for expertise networks (SEN)

To support and improve the knowledge and expertise of professionals working with specific target groups, the VAPH subsidizes four Centres for expertise networks (Steunpunt expertise netwerken SEN)[iiii]. *Two of the 4 target groups are ASS (autism spectrum disorder) and persons with mental retardation and co-occurring behavioural problems.* Children and adolescents are included but are no specific subgroups. Each province has a coordinating centre. These centres aim to stimulate and coordinate inter-professional expertise exchange, e.g. by stimulating networking among professionals, offering possibilities for website knowledge exchange on specific subjects, facilitating meetings between professionals on practical questions, announcing colloquia etc. Besides knowledge improvement, it is also the aim to make an overview of the different types of service provision in the province, in order to facilitate interagency collaboration for or referral of clients, and early detection of unmet service needs within the region.

5.7.3.2. French federated entities

- AWIPH Services related to child and adolescent mental health care

-Special education Boarding schools (24/24h) and semi-boarding schools (part of the day) providing residential care outside school hours for disabled children and adolescents (*Services résidentiels pour jeunes SRJ*)[jjjj]. Besides educational staff, para-medical personnel (nurses, speech therapists…) and medical doctors are involved.

-Day care centres for youngsters with severe disabilities, who are not able to attend schools (Services d'acceuil de jour pour jeunes non scolarisables SAJJNS).

-Short stay host centres (Le répit) for all types of disability: they provide temporary relief for the family caregivers.

-Services for early detection (*Services d'aide précoce SAP, 0-8 yrs*) and Integration support services (*Services d'aide à l'intégration SAI, 6-20 yrs*)[kkkk]: pedagogical support for parents and their children, or for youngsters, at home and in the natural living environment of the children..

- AWIPH and Education

The AWIPH has a collaboration agreement with the Education sector to support the integration process in regular schools for pupils between the ages of 6 and 20 confronted with disability. In this case, the Integration support services (see before, Services d'aide à l'intégration, SAI)[llll] collaborate closely with the school and the CPMS, and provide educational assistance at school or at home to support social and school integration as well as autonomy in all areas (see also 5.7.4).

5.7.4. Education

Since 1989, Belgium's Dutch, French and German-speaking Communities have acquired almost full authority for education[mmmm]. In the bilingual Brussels-Capital region, parents have the choice between Dutch schools (responsibility of Flemish Community) or French schools (responsibility of French Community).

In each of the 3 communities, the Ministry of education has the overall responsibility for education, including general administration and funding. Schools are stimulated to form larger educational networks in regional school communities. These educational networks, the organizing bodies of the schools and the school boards have the direct responsibility relating to

iiii http://www.senvzw.be/

jjjj http://www.awiph.be/integration/etre_accueilli/accueil+jeunes.html

kkkk http://www.awiph.be/integration/etre_accompagne/index.html

llll www.enseignement.be/index.php?page=26101&navi=2960 ; www.awiph.be/integration/apprendre_etudier/integration+scolaire.html

mmmm http://eacea.ec.europa.eu/education/eurydice/eurybase_en.php#description; http://eacea.ec.europa.eu/education/eurydice/about_eurydice_en.php; http://www.european-agency.org

operational issues. Local governments e.g. municipalities have little direct responsibility, except if they act as an organizing body.

5.7.4.1. School system

Current policy in the 3 Communities, as supported by legislation, places emphasis on educating children with special educational needs alongside their peers in mainstream schools, whenever possible. General advice is provided by the pupil guidance centers (Centra voor leerlingenbegeleiding, (CLBs); centres psycho médico sociaux (CPMS); Psycho-Medizinisch-Soziales Zentrum (PMS-centres)). However, other practical modalities especially for pupil support in mainstream schools differ between the Communities.

Collaboration with camhs in the health care system is mostly ad hoc for individual cases (through the CLB/ CPMS/ PMS-centres).

Support in mainstream schools

In the Flemish Community, support in mainstream schools can be provided by e.g. special-needs teachers in the school; special-needs coordinators have a role in coordinating the care for these children. *Support can also be provided by a teacher from a special-education school; this is called "integrated education" (Geïntegreerd Onderwijs, GON). For mental health problems, two types of GON exist: GON type 3 (severe behavioural or emotional difficulties) and GON-ASS (autism spectrum disorders).* Specific "inclusive education" measures (Inclusief onderwijs, ION) have been developed for type 2 children (see further); these pupils, in 2008 limited to a maximum of 100, receive a very intensive individual accompaniment, adapted financing is foreseen. To benefit from GON or ION, a pupil needs a certificate, which can be provided by the CLB.

In the French Community children for whom education in a special school of any type (except type 5, see further) is considered, can apply for "inclusive education" measures to be able to participate in mainstream education. Specific agreements between mainstream and special education schools are then made and adapted financing is foreseen. A certificate from the CPMS is necessary. Additionally, the Walloon agency for the integration of disabled persons (AWIPH) and their Integration support services (Services d'aide à l'intégration, SAI) can support the integration process for pupils (6-20 yrs) at school or at home (see also paragraph 5.7.3.2). Finally, schooling continuity services (Services d'Accrochage Scolaire, SAS) can help pupils undergoing a crisis by taking them in temporarily.

In the German-speaking Community, support in mainstream schools, e.g. by the own teacher or by special-needs teachers, is typically available for pupils with heightened support needs who do not (yet) qualify for special school education; these pupils also need a certificate by the Government. Besides this, the so-called "teacher for integration" assures a link between regular schools and schools for special needs in order to improve the integration in either school system.

Special education

Some children need more help than a mainstream school can provide. The organization of special schools is the same in the Flemish and the French Community[nnnn]. Special schools exist for severe learning difficulties (type 8), mild or moderate/severe mental retardation (type 1 resp. 2), *behavioural and emotional difficulties (type 3)*, physical impairment (type 4), illness (type 5, typically hospital schools), visual or hearing impairment (type 6 resp. 7). To enter special education, a certificate of the CLB/CPMS is necessary. *Children suffering from mental health problems are typically found in type 3, but many of them are found in other types (e.g. for children with ASS (autism spectrum disorders) special classes are organized in type 8, 1, 2, 3, or 7). In the French community, 9 out of 11 new hospital education services (type 5) created during the last years, have been created for children with behavioural problems, and due to a lack of other solutions to support these children, they stay in these services.* In the German Community, one centre encompasses the different types of special schools.

[nnnn] A specific problem of the special schools of the French community is that 8% of their population, as of sept. 2010, were cross-border pupils from France. The majority of these pupils are children with autism or other severe behavioural or emotional problems, and a small number are multiple handicapped children. The problem has been recognized by the French Government, but so far the financial responsibility for education rests with the Belgian French community. Many of these children are also in residential care, for which financial agreements have been made (personal communication, R.Delussu, expert (see colophon)).

5.8. Financing and funding

5.8.1. Introduction

In this part of the report, the funding mechanisms of the different child and adolescent mental health care services are described. The reporting of these services can be approached from several points of view (e.g. federal versus federated entities funding, first versus third tier services funding). It was decided to split up the description into the funding mechanisms of the federal government on the one side and the funding mechanisms of the federated entities on the other side. Special attention is given to financing initiatives stimulating integrated care.

5.8.2. Funding mechanisms on the federal government

The funding mechanisms of the federal government are reported from a dual point of view:

- Structural financing: financing of the (traditional) services for child and adolescent mental health care;
- Financing of innovative projects for child and adolescent mental health care.

5.8.2.1. Structural financing

The structural financing is based partly on a fee for service system (the nomenclature of medical acts), and partly on financing of hospital care.

The nomenclature of medical acts

The nomenclature comprises a list of medical or paramedical acts and materials reimbursed by the compulsory health insurance. This list gives a detailed description of the intervention, the convention tariff and the conditions for reimbursement. The type of reimbursable benefits and their amounts (total fee and reimbursement) are determined through a complex process of negotiations with various actors involved (insurers, representatives of health care professionals,...) within the National institute for health and disability insurance (NIHDI), all within preset budgetary limits. The negotiated fee is called the “convention tariff”.

The relevant codes concerning youth mental health care are listed below (June, 30, 2011):

- Code 102196 and 102690: fee for consultation in the office of the psychiatrist (not accredited or accredited). Note: an accredited physician is a physician meeting certain quality requirements (e.g. continuing education). This physician is allowed to ask a higher fee than a not-accredited physician. (39,67 or 42,48€)
- Code 109513 and 109631: psychotherapeutic treatment by a medical specialist in psychiatry (not accredited or accredited) (minimum duration: 45minutes). (65,09 or 68,28€)
- Code 109432 and 109454: fee for a pluridisciplinary consultation led by a medical specialist in psychiatry, non accredited or accredited, concerning a child or adolescent <18 years (requirements: a minimum duration of 90 minutes, editing a report). Participation of at least two other care giving agencies or disciplines is required (potentially with the presence of the adults responsible for the child). (185,56 or 186,49€) (maximum 4x/year)
- Code 109675: psychotherapeutic treatment of a child or adolescent <18 years, by an accredited medical specialist in psychiatry (minimum duration: 60 minutes, with the presence of one or more adults responsible for the education of the child or adolescent) (91,2€)
- Code 109653 and 109550: psychotherapeutic treatment by an accredited medical specialist in psychiatry (minimum duration: 60 minutes, with the presence of more than one patient of the same family ->family therapy) (45,61€ by patient for the first two patients and 23,15€ for the third patient)
- Code 109572: psychotherapeutic treatment by a medical specialist in psychiatry (minimum duration: 90 minutes, with the presence of maximum 8 patients) (23,15€ per patient)
- Code 109410: detailed and individual psychiatric evaluation of a child or adolescent <18 years, by an accredited medical specialist in psychiatry (requirements: a minimum duration of 120 minutes, with a contact of at least 60 minutes with the adults responsible of the child or with the child himself; editing a report; evaluation prescribed by a GP or medical specialist) (188,35€) (maximum 7x/full evaluation)
- Code 596562 and 596584: fee for a consultation led by an accredited medical specialist in psychiatry, for a young person <16 years, with

evaluation and writing of report for the coordination of care ("liaison function report") (73,1€ for the first consultation, 56,86€ for the following consultations) (prescribed by the medical specialist in charge of the young person)

- Code 590995: fee for a consultation in an emergency service led by an accredited medical specialist in neurology, psychiatry or neuropsychiatry (42,48€)
- Code 597682: fee for a multidisciplinary team consultation in a child psychiatry hospitalisation unit (K), for a patient <18 years, under the supervision of an accredited medical specialist in psychiatry, with report. This fee may be charged once a week. To this multidisciplinary consultation should participate, besides the medical specialist in psychiatry, the psychologist and the nurse or educators which hold the daily supervision, at least one social nurse, manual therapist, physiotherapist, speech therapist or teacher (77,08€).

It is important to note that for psychologists no nomenclature exists. There are some legislative requirements on the presence of psychologists in mental health care centres and K-services in the hospitals. The payment is however included in the financing of hospital care or in the financing-envelope of the CGG/SMM (see further).

Hospital care

The hospital mental health care facilities for children and adolescents consist of specific departments in general and psychiatric hospitals (K- and k-beds). The financing of these services is described in the Royal Decree of 25/04/2002 concerning the setting and regulation of the Budget of Financial Means of hospitals.

The financing of hospital care in Belgium is rather complex. Therefore, a brief overview of the different funding resources appears to be useful.

Three financial funding components can be identified: the Budget of Financial Means (BFM) (42 to 45% of the funding), the medical fees (42 to 45%; see also paragraph 5.3.2.2), and the budget for drugs, medical and pharmaceutical products. (12 to 15%)

Only the B2-part of the Budget of Financial Means is discussed in this section. The B2-part covers main operational costs including nurses and medical consumables.

In general, for each hospitalization, the number of justified hospitalization days is calculated, based on average national length of stay per APR-DRG (corrected for severity and age category). If the actual length of stay is smaller than the national average, the hospital is entitled to the national average (the justified number of days) and thus gains. On the other hand, if the actual length of stay exceeds the national average, these excess days are not reimbursed. Subsequently, the justified days are transformed into justified beds and points.

This transformation mechanism accounts for different staff ratios (the allocated points per justified bed differ across different hospital departments) as well as for different standard occupancy rates. Finally, every point has a Euro-value, allowing calculating the hospital budget.

Due to the lack of a patient classification system for psychiatric patients, the payment system is not a function of APR-DRG. Therefore, for the K-departments the number of recognized beds (corrected for standard occupancy rates) is used instead of the number of justified beds to calculate the points the hospital is entitled to. The funding for day- or night hospitalization child psychiatry (kd, kn) is based on an expected utilization of the 'partial hospital beds' during weekdays (i.e. expected occupancy of 80% of the capacity during 251 days per year – or 56% per year. The funding for 24-hour hospitalization is based on 80% occupancy rate per year. Minimum norms for staffing per bed are demanded to ensure qualitative care.

For the K-beds, 16 FTE nurses per 20 beds are administered based on an occupancy rate of 80%. Table 5.3 provides an overview of the staff standards for several hospital departments[129].

Table 5.3 Overview of the staff standards for several hospital departments[129]

Department	Staff (FTE)	Number of beds	Points/bed
C- and D-department	12	30	1
Pediatrics (E)	13	30	1
Maternity (M)	14	24	1.46
Acute Psychiatry (A)	16	30	1.33
Child Psychiatry (K)	16	20	2
Intensive Care	2	1	5

The National Institute for Health and Disability (NIHDI) conventions

There are several NIHDI conventions related to child and adolescent mental health care: conventions for ambulatory centres for rehabilitation, "7.74" or "7.845" conventions for psychotherapeutic or functional rehabilitation centres, conventions for autism reference centres, conventions for early parent-child interaction problems, conventions for residential services for adolescents with addictive behavior. Funding basic principles of these conventions are similar. This chapter will thus focus on the two main types of convention: conventions for ambulatory centres for rehabilitation and 7.74 conventions.

The NIHDI-convention for the ambulatory centres for rehabilitation (Centra voor Ambulante Revalidatie – CAR / Centres de revalidation ambulatoire - CRA)

For each target group in the ambulatory centres for rehabilitation (see 5.5.1.2) a maximum reimbursement period or a maximum budget is fixed in order to perform a multidisciplinary rehabilitation program.

To be eligible for reimbursement, the acts must have a diagnostic or therapeutical purpose. Administrative activities can never give rise to reimbursement. A distinction is made between "commencement bilan" consultations and consultations not being part of a "commencement bilan". Overlap with the nomenclature of medical acts, as explained above, is not possible.

Consultations being part of a commencement bilan

These consultations consist always of individual consultations, i.e. one or more therapists and one patient (and/or members of the family). The Insurance considers this as a consultation of one therapist together with one patient. The working time of the potential other therapists are not eligible for payment. Payment of this type of consultation is regulated by a fixed price.

Consultations not being part of a commencement bilan

These consultations consist of an individual, group or mixed consultation. Group consultations are considered as meetings with several children and/or family members (without the presence of teachers). Payment of this type of consultation is also regulated by a fixed price calculated as the actual working hours of the therapists divided by the number of expected consultations.

Each centre enters into a contract with the NIHDI in which the annual maximum number of reimbursable meetings and the affined number of staff are described. If 100% of the consultations is performed, 60% of the affined staff time is used. The remaining 40% of time can be filled in by the centre according to their own preferences. However, some requirements are established: an annual report; internal multidisciplinary team discussions; regular contacts with the school and eventually other caregivers (e.g. meeting with teacher of one child).

To stimulate the multidisciplinary rehabilitation, this convention comprises a nomenclature act for outreach services, which implicates that information and support sessions for teachers are reimbursed; these sessions should be provided by the physician of the centre and should be attended by teachers of minimum two children. Eventually, the parents of the children can also attend the meeting.

The NIHDI-convention for the 7.74 centres

7.74 NIHDI conventions finance psychotherapeutic or functional rehabilitation centres which provide residential or day care.

Each centre enters into a specific contract with the NIHDI in which are described:

- The targeted group;

- The services provided;
- The number and qualification of staff;
- The "normal invoice capacity" of the centre, i.e. 90% of the agreed capacity in terms of number of patients multiplied by the number of opening days of the centre.

Total operating and staff costs of the centre are divided by the normal invoice capacity to calculate a per diem. The centre loses money if it performs less than the normal capacity. If it performs more than the normal capacity, the per diem is reduced. If the maximal capacity (i.e.98% of the agreed capacity) is exceeded, the centre is not financed.

Reports, multidisciplinary meetings, networking, contacts with parents are included in the activity financed by the convention.

5.8.2.2. Financing for innovative projects

Pilot projects financed with the "B4" component of the BFM

The Federal Public Service of Health establishes and finances pilot projects for several target groups. The aim of these projects is to prepare the future policy of mental health care in Belgium. Three types of pilot projects exist for the target group children and adolescents with mental health problems:

- Intensive treatment services for youngster with aggressive behaviour or conduct disorder (IBE);
- Specialist services for youth offenders with mental health problems (FOR-K);
- Outreaching teams;

The financing of these pilot projects is regulated through the Budget of Financial Means (BFM) of hospitals, component B4 (Costs that are covered in a fixed way or through special budgets).

The Royal Decree of 19/09/2008 concerning the coordination of the Hospital law

There is a tendency towards the development of a more community-based mental health care with a switch from supply-driven residential care to more demand-drive mental health care based on the needs of the patients. Focus is put on the realization of "networks" and "care circuits" The articles 11 and 107 of the Royal Decree of 19/09/2008 comprise the legal aspects to establish networks of care.

Article 11 describes the new concepts of "networks" and "care circuits". The aim is to ensure that the patient will receive the most appropriate care in the most appropriate service (continuity of care). Psychiatric hospitals will have the possibility to reallocate a part of the budget of the BFM and use it for the creation, on an experimentally base, of "networks" and "care circuits" (article 107). For this, psychiatric hospitals have to contract with the Federal Minister of Social Affairs and Public Health. It was decided by the Interministerial taskforce Public Health to limit the projects concerning the article 107 in the first phase to adults and adolescents aged 16 years and older.

This initiative is enclosed into the Hospital law, but can be considered as an initiative fitting in the trend towards the creation of networks of care and integrated care.

5.8.3. Funding mechanisms of the federated entities

5.8.3.1. Camhs financing: Mental health care centres

Flemish government

Flemish Mental health care centres (Centra voor geestelijke gezondheidszorg- CGG) are acknowledged by the Flemish Agency for care and health. This agency develops and implements the health policy of the Flemish community. It is part of the Flemish Ministry for Welfare, Public Health and Family.
The financing of Mental health care centres consists of a dual budget flow. The elementary funding is regulated through an agreement between the Flemish Government and the CGG. This agreement describes the policy and determines the financing-envelope and is valid for a three-year period. The content of the agreement consists of the general and specific goals; the activities assigned to the CGG; the results to pursue.

The financing-envelope covers the staff and operating costs. The magnitude of this part is negotiated between the Flemish Government and the CGG. For the year 2010, 81% of the staff costs were paid with these resources; some staff are paid by other resources, e.g. psychiatrists can

work on a self-employed basis as well (nomenclature). Two thirds of these resources are used to pay the psychiatrists, psychologists, and social workers.

Besides the elementary funding, the CGG can invoke additional financing regulated in the "Flemish inter-sector agreement" (FIA). These grants are assigned for management support, year-end bonus, and workforce pressure reduction.

French federated entities

The French speaking Mental health care centres (Services de santé mentale - SSM) are pertaining to the authorization of the Walloon Region. The acknowledgements and financing is regulated by the Decree of 3/04/2009.

The financing consists of a budget-envelope administered by the Walloon Government covering: staff costs; operating costs (an annual fixed budget); administrative costs (an annual fixed budget); a fixed budget for "liaison".

5.8.3.2. Financing of other sectors involved in children's mental health and well-being

From the point of view of integrated care, non-mental health care services can be involved in children's mental health and well-being. This can be services in the educational system, in the youth social care or in the disability sector.

Financing of the educational sector

Every year, the Communities receive a fixed financial contribution for education from the Federal State, which they can top up with their own revenues.

In the Flemish Community, schools communities or individual schools receive from the Flemish government one lump sum to pay their staff, including supportive services such as special-needs teachers. The schools community has a certain freedom to decide how the funds are divided. The role of the school communities is to stimulate scale-advantages. Supplementary funds are also available, e.g. for a special-needs care coordinator. In the French and the German-speaking Community, each organizing body receives his funds based on the number of pupils in his school(s). In the French Community, adapted financing is foreseen for children with "inclusive education" measures; the AWIPH also delivers and finances additional services. In the German-speaking Community, extra funds are available for support of pupils with special educational needs who do not qualify for special school education.

Youth welfare and disability sector: financing of services involved in mental health care

Table 5.4 and 5.5 provide an overview of these services.

Table 5.4 Social care and youth welfare sectors

Services or centres funded by the Flemish government	Services or centres funded by the French federated entities
Centres for general social work (centra voor algemeen welzijnwerk – CAW)	Centres for social services (Centres de service social)
Centres for integrated family care (centra voor integrale gezinszorg – CIG)	
Youth care services (bijzondere jeugdbijstand – BJB)	Youth care services (Services d'aide à la jeunesse - SAJ)
Child and family agency services (Kind&Gezin)	Child and family agency services (Office de la Naissance et de l'Enfance - ONE)

Table 5.5 Disability care sector

Services or centres funded by the Flemish agency for disabled persons – VAPH)	Services or centres funded by the French agency for integration of disabled persons - AWIPH
Medical pedagogical institutions (MPI)	Special education boarding or semi boarding schools (services résidentiels pour jeunes or SRJ; IMPs)
Observation and treatment centres (OBC)	
Short stay host centres (Kortverblijf)	Short stay host centres (répit)
Support services for parents (Thuisbegeleiding)	Services for early detection (Service d'aide précoce – SAP) and integration support services (Services d'aide à l'intégration – SAI
Centres for developmental disorders (Centra voor ontwikkelingsstoornissen – COS)	
Day care centres for youngsters with severe disabilities	Day care centres for youngsters with severe disabilities

A detailed description of the financing mechanisms of these services is beyond the scope of this study. It is however important to emphasize that these services will have their significance in a health care system of integrated care. This was also concluded in the KCE report n° 135 "Emergency psychiatric care for children and adolescents"[128]. The development and financing of collaboration models between the different providers, services and disciplines involved in (mental) health care of children and adolescents is required.

5.9. Intra- and inter-sector collaboration

It is difficult to list in a comprehensive way all initiatives and existing practices on collaboration within or between sectors involved in camhs. In daily practice, there can be ad-hoc collaboration for individual patients.

Some examples of structurally embedded collaboration that emerged during the course of this report are given below.

Examples of structural inter-sector collaboration:

- the Flemish integrated youth care;
- a nomenclature act for inter- (or intra-) sector consultation among professionals, led by the child psychiatrist (Nomenclature n° 109432/109454);
- integrated care supply (therapy) in the domains of camh care and educational support by the CAR/CRA;
- some generic inter-sector service offer at tier 1 (e.g. Kind&Gezin-ONE-Kind und Familie).

- outreaching support to staff of other agencies (CGG/SMM), or to teachers (CAR/CRA);
- liaison from K-services to pediatric wards;
- some care coordinating role for the autism reference centres and for the COS (Flanders); care coordinating role for Thuisbegeleiding, SAP/SAI, Frühhilfe/ Familienbegleitung;
- Flanders: Centres for expertise networks (SEN) for autism or mental retardation with behavioural problems.

Examples of structural intra-sector camhs collaboration in the health care sector:

- a nomenclature act for short evaluation by the child psychiatrist on demand of a GP or medical specialist (Nomenclature n° 109410);
- projects for outreaching to difficult to reach patients, a collaboration between federal and federated care structures;
- a care circuit for FOR-K and IBE, including inpatient, crisis- and outreach support; and involving a care coordinator (FOR-K);
- the consultation platforms, consulting with the mental health care organizations in their region to optimize the diversity and complementarity of care supply;
- Walloon Region: Reference centres for mental disorders: coordination between SSM and other mental health care providers (to be established)

5.10. Needs assessment, workforce training, knowledge development

Some data are used to inform the Governments at the federal and the federated level on the use of mental health care services, e.g. the Minimal psychiatric data (MPD) (Minimale psychiatrische gegevens MPG, Résumé psychiatrique minimum RPM)[oooo] at the federal level. However, there is no comprehensive system of data collection in place that specifically aims at and is used to drive mental health services planning for children and adolescents, across the different governments and sectors.

Outcome measurements collected at the patient level with the aim to inform the Government and stakeholders on the effectiveness of the care system are not performed in a systematic way.

Workforce training for camh professionals after graduation is mainly a responsibility of the professional associations and is not legally specified, with exception for the child psychiatrists. Clinical psychologists are not yet recognized as a health profession.

Several institutes are involved in knowledge development in the field of camhs, among others the VVGG (Vlaamse vereniging geestelijke gezondheid), the IWSM (Institut Wallon pour la santé mentale), as well as other research teams often linked to a university.

Key Points

- **In Belgium, health care policy, including mental health care policy, is partly a responsibility of the federal Government and partly of the federated entities (three regions and three communities).**
- **In the mental health care sector, several joint initiatives have been taken by the federal Government and the federated entities, e.g. projects to promote care networks and care circuits.**
- **In Belgium, camh policy is mostly part of the global mental health care policy, children and adolescents are included as target group by age. Separate camhs initiatives have also been taken (e.g. FOR-K project).**
- **At the same time, camhs are in Flanders also part of the integrated youth care including youth social and disability care, education and camhs (mainly CGG, Mental health care centres). All these domains are under the responsibility of the Minister of Welfare, Public Health and Family. The integrated youth care aims at regional networking between services, and at the creation of a single central entrance to intensive care services; the process of change is still going on.**

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http://www.health.belgium.be/eportal/Healthcare/Healthcarefacilities/Registrationsystems/MPD(MinimumPsychiatricData)/657855_NL?ie2Term=MPG&ie2section=83; KCE report n° 144 at www.kce.fgov.be

- **Informally, 4 tiers are recognized in camhs organization; these tiers have not been officially defined. Tier 2-4 are specialized camhs.**
- **So far, there is no clear health policy emphasizing and supporting that primary care or frontline services should also provide generic first tier camh care.**
- **Tier 2 comprises specialized ambulatory services, tier 3 inpatient hospital services, and tier 4 highly specialized services by university hospitals.**
- **Specialized camhs are provided by a diversity of service types, which can have a substantial overlap in their target population, e.g. K-services and some types of NIHDI-conventions. Accordingly, funding mechanisms are diverse; some services have been funded for a long time yet as (temporary) projects.**
- **Special target groups exist: Forensic care circuit FOR-K (project), Care circuit intensive treatment of aggressive behaviour or conduct disorder IBE (project), Autism reference centres, pediatric Liaison, Early parent-child interaction centers. Less frequent: Addiction (1 service), Mild mental retardation (1 service). Camh emergency service organization is under development.**
- **With a few exceptions, access to all camhs is free, in line with the general Belgian health care policy (no mandatory gate keeping).**
- **Some examples of structural inter-sector collaboration are:**
  - **the Flemish integrated youth care;**
  - **a nomenclature act for inter- (or intra-) sector consultation among professionals, led by the child psychiatrist;**
  - **integrated care supply in the domains of camh care and educational support by the CAR/CRA;**
  - **outreaching support to staff of other agencies (CGG/SMM), or to teachers (CAR/CRA);**
  - **some care coordinating role for the autism reference centres and for the COS (Flanders);**
- **Some examples of structural intra-sector camhs collaboration in the health care sector are:**
  - **a nomenclature act for short evaluation by the child psychiatrist on demand of a GP or a medical specialist;**
  - **projects for outreaching to difficult to reach patients, a collaboration between federal and federated care structures;**
  - **a care circuit for FOR-K and IBE, including inpatient, crisis- and outreach support; and involving a care coordinator (FOR-K);**
  - **the consultation platforms, consulting with the mental health care organizations in their region to optimize the diversity and complementarity of care supply**
- **The disability sector has an elaborated support system for children with severe behavioural or emotional disorders; in these centres staff trained in camh care is at work. Further collaboration with camhs is mostly ad hoc for individual cases.**
- **The educational sector has an elaborated system of specialized educational services for children and adolescents with behavioural disorders, within mainstream and within special schools. Collaboration with camhs is mostly ad hoc for individual cases (through the CLB/ CPMS).**
- **Some knowledge centres develop and disseminate evidence-based knowledge on youth care and youth mental health care.**
- **Workforce requirements for camh specialist are not leagally specified, with exception for child psychiatrists**

6. INTERNATIONAL OVERVIEW

6.1. Introduction

The focus in this international overview is on general organizational principles in child and adolescent mental health care, but also on integration of care systems and on recent reforms. First, an overview of these topics is given for the Netherlands, Canada (British Columbia only, see further), and England (UK). Next, a short description of an interesting experiment, conducted in Nord-Pas-de-Calais (France) is presented. Finally, an overview table of the most important items of the Netherlands, Canada (British Columbia) and England is given, comparing these items to the Belgian situation (see paragraph 6.6).

6.1.1. General methodological considerations

The present section is of a descriptive and explorative nature. Given the time frame for this study, only a limited number of countries are dealt with. The aim is not to be exhaustive, but rather to give a global overview of the most important policies and practices in these countries. For in-depth information, the interested reader is referred to relevant sources for further reading (see Appendix 6 to 8).

For many aspects that contribute to the overall picture of the organizational system, only elementary information could be found. E.g., in all countries studied, it proved difficult to find figures delineating the target population and quantifying its needs. E.g., it proved difficult to assess the processes of change in the past or ongoing reforms. Methodologies other than the ones used in this report, e.g. interviews of key persons at stake in the reforms, might be more apt to discover underlying motivations for specific choices.

It is also important to notice that the results of this international overview, rely on information from grey sources and information from a limited number of contacted experts. Inherently to this methodology, a possible bias cannot be excluded. Nevertheless, the results of this section can give an overall impression of what is going on in some other countries in the field of camhs and its neighbouring sectors.

6.1.2. Structure of the next sections

In the sections of the Netherlands, Canada (British Columbia) and England, care supply within the health care system is analyzed in detail. However, multiple agencies within the domains of education, youth social care, developmental disabilities, and juvenile justice are involved as well in the provision of child and adolescent mental health care. It is beyond the scope of this report to describe each sector in-depth. Therefore, when analyzing the organization of integrated services in the selected countries, only the highlights of the adjacent sectors are addressed in order to understand their role in organizing integrated and well coordinated mental health care.

The results of the search process have been worked out in the following topics for these 3 countries:

- country profile and general overview of the health care system;
- child and adolescent mental health policy: policy plans and inter-sector collaboration at the policy level;
- camhs organization in the health care sector;
- neighbouring sectors;
- intra- and inter-sector collaboration at the services' and patient's level;
- needs assessment, workforce traning, knowledge development;
- key-points.

The paragraph on Nord-Pas-de-Calais (France) includes some highlights on the French health care system, followed by a description of the experiment conducted by l'EPSM Lille-Métropole.

The reader will notice that little quantitative information has been included. First of all, it proved difficult to find reliable and/or readily available numeric information in the domain of this report (except for England), given that exploration of primary data sources was beyond the scope of this report. Second, if data were found, it often proved even more difficult to identify the precise inclusion criteria, definitions, regional or time boundaries, or contextual factors influencing these figures. This implicates that it would be almost impossible to make a valid comparison with data from other countries, e.g. Belgium. Therefore, only the most essential data are

mentioned in this report, and also for these data the reader is warned that the full context should be taken in consideration for interpretation.

For this part of the report, no new information has been included after July 1st 2011. References to the source documents used in this part of the report can be found in Appendix 6.

6.2. he Netherlands

6.2.1. Country profile

The Netherlands is a constitutional monarchy with a parliamentary system. It has a total population number of 16.6 million (2011), of which about 3.5 million are less than 18 years of age. The territory of the Netherlands is about 41500 km², divided into twelve provinces and 430 municipalities.

6.2.2. Dutch health care system

The health care system in the Netherlands is rooted in the Bismarck social insurance model, and can be divided into preventive care, primary care, secondary care (including several tiers), and long-term care (after one year of illness). The Ministry of Health, Welfare and Sport has the overall responsibility for the health care system. It shares this responsibility with the municipalities for preventive care. For primary and secondary health services, the Health insurance act (Zorgverzekeringswet, ZVW, 2006) makes health coverage statutory for everybody. The system is a private health insurance with social conditions, operated by private health insurance companies. Insurers are at the same time responsible for "buying" health care from health care providers; they must provide a standard benefits package, but they are free to offer additional services. Long-term care, i.e. care for illnesses or disabilities that last more than one year, is defined under the Exceptional medical expenses act (Algemene wet bijzondere ziektekosten, AWBZ). Care offices (zorgkantoren) are responsible for organizing care by "buying" services from providers; services are funded directly by the Government. An independent agency, the Centre for needs assessment (Centrum indicatiestelling zorg, CiZ) decides whether one is entitled to receive a certain reimbursement or not.

6.2.3. Child and adolescent mental health policy: policy plans and inter-sector collaboration at the policy level

The Netherlands have a clearly defined camh policy, which is part of a general youth care policy. In 2005, the Netherlands introduced the "Youth care act", a specific national policy for children and adolescents, unifying the policy for youth social care, for camhs, and for children and adolescents with a mild intellectual disability. All these domains are currently under the responsibility of the same Ministry: the Ministry of Health, Welfare and Sport, which probably facilitates the development of a common policy. For some aspects of youth social care, there is a close collaboration with the Ministry of Security and Justice. In the past, there has been a short period (2007-2010) that one Ministry was responsible for coordinating all policy issues related to children, adolescents, and families; it integrated these issues for the Ministry of Health, Welfare and Sports; the Ministry of Security and Justice; the Ministry of Education, Culture and Science; and the Ministry of Social Affairs and Employment. However, this Ministry of Youth and Families has been abolished by the new Government as of October 2010.

Notwithstanding the existence of a joint policy for camhs, youth social care, and care for children and adolescents with a mild intellectual disability, specialized camhs is still a part of the health care sector from the point of view of financing and basic organizational principles. This has major consequences for the practical implementation of the policy (see below).

Since 2005, subsequent policies and policy plans further elaborated the Youth care act. These policies all put strong accents on child and family-oriented services, and on breaking down walls between different sectors. Because of ever increasing demands on specialized services of camh care and youth social care, prevention and primary care are also considered to be very important, as well as empowerment of the parents as natural caregivers of the child. Other highlights are the quality of the "environment of the child" (the "civil society" or the educational surrounding in which the child grows up) and the coherence of care that should be guaranteed.

6.2.4. Camhs organization in the health care sector

Policy in the Netherlands used to be implemented in a strong top-down way, whereby the Government directly steered the system. However, recent evolutions in health and social care devolve some responsibilities, e.g. to the health insurers and health care providers, and to the provinces and municipalities, as will be clear from further explanations (WHO HiT report Netherlands 2010[pppp]).

6.2.4.1. Three tiers of camhs; gate keeping

Within the mental health care sector, camhs are clearly described as a separate subdivision: the "youth circuit". Three tiers are recognized.

First tier camhs is provided by primary care professionals broadly qualified in health or youth care, like general practitioners (GPs) or primary care psychologists who are both financed within the health care system. Also, as of 2012 every municipality will be responsible for the organization of a Youth and family centre (Centrum voor jeugd en gezin, CJG). These centres will be responsible for preventive actions but should also provide first line advice and help for all types of health and social problems including mental health problems; finally they should coordinate collaboration between care providers. Other primary care services are the ZATs or school care and advice teams, which under the shared responsibility of the educational system and the municipalities, facilitate collaboration between schools and youth care professionals e.g. for mental health problems, in order to help or refer at an early stage. In recent years, many efforts have been made to strengthen first tier camhs.

Second tier camhs are specialized mental health care services for complex and severe mental health problems; outpatient as well as inpatient care are mainly offered by the youth departments of 32 large mental health centres and 9 child and adolescent psychiatric institutions. These centres and institutes are regionally embedded and often have local divisions. Some child psychiatrists and psychotherapists offer services in private practices. Camh emergency services are available. However, since the introduction of more market-oriented principles by the new Health insurance act (ZVW, 2006), these regional centres seem to become subjected gradually to change and more private care providers are emerging. In second tier camhs, 95% of care are outpatient services; nationally there are about 5 inpatient places in use for each 10000 inhabitants (0-18years).

At the third tier, highly specialized mental health care is provided for extremely complex disorders; it is a small care segment mainly situated at university hospitals.

For the whole Dutch health care system, there is a formal gate keeping system by the GP for access to the second or third tier, which means that besides a few exceptions, access is not possible without referral from the GP. For camhs, this gate keeping occurs through the Youth care agency, or through a GP, primary care psychologist or medical specialist. The Youth care agency, launched after the publication of the 2005 Youth care act, is mainly an assessment and referral service, offering a joint access point to second tier camhs or (non-compulsory) youth social care, or second tier care for children and adolescents with a mild intellectual disability (e.g. specialist disability care). It is financed by the Government at the provinces' level. Youth care agencies also participate in first tier services e.g. the CJGs and the ZATs, which facilitates collaboration at this level.

6.2.4.2. Specific target groups

Specific target groups exist within the specialized mental health care system; for these groups services tailored to their specific needs are developed. The most important targeted services belong to the following domains:

- Compulsory mental health care

Most mental health hospitals for children and adolescents have some places for compulsory care under the "Act on compulsory mental health care" (Wet bijzondere opnemingen in psychiatrische ziekenhuizen, BOPZ). This law only applies when a person is a danger to him-herself or the environment, due to a psychiatric disorder; an order of the Children's judge is necessary.

- Forensic care (see further)
- Ortho-psychiatric care

[pppp] www.euro.who.int

Non-compulsory, ortho-psychiatric care for severe conduct problems in combination with psychiatric problems (9 wards, with an inpatient capacity for 180 youngsters, and outpatient care). The development this type of care is supported under the Health insurance act (ZVW), additionally to the existing specialized camh services. Camhs in these institutes is embedded in the regular care supply, but if necessary, there is also collaboration with external specialized camh services.

- Addiction

Eight clinics (300 beds) within the youth circuits specifically accept young people (<18 yrs) with addiction problems, but they can also be treated in general addiction services.

- Care for young people with a mild mental retardation ("LVG-jongeren", IQ 50-85) and behavioural problems

Many of these persons suffer from important mental health problems and specific programs exist within the youth circuits for this target group.

6.2.5. Neighbouring sectors

An overview of the different sectors providing services for children and adolescents, can be found in Appendix 6 (Table 5 of Appendix the Netherlands: Additional documents).

6.2.5.1. Youth social care

Traditionally, youth social care has been active in the field of socio-educational support for socially vulnerable families, protection for children or youth in danger and resettlement of youth after criminal acts. Although not all children and adolescents in this sector have mental problems or disorders, these problems are commonly found among this population (see 5.4.2).

First tier youth social care is freely accessible and the main service providers are mostly the same as for first tier camhs. Second tier or specialized youth social care is only accessible on indication by the Youth care agency. It is funded by the national Government through the provinces, which commission services from mostly private care providers. It can be non-compulsory care in case the family or youngster seeks and/or accepts help; examples are intensive family support, foster care (pleegzorg), or institutional care (jeugdzorginstellingen). If necessary, the Youth care agency can make a referral to specialized camhs at the same time.

When secure child development cannot be guaranteed by the child's family but non-compulsory care is not accepted by the family, or when due to behavioural difficulties the child or adolescent would risk to endanger himself or his environment, the Children's judge can impose compulsory care. In this case, and if no criminal act has been committed, possible youth protection measures (jeugdbescherming) can be guardianship (voogdij), a supervision order, or a closed youth institution; all these measures are executed within the youth social care sector. In closed youth institutions, educational support is embedded in the regular care supply. Also mental health care can be embedded to a certain degree in the regular care supply, but usually there is ad-hoc collaboration with external specialized camh services if necessary.

In case of criminal acts (12-18 years), the Children's judge can impose resettlement measures (jeugdreclassering), which are executed within the youth social care sector. The Judge can also impose a real punishment to the youngster but these measures are executed under the responsibility of the Ministry of Security and Justice.

6.2.5.2. Juvenile justice

Juvenile justice belongs to the responsibility of the Ministry of Safety and Justice.

There are 2 main action domains. The first is compulsory youth protection, imposed by the Children's judge, and if no criminal act has been committed, executed under the responsibility of the youth social care sector (see before). The second pertains to youth (12-18 years) that committed a criminal act. If the Children's judge imposes resettlement measures after criminal acts, the measures are also executed by the youth social care sector. If the youngster receives a real punishment, he can be sent to one of the 12 custodial youth institutions (JJI, justitiële jeugdinrichting). The Ministry of Security and Justice is responsible for organizing and financing of the custodial youth institutions. If specialized camh services are to be offered in these institutions, they "buy" these specialized "forensic" services from health care suppliers.

Some of the custodial youth institutions have specialist services for:

- young people in psychological crisis: Forensic observation and guidance (FOBA);
- young people suffering from mental retardation (LVG) (IQ between 55-80);
- young people in need of additional care due to psychiatric disorder or personality disorder: Very intensive care service (VIC);
- young people suffering from severe sexual behaviour problems;
- young people in need of individual guidance (ITA): for those who are unable to function in a social group.

6.2.5.3. Long term or disability care

Care for people with long-lasting illnesses (more than one year) or with disabilities is defined under the Exceptional medical expenses act (AWBZ, see before). It comes under the government of the Ministry of Health, Welfare and Sport. For children and adolescents, an indication to benefit can be set by the CiZ (see before), or, for indications in the domain of the joint Youth care act, by the Youth care agency.

There exists a large service offer for children and adolescents with mental health disorders that are in need of long term care, e.g. children with autism or children with acquired brain injury and behavioral problems. Typical AWBZ indications can be specified as “treatment”, “nursing”, “accommodation”, “provision of daytime supervision” etc. Mental health care can be delivered within the indication “treatment”.

A specific service within the domain of disability care is the MEE agency. For all age categories, MEE provides independently information to and assists parents for all types of problems. Specifically for children up to 4 years of age, the MEE agency provides case management and coordinates the different services that the child and the parents need (see further).

6.2.5.4. The Education system

The overall responsibility of the Education system belongs to the Minister of Education, Culture and Science. Current policy, as supported by legislation, places emphasis on educating children with special educational needs alongside their peers in mainstream schools, whenever possible. The teacher can be supported e.g. by the school’s special needs coordinator or by teachers from special schools (“peripatetic supervision”). Four specific categories of special educational needs are recognized by the Government, and the school can get additional financial support if necessary: autistic children; children suffering from ADHD; dyslexic children; gifted children.

For those children who need special education outside the mainstream system, “special schools for primary education” provide teaching for children with learning difficulties with or without behavioural difficulties, or for pre-school children with developmental difficulties. These schools fall under the same legislation as mainstream schools.

For children with very severe problems who cannot cope in the two educational systems mentioned above, Regional expertise centres (RECs) have been set up under a separate legislation. RECs are consortiums of special schools and secondary special schools within a certain region. One category is for pupils with behavioural disorders; severely maladjusted children, chronically sick (psycho-somatic) children and pupils in “paedological” (pedagogic) institutes (category 4); the other categories are: visually handicapped pupils; hearing-impaired pupils and pupils with severe speech disorders; physically, mentally (IQ<55) and multi-handicapped pupils and chronically sick pupils.

Pupils for whom a special educational need is suspected, be it in be a mainstream or a special school, need an indication for it by a regional independent agency (commissie voor indicatiestelling, CvI). If a special school is indicated, the parents receive a funding, assigned to the pupil, to choose between education in a mainstream school with additional support paid by the funding, or care within special educational settings. (This is called ‘leerlinggebonden financiering’, 'pupil-bound budget’ or “financial backpackage”). At this moment, new legislation is being prepared, which would dramatically change the current situation; one proposal is to abolish the 'pupil-bound budget’.

6.2.6. Financing and funding of camhs

The benefit package of the basic health insurance (ZVW, see before) includes ambulatory and inpatient mental health care for the first year. Reimbursement of psychologists is included in the basic package. Medical specialists and inpatient care are funded through the Diagnosis Treatment Combinations (DBC) system; within the mental health care DBCs, there are “treatment” and “stay” groups. In 2009, 145 treatment groups and 70 stay groups were established.

Long-term care providers (after 1 year of illness, AWBZ) are paid according to care intensity packages (zorgzwaartepakketten). For long-term inpatient mental health care, 13 care intensity packages have been defined. The actual payment of the AWBZ benefit depends on whether the person with an indication receives the care in-kind (natura), or whether he chooses a personal budget (PGB, persoonsgebonden budget). In the first case, the Governmental care offices pay the care provider directly, in the second case the person with an indication himself pays the provider.

6.2.7. Intra- and inter-sector collaboration

6.2.7.1. Collaboration at the level of the local services

Intra-sector collaboration

In the Netherlands, it belongs to the tasks of specialized camh professionals to advice, support and assist first tier camh professionals.

Inter-sector collaboration

The Youth care agency coordinates access to specialized services of different sectors, and has to play an important role in inter-sector collaboration at the diagnostic and orientation phase of the care process. Patients with different types of problems can be oriented towards one or more services of specialized camhs, specialized (non-compulsory) youth social care or specialized care for persons with a mild mental disability, or can be re-oriented to first tier care. Although the educational sector is not explicitly involved in the Youth care act, referral to specialized educational services is possible but access cannot be claimed.

The Youth care agency participates in the CJGs and the ZATs, which facilitates collaboration at the first tier of care. At this level, the CJG should also play a role in care coordination between different care providers, as of 2012. Also the ZATs can take this role if necessary.

Inter-sector collaboration between the specialized services of the different sectors (e.g. between specialized camhs and specialized youth social care for instance foster care) is ad–hoc for individual cases by their caregivers or by social assistants; coordinating care elements are not structurally embedded. One exception is the MEE agency. This agency provides case management for young children up to 4 year of age and their parents, when confronted with disability or chronic illness, e.g. motor handicap, autism. The MEE agency coordinates the different services involved in early intervention and care, e.g. child rehabilitation, hospital care, home care, etc.

6.2.7.2. Collaboration at the level of the patient

Intra-sector collaboration

Specialized camhs is mainly organized by the youth departments of large mental health centres and institutions. In the Netherlands, large regionally embedded integrated mental health facilities emerged since the 1990’s including services for adults as well as for children. These facilities offer a comprehensive spectrum of integrated inpatient and outpatient mental health care services. Only little information is available on the precise components and care delivery processes. It is generally assumed that their unique financing system (mental health care used to be a separate sector that was financed completely through the system of long term care (AWBZ)) contributed a lot to the ease and success of service integration. They continue to have an important influence on the organization of mental health care, although their unique financing system was abolished in 2008 after the introduction of more market-oriented principles by the new Health insurance act (ZVW, 2006); the effects of this measure remain to be evaluated. In some youth departments, the influence of the integrated care supply system can still be noticed.

Inter-sector collaboration

At the first tier level, advice and support are generic and often inter-sectorial in nature, and the main service providers are often the same for general health care, camhs, youth social care, educational support etc. Inter-sector care supply is one of the key features at this level.

Another element that contributes to inter-sector collaboration at the patient level, is the "Reference index for youth at risk" (Verwijsindex Risicojongeren, VIR). This is a national electronic signposting system, introduced in 2009, that brings together risk signals of youth (up to 23 years), as reported by social workers. It aims to stimulate collaboration within the network of services and it is compulsory for the Youth and family centres, the ZATs and the Child protection services of the Youth social care sector.

6.2.8. Needs assessment, workforce training, knowledge development

The VIR (see before) can be used to add to the global view on what are the real care needs at the population level. Although some other data are used to inform the Government on (health) care needs, there is no comprehensive system of data collection in place that specifically aims at and is used to drive (mental) health services planning; rather, market-driven principles influence health care supply. Outcome measurements collected at the patient level with the aim to inform the Government and stakeholders on the effectiveness of the care system are not performed in a systematic way.

Workforce training for camh professionals after graduation is mainly a responsibility of the professional associations.

Several knowledge centres, e.g. the Netherlands Youth Institute (NJI), the Trimbos institute and the National knowledge centre for child and adolescent mental health care (Landelijk Kenniscentrum Kinder- en Jeugdpsychiatrie), are involved in development and dissemination of evidence-based knowledge on youth care and youth mental health care.

6.2.9. Main criticisms

All 4 experts provided additional information to improve the content of the draft; 2 experts also expressed their overall evaluation, mainly criticisms, on the system in their country.

6.2.9.1. The joint policy for camhs, youth social care and mild intellectual disability

The main criticism concerns the joint policy introduced by the Youth care act. Although camhs is one of the sectors included in this policy, together with youth social care and care for children and adolescents with a mild intellectual disability, specialized camhs is still a part of the health care sector from the point of view of financing and basic organizational principles. This includes e.g. that main financing is through private health insurers who are, within the borders of some social corrections, susceptible to market principles. By contrast, youth social care is directly and fully financed through the Government, at the level of the provinces and the municipalities. Another difference is that youth social care must be provided within a certain time limit once a child has received an indication for this care, a rule that is not applicable to camhs. According to the experts, these and other differences hamper the practical implementation and lead to integration difficulties between the different partners included in the joint policy. The same point of view has also been found in several reports (see Appendix) retrieved in the grey literature. These reports stipulate that the Youth care act has been mostly positively evaluated and contributes to a more efficient collaboration within the traditional fields of youth social care. However, many difficulties have arisen in the other sectors with regard to the implementation of the new rules. Besides the cultural and organizational difficulties between the different sectors, the competences of the Youth care agency in putting the right diagnoses and care indications within the different domains are debated. The Government prepares solutions for these problems, and already suggested to transfer all financing for the sectors under the joint policy to the level of the municipalities, who would become responsible for commissioning of care. Camhs would then be taken out of the health care sector and put under the municipalities, together with (non-compulsory) youth social care and the preventive sector. However, this is heavily contested, not at least by the child psychiatrists, child psychologists, and other camh workers, who don't agree to tear camhs apart from the rest of mental health care, and from the health care sector as a whole.

One of the consulted experts expressed it as follows:

"The legal situation as described in papers, e.g. the tasks of the Youth care agency, is not how it works in reality... The idea that organizing one entrance gate with a mandatory entrance ticket, gives control over the influx to care and gives a good evaluation of care needs, has been abandoned in the Netherlands since a long time. It rather creates a separate cost…. It is currently debated whether the Youth care agency

should be continued or not…. As demonstrated in the study of van den Berg et al (2009)[qqqq], many young people find the care they need in the current system, but for a small group with multiple problems it is not possible to find the right combinations of care… To serve this small group, several solutions are possible that are less far-reaching than changing the whole system… It is difficult to find good publications on the discussion that is currently going on, especially because it is complex and because nobody has found yet the right solution." The expert also refers to another report (2009)[rrrr], which concludes that more inter-sector collaboration is possible within the existing legal and financial structures although further harmonization of these structures might have a facilitating role. At the same time this report states that collaboration is a bottom-up process and has to be realized mainly in the minds of the professionals by creativity, endurance and adjustments in culture and competences; the latter attitudes should be encouraged and developed.

6.2.9.2. The bureaucracy of the system

The same expert also refers to another essay[ssss] that contests the global bureaucracy of the system, not at least by the way the Youth care agency currently works. It is also very critical for the CJG (Centra voor jeugd en gezin), that are named "soft" and "adding to the bureaucracy instead of really delivering care". In the same essay, it is stated that a new equilibrium has to be found between several break-points:

- Supporting civil society / professional care
- Delivering care in the family (outreach) / institutionalisation (out of home placement, clinics)
- Generalist / specialist care
- Professionals' judgement / political-administrative judgement (e.g. indication Youth care agency)
- Collective prevention / curative care

Key-points

- **The consolidation of all policy initiatives for children and families under one Ministry of Youth and Families, has been abandoned by the 2010 new Government.**
- **Since 2005, one national policy has been introduced unifying the policy for camhs, for non-compulsory youth social care, and for children and adolescents with a mild intellectual disability. All these domains are currently under the responsibility of the Ministry of Health, Welfare and Sport.**
- **There are 3 clearly defined tiers in camhs.**
- **Tier 1 can be provided by GPs, primary care psychologists, Youth and family centres (CJGs), school care and advice teams (ZATs) etc. Advice and support at this level is generic and often inter-sectorial by nature. The national policy plan puts a strong accent on tier 1 and on prevention.**
- **Tier 2 and 3, or specialized camhs, is a separate subdivision of the mental health care sector, defined as the "youth circuit". Many aspects of its policy are defined independently from adult and elderly mental health policy.**
- **At tier 2, regionally embedded inpatient and outpatient centres provide care, sometimes integrated. There are some private practices of child psychiatrists and psychotherapists. Small highly-specialized tier 3.**

qqqq "Combinaties van zorg bij jeugdigen. Rapport. Yorick van de Berg, Carlo Hover, Peter van der Loos, Yermo Wever. Den Haag, 20 april 2009. B&A Consulting bv." http://ikregeer.nl/documenten/blg-21265

rrrr Jeugdzorg: samen sterk! Van Ojen Beleidsonderzoek. Beverwijk, 31 juli 2009. www.rijksoverheid.nl

ssss Een betere zorg voor jeugd. Decentralisatie van de jeugdzorg als kans. May 2011, Drs. Steven P.M. de Waal, PublicSpace, for GGD Nederland. www.publicspace.nl; www.ggd.nl

- **Several special target groups exist: Compulsory mental health care, Forensic care, Ortho-psychiatric care, Addiction, Mild mental retardation. Camh emergency services are universally available.**
- **The Dutch health care system is characterized by a formal gate keeping system for access to 2nd and 3rd tier care. Likewise, access to specialized camhs is limited; gate-keepers are GPs, primary care psychologists, medical specialists and the Youth care agency. The latter coordinates access to specialized services for all the sectors under the joint policy (2005).**
- **The Youth care agency also participates in the CJGs and the ZATs, which facilitates collaboration at the first tier of care.**
- **The common entrance door to specialized youth social care and specialized camhs, the Youth care agency, assures that a child can get a referral to both types of services at the same time.**
- **Direct collaboration between specialized youth social services and specialized camhs is mostly ad hoc for individual cases.**
- **Within the sector of juvenile justice, a neatly differentiated system of forensic care supply exists, financed by the Ministry of Safety and Justice who "buys" these services from health care suppliers.**
- **Within the disability care sector, which belongs to the health care system, a large service offer exists for mental disorders that need long term care (> 1 year). Entrance is by the Youth care agency or by the CiZ, the general access point to the disability sector. For children < 4 years of age, case managers of the MEE agency provide intra- or inter-sector care coordination.**
- **The educational sector has an elaborated system of specialized educational services for children and adolescents with behavioural disorders, within mainstream and within special schools.**
- **The joint policy (2005) does not apply to the educational sector, but through the ZATS there is some collaboration with the Youth care agencies. Direct collaboration between specialized educational services and specialized camhs is ad hoc for individual cases.**
- **Several knowledge centres develop and disseminate evidence-based knowledge on youth care and youth mental health care.**
- **Main criticisms are on the practical implementation of the joint policy. Adjustments proposed by the Government are heavily debated.**

6.3. Canada (British Columbia)

6.3.1. Country profile

Canada is a federation that is governed as a parliamentary democracy and a constitutional monarchy. The official languages are English and French. There are ten provinces and three territories. Given the geographical location of the territories in the very north of the country, which makes comparison to the Belgian context difficult, they will no further be mentioned. The provinces have jurisdiction over most of Canada's social programs (e.g. health care, education, and welfare). To finance these programs the provinces extract their own taxes but also receive "transfer payments" from the federal Government. As a consequence, the federal Government can theoretically use these transfer payments to influence these provincial areas.

A recent policy analysis in Canada revealed that only four provinces have a Child and adolescent mental health policy and (or) plan[22]. Alberta, Ontario and Saskatchewan released their plan in 2006. British Columbia was, in 2003, the first province to release a child and adolescent mental health plan and continues to be a leader in child and youth mental health programming and services. Therefore, we will limit the study to the federal level and British Columbia.

British Columbia has a surface area of about 944700 km². It has an estimated population of 4.5 million inhabitants, which is 13% of the total population in Canada (34.3 million). Aboriginals are distinct groups having

unique heritages, languages and culture (First Nations, Inuit and Métis). In Canada and British Columbia, 3.8% and 4.8% respectively, identified themselves as an Aboriginal person. In Canada, the age of majority is determined by each province and territory. The threshold of adulthood in British Columbia is the age of 19. In 2010, the number of minors in British Columbia is estimated to be 970428.

6.3.2. Health care system

6.3.2.1. Health policy

In Canada, health policy is both a responsibility of the federal Government and the authorities at the provincial and territorial level. The federal approach to health care in Canada is under the jurisdiction of the Canada Health Act (1983) which identifies the conditions under which transfer payments will be provided. The federal Government is responsible for providing health data, research and regulatory infrastructure. It also directly finances and administers a number of health services including those for First Nations people living on reserves, Inuit, members of the armed forces, veterans, etc. The federal Government also funds and operates the Public Health Agency of Canada and some other bodies involved in various national health related activities.

The provinces are responsible for administration of public health care. However, they deliver few health services directly. In all provinces most health care services (hospital care, adult mental health care, nursing homes, some home care and community care) are administered by geographically based Regional health authorities. Regional health authorities receive global budgets from the provinces which they can allocate in a manner that optimally serves the needs of their respective populations.

The provincial and territorial Governments fund health care services with assistance from the federal Government in the form of fiscal transfers. In order to receive their full funding for health care, the provincial and territorial health insurance plans must meet the principles and criteria specified in the Canada Health Act. These criteria require universal coverage (for all "insured persons") for all "medically necessary" hospital and physician services, without co-payments.

Canada's federal, provincial, and territorial Governments collaborate on various health care policy and programming issues. The key vehicle for strengthening partnership and collaboration is the annual Conference of Ministers of Health where Canada's ministers of Health discuss a broad range of issues. Ministers of Health are supported by the Conference of Deputy Ministers of Health which holds regular conferences and meetings.

6.3.2.2. Financing and general healthcare organization

Canada has a Beveridge-type predominantly publicly financed health system. The Canadian health care system includes ten provincial and three territorial health insurance plans which cover the majority of health care services. The system, known as “medicare”, provides access to universal, comprehensive coverage for medically necessary hospital and physician services.

Health care services include primary health care (e.g. the services of physicians), and care in hospitals, which account for the majority of provincial and territorial health expenditures. In general, primary health care (e.g. family physicians, nurse practitioner) provides direct provision of first-contact health care services and coordinates patients health care services to ensure continuity of care and ease of movement across the health care system when more specialized care (e.g. specialists, hospitals) are needed. However, no formal gate-keeping system exists and there are variations in how primary health care is structured both across and within Provincial jurisdictions.

6.3.3. Child and adolescent mental health policy: inter-sector collaboration at the policy level and policy plans

In 2003, British Columbia was the first Canadian province to launch a comprehensive Child and youth mental health plan. The plan included a doubling of the camhs budget in the first five years of implementation. In 2006, the Canadian Senate published a report in which children’s mental health services were declared the most neglected piece of the Canadian health care system, “the orphan’s orphans”. In reaction on this, a national Canadian framework “Evergreen” was published in 2010 to support provinces in the creation or modification of their child and youth mental health policies and plans. Also in 2010, BC introduced a new cross-governmental 10-year mental health plan that encompasses children as

well as adults, and also encompassing both prevention and treatment. This new plan is actually considerably more comprehensive than the 2003 plan.

Responsibilities for the organization of camhs are mainly situated at the provincial level and there is variation amongst provinces in how these services are structured and funded. In British Columbia three ministries are involved (The Ministries of Children and Family Development; Health and Education) in camhs organization; the BC camhs plans attempt to coordinate efforts across these Ministries.

The **Ministry of Children and Family Development** is responsible for most community-based camh services. Also some juvenile justice services, e.g. youth forensic psychiatric services, are integrated in this Ministry. Finally, it clusters a variety of other responsibilities in the field of youth social and disability care, and in the field of childhood development and child care (i.e. child protection and family development; adoption; foster care; early childhood development and child care; youth services; special needs children & youth).

The **Ministry of Health** is responsible for public health programs, including prevention programs on mental health care. It is also responsible for primary care (e.g. family physicians), hospital services and programs, addiction services and adult mental health. Six health authorities are responsible for the organization of the health services. Five regional authorities serve geographic regions of British Columbia while the provincial health services authority ensures that residents of British Columbia have access to a coordinated network of high-quality specialized health care services (e.g. British Columbia Children hospital). The **Ministry of Education** is responsible for school based programs, including some prevention programs.

Key policy elements

The overall accent in BC camh policy papers is on the child and his family, who should be at the first place in care delivery. The accent is also on community based care, as expressed by the central role that is given to the Child and youth mental health offices (see further). Next, there is a strong focus on prevention, and the 15% of total camhs resources targeted for disorder prevention is 3 times higher than the overall 5% of the global health care budget spent to prevention. There is also a focus on an improved collaboration between primary care physicians and specialized camhs, to tackle the waiting lists for specialist mental health services. In adult mental health care, Canada has been a pioneer in developing models for collaboration between primary care physicians and specialized mental health care, called “collaborative care”.

6.3.4. Camhs organization in the health care sector

The organization of camhs in British Columbia is specified and regulated in the provincial plan. It is implemented at the level of the regional level, except for third tier care (see further) that is implemented at the level of the province. In 2010, a national framework has been released to support provinces in the creation or modification of their camh policies and plans.

6.3.4.1. Three tiers of camhs; gate keeping

In British Columbia three levels (“tiers”) of camhs are recognized. Specialist camhs are provided at tier 2 and 3.

First tier

Frequently, physicians (family physicians or paediatricians) are the first point of contact for families with a child with mental health care needs. These physicians can refer patients to more specialized services or remain the primary support for these patients. Other entry points into (mental) healthcare are tele-help lines, special education services, school counselors or teachers.

Second tier

Child and youth mental health offices are pivotal at the secondary tier. These community-based services, specifically addressing children and youth (0-18 years) affected by serious mental health problems and disorders, are publically funded by the Ministry of Children and Family Development, are freely accessible and are available free of charge. There is a network of around 120 local mental health offices, operated by the Ministry of Child and Family Development, and staffed by multidisciplinary teams (typically psychologists, social workers, counselors with graduate degrees, nurses and child psychiatrists). In addition, an extensive program of more than 130 contracted service agencies extends these programs by providing specialized and complementary mental health-related

community-based services. They offer a flexible way of responding to varying regional needs. While these services are funded directly by Ministry of Child and Family Development, they can be funded jointly with other ministries, and non-government sources.

The Child and youth mental health offices provide four types of services:

- early intervention: e.g. the "FRIENDS for Life" program, an early intervention and prevention program for anxiety disorders among elementary school children;
- assessment and treatment, including case management for care coordination;
- crisis response (short term therapy, resources and referral coordination);
- targeted community development: mental health education for other service providers (e.g. school counsellors, family physicians); currently often unavailable due to over-riding demands of direct clinical services.

Private psychologists can diagnose and provide psychotherapy but are not qualified to prescribe medication. These services are not covered by the Ministry, although they can be included in extended health benefit programs paid by employers. Also private (child) psychiatrist offices exist; referral through primary care is necessary. Their services are fully paid for by the Ministry of Health.

Regional Hospitals admit children and youth with severe mental health problems and mental disorders, based on a referral by a physician. They provide specialized inpatient and hospital-based outpatient mental health services. The emergency departments of community hospitals admit children and youth experiencing acute psychiatric problems. The Ministry of Health, through the regional health authorities, is responsible for these services.

Third tier

Third tier province-wide services are provided by the Ministry of Children and Family Development (i.e. Maples Adolescent Treatment Centre & Youth Forensic Psychiatric Services) and the Ministry of Health (i.e. British Columbia Children's Hospital Child and Adolescent Mental Health Programs).

The Maples Adolescent Treatment Centre targets psychiatric and behaviourally troubled young people aged 12 -17, as well as those found not criminally responsible due to a mental illness. It is mandated to provide residential, non-residential and outreach services to support youth, families and communities. Youth can only be admitted if they are referred by a regional Child and youth mental health office (including youth admitted in a hospital). To be eligible youth should have a Case manager, to coordinate care before and after admission to Maples. The maples programs provide a period of stabilization and intensive intervention followed by support for families/caregivers to implement a long-term community-based care plan. The 2003 BC camhs plan provided funding to allow the re-focusing of some existing resources from institutionally-based programs at the Maples to specialized community-based programs (e.g. multi-systemic therapy).

Youth Forensic psychiatric services provide court-ordered and court-related assessment and treatment services to adolescents aged 12 - 17 years old in need of services for mental health and/or behaviour problems. Only direct referrals from juvenile justice services are accepted. Outpatient services are provided throughout the province by 7 community clinics and a network of private contractors. Each clinic provides a full range of assessment and treatment services (e.g. specialized programs for sexual and violent offences). Inpatient services are provided by the Burnaby inpatient assessment unit which is a designated place of temporary custody. It is staffed by nurses, health care workers, psychiatrists and a general practitioner.

The **Child and youth mental health program at British Columbia Children's hospital** is a provincial resource providing mental health assessment and treatment for British Columbian and Yukon children, youth, and their families. The program includes both inpatient and outpatient clinical services to complement community-based mental health centres and regional hospitals by providing specialized consultation, outreach, and education services. All programs and clinics require written referrals from physicians. The inpatient programs only accept referrals from Child and youth mental health offices.

Gate-keeping

There is a formal gate-keeping role for access to third tier care, hold mainly by second tier camhs, namely the Child and youth mental health offices.

6.3.4.2. Specific target groups

Youth Day treatment programs target youth (aged 13 to 18) requiring intensive psychiatric treatment and an educational program; Child and youth mental health offices make referrals. The daily schedule includes a school session, group or individual therapy, and recreational activities. Youth Day treatment programs are a partnership between the Regional Board of Education, the Ministry of Child and Family Development and the Regional Health Authority.

Autism. A program of the provincial Health services authority (under responsibility of the Ministry of Health) is responsible for assessing and diagnosing children who may have autism, on referral of a physician. Once diagnosed with autism, the Ministry of Children and Family Development provides two Autism funding programs that assist parents in purchasing eligible autism intervention services (e.g. behaviour consultants).

Addiction. Specific addiction treatment services (e.g. outpatient/outreach services; intensive day treatment; residential programs) for youth in British Columbia are delivered by the five regional health authorities. In case of a dual diagnosis (i.e. addiction and mental illness) youth are typically referred over to Child and youth mental health offices. These programs are co-funded by both the Ministry of Children and Family Development and the Ministry of Health since the former is responsible for youth mental health and the latter is responsible for addiction services.

Other specific target groups are Youth Forensic psychiatric services (see before); mental health services for children and adolescents with intellectual disabilities (see further); some specific services for the Aboriginal community. The national Canadian framework advises a focus on transition to adulthood.

6.3.5. Neighbouring sectors

6.3.5.1. Child Welfare

The Minister of Children and Family Development is also responsible for policies, standards and programs, and for the overall quality of services provided to children and families in the domain of welfare and social care. This is regulated by the Child, Family and Community Service Act. The Minister designates the Director of Child Protection, with the responsibilities over adoption, child protection and guardianship services. A range of ministry staff (e.g. social workers) manage the service delivery system, and ultimately carry out the provision of services in the community (e.g. Child abuse team, Child protection manager, Rapid response team). These services are organized per region with a total of approximately 430 ministry offices and a number of delegated Aboriginal agencies.

Children are only removed from their homes when they are in immediate danger and nothing less disruptive can protect them. Whenever a child is taken away from their family for their own protection a court process starts. The Family Court judge decides about who the child will live with and under what circumstances. Children who cannot safely stay at home go to foster homes or residential care facilities.

6.3.5.2. Juvenile Justice

Since April 2003, the federal Youth Criminal Justice Act came into effect regulating the provincial juvenile justice systems. The primary objectives of the act that deals with youth aged 12-17 years were the reduction of custody of young offenders, the encouragement of community-based responses and the harmonization of youth justice in Canada.

In British Columbia, three ministries are involved in administering youth justice services – the ministries of Children and Family Development, Attorney General and Public Safety and Solicitor General. The Attorney General ministry is responsible for charge policy, criminal prosecution, provision of legal aid and court services. The Public Safety and Solicitor General ministry is responsible for police services, adult probation and correctional facilities. The Ministry of Children and Family Development holds responsibility for Community Youth justice services, Youth Forensic psychiatric services (see above) and Youth custody services.

Community Youth justice services are central in the juvenile justice services provision of the Ministry of Children and Family Development. A wide range of community services are provided to youth involved with the justice system. These services include extrajudicial sanctions, intensive support and supervision program orders, supervision in the community, reintegration leave from a youth custody centre, community-based non-residential and residential programs etc. Youth probation officers (approximately 130 in British Columbia), who work in multidisciplinary community teams, can refer youth to additional services (e.g. drug and alcohol programs, specialized residential treatment).

Youth Custody services, also under the Ministry of Children and Family Development, are responsible for youth who are sentenced to spend time in open or secure custody, or are detained pending trial. There are 168 places in three separate youth custody facilities. A number of programs are available for youth in custody, ranging from specialized programs such as mental health and addictions counseling, to specialized education and community reintegration programs intended to lower the risk for youth to re-offend when they return to their community. There are also 180 community residential beds (mostly family-based care) that are used as an alternative to detention or a custody sentence. Twenty-four of these beds are full-time program places to treat youth with serious addictions problems.

For many years, British Columbia has had a rate of youth incarceration substantially below the average rate in most other provinces. Average counts per day of youth custody in British Columbia have dropped from 400 youth in 1995 to 129 youth in 2007.

6.3.5.3. Disability care

In this domain, most information found within the short time frame of this study, was about people with intellectual disabilities. British Columbia closed all its institutions for people with intellectual disabilities during the late eighties. The Ministry of Children and Family Development undertook the responsibility for the resettlement of these services within the community. With the closure of institutions, specific health and social care protocols were developed between the Ministries of Health and of Children and Family Development.

One team per Health Authority provides specialized community mental health services for people aged 14 years and older with intellectual disabilities. These teams are multidisciplinary and consist of psychiatrists, mental health nurses, behavioural therapists/psychologists and neuropsychologists. Initially, these specialized teams were seen as temporary, only necessary until mainstream mental health services could take on this work. However, since the specific expertise that is required to care for people with intellectual disabilities and mental health needs, these teams are still active.

No specific mental health funding is allocated for children with intellectual disabilities under the age of 14 years. They are seen by the mainstream Child and youth mental health offices for evaluation and management. However, these services have little expertise in working with children with intellectual disabilities. Therefore, Child and youth mental health offices invested recently in specific intellectual disability training of their staff.

There are no dedicated psychiatric units for children and adolescents with intellectual disabilities. The Neuropsychiatry unit of British Columbia Children's Hospital sees some of these children. Also the local hospital's psychiatric unit can accommodate children with mild intellectual disabilities. However, these children do not well on these units, and there is a need for specialized inpatient beds for such complex, high needs children.

It is noted by Tang et al. (2008)[130] that British Columbia is still grappling with providing appropriate and sufficiently funded community based services for mental needs after closing institutions for people with intellectual disabilities in the late eighties.

6.3.5.4. Education

In British Columbia, the Ministry of Education has overall responsibility for the administration of education, defines educational standards and allocates funds to the 60 school districts. The school districts are responsible for the general organization, supervision and evaluation of all educational programs provided in their region, and for the operation of schools in the school district.

Most schools in British Columbia are public schools funded by the Ministry of Education. However, a network of private schools (including schools targeting children with learning disabilities) also exists. These private

schools are under certain conditions partially funded by the Ministry of Education.

British Columbia promotes, for its public schools, an inclusive education system in which students with special needs are fully participating members of a community of learners. Students with special needs, e.g. learning disabilities, mild intellectual disabilities, students requiring moderate behaviour supports and students who are gifted may require additional support (e.g. by a school counselor or learning assistance teachers) and accommodations to enable them to participate in mainstream educational programs. The emphasis on educating students with special needs in neighbourhood school classrooms with their age and grade peers, however, does not preclude the appropriate use of resource rooms, self-contained classes, community-based programs, or specialized settings. Students with special needs may be placed in settings other than a neighbourhood school classroom with age and grade peers, but only after all reasonable efforts to integrate the student remained unsuccessful. A formal system of special education schools does not exist in British Columbia, but supplementary funding recognizes the additional cost of providing programs for students with special needs in the following categories: dependent handicapped, deaf-blind, moderate to profound intellectual disabled, physically disabled/chronic health impaired, visually impaired, deaf/hard of hearing, Autism spectrum disorder, and intensive behaviour interventions or serious mental illness.

6.3.6. Financing and funding of camhs

In British Columbia, the community-based Child and youth mental health offices are funded by the Ministry of Children and Family Development through a global budget, but they can be funded jointly with other ministries and non-government sources. Child psychiatry services of regional hospitals, as well as addiction treatment services are funded by the Ministry of Health. Third level province-wide services are partly financed by the Ministry of Children and Family Development e.g. the Maples centre, and partly by the Ministry of Health, e.g. services at the British Columbia Children's hospital.

Private psychologists services are not reimbursed by the Ministry, but are often included in extended health benefits programs paid by employers. Private (child) psychiatrist services are reimbursed by the Ministry of Health Services, on a fee-for-service basis or on contract basis (global funding).

6.3.7. Intra- and inter-sector collaboration

6.3.7.1. Collaboration at the level of the local services

Intra-sector and inter-sector collaboration

Tier 2 and tier 3 professionals can advice and support tier 1 health care professionals (in Canada called "collaborative care", mostly involving GPs and (child) psychiatrists), or professionals of primary and specialized services at other sectors. However, this is currently often unavailable due to over-riding demands of direct clinical services.

6.3.7.2. Collaboration at the level of the patient

Intra-sector and inter-sector collaboration

At tier 2 and 3, case managers are at work for intra- or inter-sector care coordination at the patient level. At tier 3, integrated care services including inpatient, outpatient or outreach services are available. Some other examples of inter-sector collaboration at the patient level are available, e.g. collaboration between camhs and the educational sector at the Youth Day treatment programs, and some camh care provision in youth custody services. However, collaboration between camhs and services of neighbouring sectors, e.g. youth social care, is mostly poorly described.

6.3.8. Needs assessment, workforce training, knowledge development

In British Columbia, there is no specific assessment instrument in use to support evaluation of child and adolescent treatment needs. In the BC camhs plan, a regular performance measurement is recommended.

The Government does not set professional standards for post-graduate education; post-graduate continuing education is often provided by professional organizations. Training standards and packages are being developed, e.g. a primary care physician training program for identification, diagnosis and treatment of the most common child and youth mental disorders (ADHD; Depression; Anxiety Disorders). The initiative is lead by the British Columbia Medical Association in partnership with numerous

stakeholders from the Government, professional associations, and NGOs (non-governmental organizations).

Knowledge institutes e.g. CADTH (Canadian Agency for Drugs and Technologies in Health) and the Children's Health policy centre of the Simon Frazer University provide evidence-based guidelines. Also Canadian NGOs can be involved in disseminating scientifically-validated information about mental health, e.g. the NGO Teen Mental Health.

6.3.9. Main criticisms

Of the 4 experts invited to participate, 2 effectively returned their comments. These 2 experts provided additional information to improve the content of the draft; 1 expert also gave an overall appraisal of the system. This expert especially criticized the fragmented service implementation, meaning that services are unevenly spread across regions, provinces and throughout the country. A lot of initiatives are also provided by NGOs (non-governmental organizations), which receive some funds from the Government but don't have the same accountability to the Government as public services. This adds to the fragmented service supply. This expert also criticized the national framework which has to be worked out in the legislation of the provinces. A drawback is that nobody is responsible to implement the national framework, so that it can take long before it gets adopted by the provinces.

Key Points

- **Most services for children and families in British Columbia have been consolidated under one ministry, the Ministry of Child and Family Development. This Ministry encompasses youth social and disability care, juvenile justice, and many camh services. However, coordination with other camh services under the responsibility of the Ministry of Health, and with the Ministry of Education remains necessary.**
- **In 2003, British Columbia was the first province to launch a specific camhs policy and plan. In 2010, a national camhs framework was released. British Columbia introduced a new mental health plan in 2010, encompassing adults as well as children.**
- **The camhs plan includes large investments in prevention and mental health promotion.**
- **In British Columbia, there are 3 tiers in camhs; the role of primary care has been recognized at the first tier.**
- **Services are organized per region. Both the Ministry of Child and Family Development and the Ministry of Health organize services per geographical region (n=5). Tertiary care is organized at the provincial level.**
- **There is a strong accent on ambulatory, community delivered tier 2 services, through the Child and youth mental health offices which serve children and adolescents only. Emergency services are through regional general hospitals.**
- **Tier 3 includes specialized inpatient services, integrated with non-residential and outreach services.**
- **There is a formal gate-keeping for access to third tier, mainly hold by the Child and youth mental health offices.**
- **Several specific target groups exist: Youth Day treatment programs, Autism, Addiction, Youth forensic psychiatric services, services for the Aboriginal community. Less frequent are services for children and adolescents with intellectual disabilities. The national framework advises a focus on transition to adulthood.**
- **Tier 2 and tier 3 staff can advise tier 1 professionals; Canada has been a pioneer in this type of "collaborative care" within adult mental health care. However, it is often unavailable due to time constraints.**
- **At tier 2 and tier 3, case managers provide care coordination at the patient level.**
- **A formal system of special education schools does not exist in British Columbia, but supplemental governmental funding for education of children with autism or with moderate or severe emotional/ behavioural difficulties is foreseen.**

- **Reforms at the end of the 20th century focused on community-based care. This trend of deinstitutionalization caused problems in some areas, e.g. dual diagnosis of intellectual disabilities and mental health problems.**
- **Several knowledge centres develop and disseminate evidence-based knowledge on youth mental health care.**
- **A main criticism is on the fragmentation of the service supply, and on the uneven spread throughout the regions, provinces and the country.**

6.4. England (UK)

6.4.1. Country profile

England is with Wales, Scotland, and Northern Ireland one of the four constituent countries of the United Kingdom, which is itself a constitutional monarchy, governed by two houses of parliament. Health and social care matters are organized on the level of each constituent country. This study is limited to England, the largest and most populated constituent country. England has a population number of 51,8 million inhabitants (83% of UK population), of which nearly 11,012 million are <18 years of age (2009). The territory of England is about 130400 km². There are 354 local authorities (counties); these are re-organized in 150 Local authorities (LAs) which have a main responsibility in the organization of social care, education and disability care; there are 38 local justice areas.

6.4.2. Preliminary remark

After the general UK elections of May 2010, a new Government took office. During the writing of this report (Jan-June 2011), new policies and policy guidelines have been gradually released. Obviously, it will take some time before these policies will be further specified and fully implemented. Therefore, much of the information in this report still largely describes the transitional situation from the previous to the present Government. Where possible, it will be indicated which domains are clearly subjected to change, or have been abandoned. However, it was not possible to describe yet in detail what will be the results of the decisions and policy guidelines introduced by the new Government.

6.4.3. Health care system

The health care system in the UK consists of a Beveridge model; and the National health service (NHS), the UK's publicly funded health service, is centrally funded from national taxation. The NHS services in the constituent countries are managed separately; the NHS in England is the biggest part. With some exceptions NHS services are free of charge at the point of delivery for any resident of the UK.

The Department of Health (DH) holds the overall responsibility for health care; it controls the NHS. It has a joint responsibility with the Department for Education for disabled children's care.

Health care policy in England is implemented in a top-down way, but elements of administration of this policy are decentralized. The local organizations, the NHS Trusts, have a large responsibility in implementing health care policy and in practical organization of service delivery. There is a central role for the Primary care trusts (PCTs), which are in charge of organizing primary care providers and commissioning secondary care (specialist care and emergency care) in a way that local needs are met. They also hold the responsibility for public health and prevention. There are about 150 PCTs, they control +-80% of the NHS budget.

Another type of Trusts are the Mental health trusts that provide specialist mental health care services; they are overseen by the local PCT.

The UK Government (May 2010) has set out major reforms to the NHS which will be gradually implemented.

6.4.4. Child and adolescent mental health policy: policy plans and inter-sector collaboration at the policy level

England has a clearly defined camhs policy, outlined in the NHS National service framework for children, young people and maternity services (NSFCYMS, 2004, standard 9).

Between 2003 and 2010, the broader context of this policy was defined in the "Every child matters" or ECM program (2003) and the Children act (2004), which came as a response to the report into the death of Victoria Climbié, an 8 years old girl, abused and murdered by her guardians. The ECM-program does not reflect the national policy of the new Government (2010) anymore, but many elements still influence the actual policy.

In April 2011, a new policy document on mental health care was launched, “No health without mental health”. In this document, mental health care for children and adolescents is comprised in the general mental health care policy, as one of the target groups by age. Currently, further guidelines on this policy are gradually being released.

Camhs agencies in a local area tend to be grouped in a Camhs partnership, a multi-agency group of stakeholders involved in the emotional wellbeing and mental health of children and young people. Over recent years, the camhs partnerships have had much influence in setting the strategy and priorities for camhs in their area.

Children’s trusts (2003-2010)

The ECM program initiated a shift towards a child centred approach of care. Its focus was on interagency working; it stressed local collaboration between the health care sector (including mental health care), the social care sector, the education and disability sector and the juvenile justice sector. To develop collaboration and promote service integration between different sectors, Children’s trusts were launched.

A Children's trust was defined as a local area partnership led by the Local authority bringing together the key local agencies to improve children's well-being through integrated services. Some agencies were under a statutory "duty to co-operate", e.g. social care services, PCTs, police, youth offender teams, educational support services. Children’s trusts held the overall responsibility for overlooking, joint planning and commissioning of all services for children and adolescents in their area, be it health care, mental health care (including specialized camhs), social care, educational or disability support, or juvenile justice services.

Children’s trusts were made possible through joint policies of the Department for Health (DH) and the Department for Education (DfE, see further); the Department of Justice was involved as well. As Primary care trusts (PCTs, health care commissioning) and Local authorities (LAs, social care and disability care commissioning; organization of education) have distinct systems of financial management, new mechanisms to align local PCT and LA budgets were developed. Central activities of the Children’s trust included the Joint strategic needs assessment (JSNA), evaluating the local needs, and the development of the Children’s and young people’s plan (CYPP), defining the local priorities and goals for the next three years. However, as a part of new policies after the 2010 elections, the obligation for local communities to establish a Children’s trust is withdrawn. The expectation however remains that the partnership working between local services will be continued.

Key policy elements

The main principles described in the ECM policy, taken over and further elaborated in the NSFCYMS and other policy documents of the former Government, put a strong accent on integrated care delivery between all children's services, built around the needs of children, young people and their family. Also, services should be shifted as much as possible to prevention and early intervention, with an important accent on frontline care delivery. However, specialized services should be available if needed. Accessibility can be enhanced by co-location in place of different services.

6.4.5. Camhs organization in the health care sector

6.4.5.1. Four tiers of camhs and four types of camh teams; gate keeping

Four tiers of camhs

Child and adolescent mental health services in England are delivered in a variety of ways and a schematic approach to a “tiered” delivery system has proved helpful. The official NHS National service framework for children, young people and maternity services (NSFCYMS, 2004) describes four tiers of camhs; the system is intended to be a stepped care model.

At tier 1, camhs is delivered by primary care workers who are not specialist camh workers but rather general (health) care workers, such as GP’s, community nurses and social services, school staff, youth justice workers. The Children’s centres have to play a role as well (see further).

Specialist camhs are delivered at tiers two to four.

At tier 2, specialist camh workers or community paediatricians, mostly individually working, deliver services in community and primary care settings.

At tier 3, specialist multi-disciplinary teams provide ambulatory camhs for more severe problems in a community mental health clinic or child psychiatry outpatient service.

At tier 4, services are provided at a very specialized level for the most severe problems. At this tier, inpatient-, day care or outreach services, or other highly specialized consultation and intervention services are provided; usually more than one area is served. Inpatient psychiatric services are separately provided for children and adolescents to ensure that the developmental needs of different age ranges are met. There are overall 725 inpatient beds in England, or 0,66/10000 inhabitants (0-18 years) (2009/2010). Besides this, there are 1175 day care and other tier 4 *intensive* ambulatory care places, or 1,07/10000 inhabitants (0-18 years). The NSFCYMS (2004) admits that the number of inpatient adolescent beds is insufficient, and that some adolescents inappropriately are being cared for in adult psychiatric beds.

Four types of camh teams

Within camhs tiers 3-4, four types of teams may be distinguished:

- Generic team:

Generic camh teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area. Generic (multi) teams are made up of camh professionals from a number of different disciplines; generic (single) teams are single disciplinary groups of staff.

- Targeted team:

These teams provide services for children with particular problems or requiring particular types of therapeutic intervention. Targeted teams exist for looked-after children (see further), for youth offenders, and for children/ adolescents with learning disabilities or mental retardation; less frequent are teams for child abuse, substance misuse, self-harm, eating disorders, ADHD and ASD and teams for pediatric liaison.

- Dedicated worker team:

Dedicated workers are fully trained camh professionals who are out-posted in teams that are not specialist camh teams but have a wider function, such as a youth offending teams or a generic social work children's team.

- Tier 4 team:

These services provide longer term or more intensive treatment, which cannot be offered by tier 3 services.

Gate-keeping

Within the English health care system, GPs tend to play a gate-keeping role in determining access to more specialized services, including specialized mental health care services. However, a GP referral is not mandatory.

6.4.5.2. Specific target groups

Targeted teams exist for several subgroups (see before). The Government also pays special attention to the availability of on-call services and emergency care provision or care plans, appropriate services for 16-17 year olds including transition to adult mental health care services, appropriate services for children and young people with learning disabilities, and the availability of early psychosis intervention teams; these services are considered to be underdeveloped. LAs and camhs providers have to report to the Government on the availability of these services in their care offer.

6.4.6. Neighbouring sectors

6.4.6.1. Youth social care

Although not all children and adolescents in the social care sector have mental problems or disorders, these problems are commonly found among this population (see 5.4.2).

Social care for children is due to the Department for Education (DfE) that is overseen by the Secretary of State for Education and his ministerial team, of which the Minister of State for Schools and the Minister of State for Children and Families are a team member. The Minister of State for Children and Families has the overall responsibility for youth social care; additionally he is responsible for special education needs and partially for disabled children.

In general, organizing or commissioning social care services comes under the responsibility of the Local authorities (LAs). Until 2010, the ECM policy,

including the central role of the Children's trusts, also applied to the child and adolescent services within the social care sector (see before).

For children and young people, several service types exist.

At the first tier or generic level, Children's centres for children up to 6 years deliver, in an integrated way, a variety of professional advice and support on health care and family matters, and often also child care and early learning programs. The centres are managed through partnerships that represent all agencies involved in delivery as well as the users of services themselves. Under the new Government, it is advised to direct the Children's centres services especially to vulnerable families.

Children that need specialized social care services are called looked after children. Depending on the level of cooperation of the parents and youngsters to the proposed measures, care can be on a voluntary or non-voluntary basis; in the latter case it is the Youth court which imposes measures. About 0.5% of the 0-18 years of age in England are in some type of specialized social care, e.g. residential places or foster care. Child protection services execute the local safeguarding and protection strategy including e.g. child abuse and neglect.

Actually, a reform of the social work is on its way, covering all aspects of social work for adults and children. Aim is to empower social workers to do their job effectively, and to reduce bureaucracy.

6.4.6.2. Juvenile justice

Juvenile justice belongs to the responsibility of the Ministry of Justice.

A first task of the Youth court is to impose measures when secure child development cannot be guaranteed by the child's family but non-compulsory care is not accepted by the family; this compulsory care is executed under the youth social care system.

A second important task of the Youth justice system, is to deal with children and young persons (10-18 years) committing offensive or anti-social behaviour. Prevention for youth at risk of offending and anti-social behaviour (targeted prevention) is an important task of the English Youth justice system. However, when a young person is charged with a serious offence he/she can be referred to the Youth court, and for very serious offences even to the Crown Court (adults).

Youth offending teams (YOT) are key actors in the youth justice system. There is a YOT in every Local authority in England. They are made up of representatives from police, juvenile justice services, social services, health care, education, drugs and alcohol misuse and housing services, and had a statutory participation in the Children's trusts (2003-2010). Because the YOT incorporates representatives from a wide range of services, it can respond to the needs of young offenders in a comprehensive way. They are involved through the entire youth justice system and are central in the prevention services; they also had a statutory participation in the Children's trusts.

Young offenders (12-17 years) found guilty can have a Detention and training order (DTO) placed on them as a sentence. The first half of the sentence is spent in custody, while the second half is spent in the community under supervision of the YOT. Children and young people in the youth justice system can be taken in custody in:

- Secure children's homes (run by the LA social department and overseen by the Department for Education),
- Secure training centres (STCs, four private institutions in England under contract of the Youth justice system),
- young offender institutions (YOIs, run by the Prison service and private providers, separate wings for 15-17 year-olds and 18-21 year-olds).

Since YOIs have lower staff ratios than STC and Secure children's homes they are considered inappropriate for vulnerable young people with high risk factors such as mental health problems or substance abuse. Secure children's homes are generally used to accommodate young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed as vulnerable. STCs house vulnerable young people who are sentenced to custody or remanded to secure accommodation; as in YOIs all services (education, primary healthcare,…) are provided on-site.

In all three types of custody institutes, education is compulsory. Likewise, substance abuse teams are at work in all three types of custody; PCTs (Department of Health) are responsible for commissioning these and other (mental) health services. For young people with severe mental health needs, a limited number of secure mental health beds are available,

offered by 5 providers throughout England, under the responsibility of the Department of Health.

6.4.6.3. Long term or disability care

Care for disabled children is a joint responsibility of the Minister of State for Children and Families belonging to the DfE, and of the Secretary of State for Health of the Department of Health. On the local level, the Local authorities and the Primary care trusts are responsible for providing the necessary services. Until 2010, the ECM policy, including the central role of the Children's trusts, also applied to the child and adolescent services within the disability sector (see before).

Service need and access is done through a needs assessment (CAF) by the local social services, GP or health visitor, as a part of integrated frontline offer. An extensive range of services is offered for the different types of disabilities, e.g. autism.

6.4.6.4. The Education system

The Department for Education (DfE) holds the overall responsibility for the educational system, as well as the responsibility for children's social care and part of the responsibility for disabled children's care. At local level, the responsibility for organizing publicly funded school education lies with the 150 LAs. Until 2010, the LAs had to follow the 'Every child matters' agenda and the Children act 2004.

Current policy, as supported by legislation, places emphasis on educating children with special educational needs (SEN) alongside their peers in mainstream schools, whenever possible. Pupils need a SEN statement (assessment and official recognition of SEN), which means that the special help a child needs cannot reasonably be provided within the resources normally available to the school. Special attention is paid to "low incidence" SEN, who should also stay in mainstream schools as long as possible: children with severe autistic spectrum disorders (ASD); severe behavioural, emotional and social difficulties (BESD) including those with mental health needs; severe visual/ hearing/ multi-sensory impairments; profound and multiple learning difficulties; other (e.g. physical/ medical difficulties).

Support in mainstream schools can be provided by the services of Educational psychology; by the Special educational needs coordinator (SENCO), a person in the school who has a particular responsibility for coordinating help for SEN children; or by other persons from within or from outside the school e.g. a specialist teacher, a speech and language therapist etc. Sometimes special classes are provided in mainstream schools for SEN pupils. Another option is Pupil referral units (PRUs), which provide education on a *temporary* basis for school age children who may otherwise not receive suitable education. A small minority of children need more help than a mainstream school can provide. Special schools exist for BESD, visual or hearing impairment, severe learning difficulties. A few special schools exist for ASD exist. Specialist schools are expected to undertake outreach activity and share their expertise.

Under the former Government, a temporary school-based project (2008-2011) was launched for children aged 5-13 years who were at risk of, or were experiencing, mental health problems. The project was called TaMHS, Targeted mental health in schools. Assessment and/or short-term early intervention were provided at the school, typically by a primary mental health care worker, a dedicated camhs worker or an outreaching camh specialist, who worked in close collaboration with the school educational psychologist.

As of March 2011, the new Government launched a Green paper in which a preliminary version of their new policy views is expressed; the final governmental directions will be published as of December 2011.

6.4.7. Financing and funding of camhs

To realize the aims of the ECM policy and the Children's trusts, new mechanisms to align local PCT and LA budgets were developed. Examples are "aligned budgets" and "pooling budgets" (see Appendix 8). As of the new Government installed in May 2010, Children's trusts are not statutory required anymore and commissioning will gradually be taken over by GP consortia and by new local health and wellbeing boards. The NHS initiated financial reforms that aim at introducing payment by results (PbR); the first experiments recently started for PbR of camhs.

6.4.8. Intra- and inter-sector collaboration

6.4.8.1. Collaboration at the level of the local services

Intra-sector collaboration

It belongs to the tasks of specialized camh professionals to advice, support and assist camh professionals of less specialized tiers, or professionals at the first generic tier.

Inter-sector collaboration

Outreach services

A specific characteristic of the English specialized camh sector is the abundant availability of outreach work. Outreach can be ad hoc for individual cases, or through dedicated workers based in teams of other sectors (see before). Outreach can be directed towards generic services, e.g. GP practices, but also towards specialized services of other sectors. Outreach to the patient's home is possible as well. In 2007/8, 49% of all teams outreached into other health settings such as community health centres and GP practices; 37% of teams provided outreach in education settings (mainstream as well as special schools); 28% of teams provided home visits on a regular basis, 11% worked in children's centres, 7% in secure residential settings and 9% with youth offending teams. Likewise, consultation and liaison services (i.e. not including intervention) in other sectors are very common as well.

Under the former Government, for some time (2008-2011) there were experiments with camh early intervention care supply provided at the school for children aged 5-13 years. The project was called TaMHS, Targeted mental health in schools, and can be seen as one example of an outreach service.

Team around the child (TAC)

A key element to enhance interagency integrated working, is the Team around the child (TAC). The TAC is a multi-disciplinary team of practitioners, established on a case- by case basis to support a child or young of person. This team can be considered to be a "virtual" or flexible multi-agency team that regularly meets but that will change as needs change. A Lead professional is to coordinate the delivery of agreed actions which are expressed in one common TAC support plan. The teams can be enlarged as Teams around the family (TAF), or Teams around the school (TAS). So far, TACs seem to be used preferably to offer early intervention when first tier services are not sufficient, and when at the same time most of the child's needs are at the lower level of complexity. TACs are intended to involve all types of children's services (social care, health care and mental health care, educational or juvenile justice services etc.).

Other mechanisms to enhance interagency integrated working exist, such as regular inter sector meetings at the level of a local area to discuss specific cases, to appoint a Lead professional, etc.

6.4.8.2. Collaboration at the level of the patient

Intra-sector collaboration

At tier 4, different types of services are provided in an integrated way (see before).

Inter-sector collaboration

At the Children's centres, generic advice and support, including generic mental health support, is delivered to families with young children (0-6 years) by several types of care providers, in an integrated way (see before).

YOTs are an example in the juvenile justice sector of inter-sector collaboration (see before).

6.4.9. Needs assessment, workforce training, knowledge development

To improve the overall planning and evaluation of the services delivered, several monitoring systems have been developed, among which an *outcome evaluation and national data collection*.

Within the field of camhs, the Camhs outcome research consortium (CORC) is a not for profit collaboration between camh services across the UK (and internationally) with the aim of instituting a common model of routine outcome evaluation; over half of all services in England are members (2011). Currently 5 different scientifically validated outcome measurement instruments are routinely used, e.g. HoNOSCA (Health of the nation outcome scales for children and adolescents). Collected data

are analyzed and made available. Some efforts have been made to collect inter-sector data on all types of children's services, but this initiative, the Children's mapping service, has come to an end in 2010. The NHS currently is developing a new initiative to collect routinely a comprehensive set of data, among other in the field of camhs; data on e.g. demographics, family history, diagnosis and care planning, intervention, outcome measure etc. will be included.

Several *instruments exist to improve the process of service integration* between the different sectors and agencies serving children and adolescents. The Common assessment framework (CAF) is a standardized approach for joint assessment of children's needs, used by practitioners from a range of backgrounds in the frontline services. Information-sharing between professionals is another important issue in conquering barriers of integrated working. National standards for intra- and inter-sector information sharing across local children's services have been developed, as well as a legally based index system to facilitate information sharing.

An innovative system has been developed by York and Kingsbury to improve *efficacy of camhs planning* and to reduce waiting lists, while at the same time respecting the choice of the patients and families and engaging them in change. This system, the Choice and partnership approach (CAPA), gradually gets more and more adopted in England and abroad (for further details, see Appendix).

The College centre for quality improvement (CCQI) offers quality control by professional peer review, and measures *services' performance* against nationally agreed standards for the organization and delivery of mental health services. The network encourages quality improvement and information sharing between peers; a quality network exists for inpatient camhs, for community camhs, and for perinatal mental health services.

Several policy documents endorse appropriate *Workforce training* (ECM, NSFCYMS, Children's and Young People's Workforce Strategy (2008)). Inter-sector standards have been set out on knowledge, competencies and "common core" skills in the field of child and adolescent mental health, for all staff working with this age group. Core competencies for specialized camhs staff have been specified as well.

Several *knowledge centres* support clinicians in their clinical decision making. The Child and maternal health observatory (ChiMat) is a national public health observatory established to provide evidence, authoritative data, and information on practice related to children's, young people's and maternal health. The National institute for health and clinical excellence (NICE) has already developed several EBM guidelines in the field of camh care.

6.4.10. Main criticisms

Of the 4 experts invited to participate, all 4 effectively returned their comments. All 4 experts provided additional information to improve the content of the draft; 1 expert also gave an overall appraisal of the system.

Strengths of the system:

- the comprehensive policy frameworks;
- many vigorous and dedicated professionals in the field;
- an expanding evidence base as well as organizations nationally recognized that incorporate it into practice guidelines (in particular NICE).

Weaknesses of the system:

- policy recommendations, e.g. the comprehensive partnership across agencies, are not always as widely enacted on the ground as the policy would like to see;
- variable implementation of the policies across area's;
- lack of capacity of the system to deliver enough quantity of these practices for which an evidence base exists;
- different philosophical bases arising within and from the NHS and the education and social care system, also different knowledge;
- Lack of systematic data (across services and for all cases) reflecting care and outcomes;
- commissioning by "block contracts", which not always best reflects the actual services delivered and which does not imply the quality of the delivered services.

Opportunities of the system:

- a currently significant and sustained focus on the first decades of life (0-25 years) with significant interest in effects of early intervention;
- the new forming NHS and social care structures and policies enabling joined up care pathways;
- renewed focus on outcomes, evidence and quality.

Threats of the system:

- the current financial challenges of all public sector bodies;
- children's services are particular vulnerable due to multiple lines of commissioning and often weaknesses in commissioning.

Key Points

- **After the general UK elections of May 2010, a new Government took office and major reforms have been announced. During the writing of this report (Feb-July 2011) it was not yet possible to describe in detail the results of the new policy directions.**
- **In 2003, a joint children's policy between the Department of Health (health care, mental health care, part of disability care) and the Department of Education (education, youth social and disability care) has been launched; the Department of Justice was also involved.**
- **The aim was to provide integrated child-centred care through interagency working.**
- **At the level of the Local authorities (LAs), Children's trusts had to bring together local key-agencies of the different sectors; these trusts were responsible for joint planning and commissioning of all services for children in their area. To realize this, new systems were developed to align or pool at the local level the budgets provided by the different sectors' funding mechanisms.**
- **After the 2010 elections, the Children's trusts have been withdrawn, but the expectations are that local partnership working will be continued.**
- **As one part of the children's policy, there was a clearly defined camh policy. Under the new Government camh policy has become part of a general mental health care policy, as one of the target groups by age.**
- **Camhs organization is characterized by four tiers; it is intended to be a stepped care model.**
- **There is a strongly developed tier 1, provided by primary care workers not specialized in camh care, e.g. GPs, school staff. Advice and support at this level is generic and often inter-sectorial by nature. The children's policy plan puts a strong accent on tier 1 and on prevention.**
- **Specific tier 1 care providers are Children's centers. These centres provide, in an integrated way, advice and support for health and family matters, as well as child care and early learning programs; they are steered by representatives of the different sectors. Under the new Government, they should preferably address vulnerable families.**
- **Likewise, youth offending teams (YOTs) are multi-disciplinary teams composed of staff from different sectors, including camhs. They are in charge of prevention and early intervention for young offenders, under the global responsibility of the Department of Justice.**
- **Specialized camhs are provided at tier 2-4. There is a strong accent on ambulatory care delivery, including mono- and multi-disciplinary services by tier 2 and tier 3, respectively.**
- **Tier 4 provides highly specialized care for the most severe problems, including inpatient care but also day care, outreach or other specialized services. These different modalities are often provided in an integrated way.**
- **At tier 3 and 4, there are four types of teams: generic teams; targeted teams for particular problems or types of intervention; dedicated teams with specialized camh staff out-posted in teams of other sectors; tier 4 teams.**

- **Several special target groups exist: children in social care, youth offenders, learning disabilities or mental retardation; less frequent are teams for child abuse, substance misuse, self-harm, eating disorders, ADHD, autism, pediatric liaison.**
- **Some underdeveloped services are to be improved by specific Governmental measures: emergency care, transition to adulthood, learning disabilities, early psychosis intervention.**
- **In England, there is no formal gate keeping system but GPs tend to determine access to specialized care, including specialized mental health care.**
- **It belongs to the tasks of specialized camh staff (tier 2-4) to advice and assist staff from less specialized tiers, which enables intra-sector collaboration.**
- **Further, there is a strong focus on out-reach services from specialized camhs toward generic first tier services as well as toward specialized services of other sectors or toward the patient's home. Outreach can be ad-hoc or by out-posted dedicated workers.**
- **Besides this, flexibility is added to the system by the possibility to organize a Team-around-the-child (TAC), the family (TAF), or the school (TAS). This is a "virtual" team with a coordinating lead professional and staff from different sectors, according to the child's need. The team changes as needs change.**
- **Other systems of inter-sector care coordination exist as well, e.g. regular local area meetings of professionals from different sectors.**
- **Within the juvenile justice custody institutions, specialized camhs outreach is provided for substance abuse and other mental health needs, under the responsibility of the Department of Health. A limited number of beds for forensic mental health care is available.**
- **The educational sector has an elaborated system of specialized educational services for children and adolescents with behavioural disorders, within mainstream and within special schools. A project for outreach and early camh intervention within mainstream schools (TaMHS) was ended in 2011.**
- **A uniform assessment system for generic tiers (Central assessment framework CAF) and a uniform information sharing system for all tiers, improves intra- and inter-sector camhs collaboration.**
- **"Core" and "specific" workforce training is defined by the Government for generic respectively specialized camh workers.**
- **A system of systematic outcome evaluation exists ("CORC"); the NHS plans a comprehensive uniform data collection within camhs.**
- **Several knowledge centres develop and disseminate evidence-based knowledge on youth care and youth mental health care.**
- **Main criticisms are the difference between policy guidelines, e.g. on interagency working, and practical implementation; a variable policy implementation across area's; cultural and knowledge differences between different sectors; a lack of capacity for evidence based practices.**

6.5. An example in France: L' EPSM Lille-Métropole in Nord Pas de Calais

In this chapter we give an example of the camhs organization in the Department of North-Pas-de-Calais. As of 2002, the care supply for adolescents in one part of this Department was re-organized substantially to increase accessibility to care. The initiative is an example of bottom-up care organization in a well-defined geographical care region. To situate this example within the general system, we give in a nutshell an overview of the French health and mental health care system, and of the service organization for camhs.

6.5.1. Organization of health and mental health care in France

6.5.1.1. Health and mental health care system: some highlights

France is a democratic republic with a bicameral parliamentary system. It has a surface of 543965 km², and a total of 63.8 million inhabitants (Jan, 1st, 2008). It is divided in 26 regions (of which 4 overseas) and 100 departments (of which 4 overseas).[tttt]

In France, the Statutory health insurance (SHI, assurance maladie) covers almost the total of the population[131]. Long-term psychiatric conditions, as one of the 30 ALD conditions (affection de longue durée) are fully covered, including mental health care by GP's and psychiatrists in private practice, and care provided in public mental health care hospitals or in private psychiatric hospitals for adults and children. Care provided by psychotherapists is fully financed out-of-pocket by the patients.

Mental health care services are provided by the health care sector. Along with the health care sector and the social sector there is a so-called third sector in France, the social and health care sector, providing services for the elderly and the disabled.

Services are provided in geographically defined areas, called mental health areas (secteurs de soins de santé mentale)[uuuu]. These areas are separately defined for adults and children. The average number of inhabitants in an area for adult mental health care is 57000. The average number of inhabitants in child and adolescent mental health care areas is 46000 young people under age of 20 years, corresponding to an average of 210000 inhabitants, meaning a much wider geographical area as for adults[131]. The coordination of care in each area belongs to a hospital and covers prevention, diagnostics and therapeutic services in inpatient and outpatient settings, such as the ambulatory centres médico-psychologiques (primary mental health care). Private as well as public services provide both inpatient and outpatient care. In most areas the public service for mental health, the Etablissement Public de Santé Mentale (EPSM), coordinates the care.

On the policy level, the government launched a policy plan in 2005, the Psychiatry and mental health plan (plan psychiatrie et santé mentale 2005-2008)[vvvv] to meet criticism about lack of coordination of services. This plan mentioned some specific actions to take in the field of camhs. First the plan made it possible to build capacity for camhs by creating child psychiatric beds in areas deprived from hospitalization possibilities, since hospitalization capacity was unequally available. Secondly the plan stimulated to develop networks of care by reinforcing cooperation between paediatric services and psychiatric services and by integrating hospital facilities in a camh pathway, along with primary care services. This pathway should be reinforced by creating a comprehensive and diverse care offer, by developing a network of complementary camhs providers within the health sector, and through collaboration with the social sector, the education sector and the judicial sector.[wwww]

6.5.1.2. Camhs organization in France: short overview

In many areas the Public mental health services, Etablissements Publiques de Santé Mentale (EPSM), coordinate the offer of mental health services for children and adolescents, from consultation to functional units with in- and outpatient care prior to and after hospitalization, to home delivered care and socio-educational support. There are also infant services, supporting parents and infants up to 3 years as well at home as in medico-psychological centres or the maternity ward, in collaboration with other disciplines.

The camh service supply can be described as follows:

- Primary care camhs: Primary camhs most often is provided by the GP, but Medico-psychological centres also offer primary camhs. These centres are first contact points for information, advice, first intervention or more specialist treatment on an ambulatory base.
- Specialist camh services offered: Every area for child and adolescent mental health care (secteur) disposes of a multi-disciplinary team that is part of an EPSM, and that is responsible for delivering the services

tttt http://www.diplomatie.gouv.fr/en/espaces_dedies.php3?id_rubrique=159

uuuu http://www.sante.gouv.fr/les-etablissements.html viewed on 16/06/2011

vvvv http://www.sante.gouv.fr/le-plan-psychiatrie-et-sante-mentale.html viewed on 16/06/2011

wwww http://www.sante.gouv.fr/le-plan-psychiatrie-et-sante-mentale.html viewed on 16/06/2011

needed, ranging from home visits to hospital admission. Several structures of care delivery are part of the EPSM:

- Medico-psychological centres (CMP). In France 97% of the children and adolescents in need of mental health care and treatment receive this care in an ambulatory setting, in the cities of the area and with local contact points; it are merely the CMP's that account for this care.
- Care is also offered trough Medico-psycho-pedagogical centres (CMPP)
- Part time therapeutic reception centres (CATTP)
- Day hospitalisation (Hospitalisation de jour, HJ)
- Independent working psychiatrists and psychologists (on a fee-for-service base)

- Child psychiatric hospitalisation: Full hospital admission is reserved for the very difficult or complex situations or in case of acute crisis. In 2000, the mean admission time was 2 days[xxxx].
- Mental health services for disabled children. A specific offer is provided through the health and social sector for children with mental health-related disabilities as mentioned in the HiT report (2010)[131]:

6.5.2. CAMHS offered by the EPSM Lille-Métropole

As an illustration of integrated working and partnership development in France we describe the model of camhs delivery for adolescents developed by the child and adolescent psychiatry pole of the EPSM Lille Métropole at the Armentières-Tourcoing area, under the supervision of Dr V. Garcin.

Key issues in this model are putting the adolescent in the centre of the care, networks of community based care in combination with a well defined hospitalization offer for adolescents, and partnerships for continuity of care. The model is recognized as a good practice (action exemplaire) by the Supreme Health Authority (Haute Authorité de Santé) and is ISO 9001 (2008) recognized. First we situate the EPSM and then we discuss the camhs offer.

[xxxx] Buisson, J-R, La pédopsychiatry: prévention et prise en charge, conseil économique, social et environemental, Paris, 10/02/2010

6.5.2.1. The EPSM Lille-Métropole

The mission of the EPSM is to take care of the mental health in its area.

The services provided range from prevention, diagnose, cure and care for adults, children and adolescents.

The EPSM Lille-Métropole is based at Armentières and acts in a region with 632038 inhabitants, in 82 municipalities, for the adult population, and in an area of 263916 inhabitants for the camhs. For this region the EPSM has 9 "poles" (secteurs) of general adult psychiatry and 1 "pole" (secteur) of child and adolescent psychiatry (psychiatrie infant-juvenile). It is a dense region with a population that consists of 30 % of young people below 20 years which is far beyond the average in France of 17 %. Economically, it is a mixed suburban region with industry and country side, at the east of Lille. However there is a certain amount of unemployment (fig 6.1).

Fig 6.1: CAMHS area Lille Métropole (secteur infantojuvénile) (source: www.epsm-lille-metropole.fr)



The EPSM offers inpatient services as well as community based services. One of the important characteristics is the investment in different partnerships, leading towards strong care networks, in a continuum of care.

To reform its services in the actual way the EPSM Lille-Métropole was inspired by the Inter-ministerial conference of Helsinki and the French Plan Santé Mentale 2005-2008. The EPSM is also a WHO collaborative centre for research and information on mental health.

6.5.2.2. Camhs at the ESPM Lille-Métropole

The EPSM disposes of 1 pole for child and adolescent psychiatry (psychiatrie infant-juvenile), which coordinates and organizes the public camhs in the area.

The services that are offered by the pole consist of:

- Hospitalisation at Armentieres and day hospitalisation at Tourcoing.
- Mental health centres (CMP, CSM) at Armentieres, Halluin, Tourcoing
- Therapy centre for children and adolescents at Tourcoing
- Family support centre at Tourcoing
- Confidentiality centre for adolescents (espace Tom) a Tourcoing (CATTP)
- Mobile team for adolescent mental health care
- Mobile team for infants
- 14 additional consultation points (antennes de consultation) spread over the area

Actually 16% of the children and young people is admitted for full hospitalization; while 84% of the children and young people receive ambulatory care or care in alternatives for hospitalization.

Integrated working model

The key elements in the integrated working model is putting the adolescent in the centre of the care network and ameliorating access to care.

It was the experience of the Adolescent unit that services for adolescents were poorly accessible due to long waiting lists and, because of this, there was a perception of lack of capacity and workforce. The Hospital facility of 8 beds was overbooked with long waiting lists and long admission times. With the reform of the EPSM as of 2003, even before, but in line with the “plan psychiatrie 2005-2008”, the pole decided for a radical shift.

Mobile team

To increase accessibility to care for adolescents that are not able to enter the required service, the EPSM decided to create a mobile team approaching the youngsters, in order to answer quickly (no waiting list delay), in the environment of the adolescent (outreach), and adapted to his/her needs (age-appropriate). This way of working implicated a reorganization of the hospital staff and other camhs workforce by attaching medical and psychological functions and nurses and social workers to the mobile team. In 2010 the mobile team consisted of 3 psychiatrists, 1 internist, 2 psychologists, 8 nurses and 1 social worker, together representing 1 FTE medical function and 4,4 FTE non-medical function. This means that the mobile team members also are part of different other EPSM teams. This overlap aims to create more permeability between the camhs teams around a youngster.

This mobile team that reaches out as a duo of non-medical functions engages to meet the adolescent within 24 hours after signaling, from Monday to Saturday morning, on a 24 hours schedule. A psychiatrist (always at reach by telephone) is asked to be involved after a first contact, if required. The mean number of consultations by the mobile is 2,4, leading to access of regular ambulatory care. The EPSM reports that as a consequence of the initiative, waiting lists dropped dramatically, as did also admissions to the adolescent psychiatric ward. Admission times reduced from several months (average 8 months) to an average of 18 days.

Network-partnership

The referrals are made by a network of partners of the EPSM. Interventions of the mobile team take often place in the facility of this partner, or with the partner in a home visit, and the partner engages to take responsibility for the care of the adolescent. Important involved partners are the 2 general hospitals at Armentières and Tourcoing, private and public secondary schools in the region, youth centres and youth shelters, GP’s, judges. The partners engage in written agreements with the EPSM, on service level, bringing in a complementary offer. The viewpoint was rather being a partner instead of having partners.

The mobile team acts as a connection between the different sectors, bridging the gap between the sector walls. Besides the quick and early

intervention, they also serve as liaison within the camhs of the EPSM and between the EPSM and its partners.

The number of hospitalization admissions for adolescents has been strongly reduced: only four of the eight beds for adolescents are in use, with a mean admission time of 18 days. There are no waiting times. Meeting the patient quickly in his own environment and in a way adjusted to his needs, seems to prevent hospitalization. Much of the troubles can be tackled in an early stage. By developing strong partnerships within the sector and with other relevant sectors, the mobile team is able to transfer psychiatric expertise to partners in the near environment of the adolescent. When necessary or appropriate, hospital admission or hospital day care are an accessible service in a continuum of care.

6.6. General Overview: the Netherlands, Canada(BC), England, Belgium

The Table below is based on chapters 5 and 6 in this report.

For the Netherlands, Canada (British Columbia), England and Belgium, the following points are consecutively dealt with: Population; 2. Health care system; 3. Values in camhs policy documents; 4. Camhs policy & plan; 5. Initiative level; 6. Level of Governmental policy: inter-sector collaboration; 7. Specialized camhs funding principles; inter-sector mechanisms if available; 8. Camhs organization; 9. Gate-keeping within camhs; 10. Target groups within camhs; 11. Local services level: intra-sector collaboration; 12. Local services level: inter-sector collaboration; 13. Patient level: intra-sector collaboration; 14. Patient level: inter-sector collaboration; 15. Needs assessment and monitoring at the level of the Government; 16. Outcome measurement; 17. Workforce training & training requirements; 18. Knowledge development; 19. Main criticisms by stakeholders.

TABLE 6.1 General Overview camhs in The Netherlands, Canada (BC), England, Belgium

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
1.Population	0-18, some cases up to 23	<19 years	0-18	0-18
2.Health care system	Bismarck, compulsory private basic health insurance through ZVW for short term care (<1year), mental health care covered by basic package. Long-term care covered by AWBZ and directly funded by Government. National governance.	Beveridge, National health insurance model, universal coverage, no co-payments. National framework, with large responsibilities for provinces/ territories in health care governance and organization.	Beveridge, National health insurance model through National Health Service (NHS), universal coverage, no co-payments. National governance, with large responsibilities for local administration (NHS Trusts) in implementation.	Bismarck, compulsory not-for-profit health insurance model with broad benefits package. Governance partly by Federal government, partly by Federated entities.
3.Values in camhs policy documents	Child- and family oriented, empowerment of parents, quality of child educational surrounding ("civil society"). Strong accent on prevention and first tier care.	BC: Child- and family oriented; community oriented. Focus on prevention and on improved collaboration between primary care physicians and specialized camhs.	Child- and family centred. Integrated care delivery between all children's services. Strong accent on prevention and generic care delivery.	Values in global mental health care policy: Care networks and care circuits to realize coordinated, integrated services; needs based care.
4.Camhs policy & plan	Camhs policy as a part of a joint policy for youth care (camhs, non-compulsory youth social care, youth with mild intellectual disabilities)	National framework Canada, Camhs policy plan (Br. Columbia). In 2003, specific BC camhs plan; in 2010 BC camhs plan part of global mental health care plan. No joint policy with neighbouring sectors.	Until 2010 separate camhs policy and plan, part of global children's policy (cfr below). Recently incorporated in a general mental health care policy.	Federal: global mental health care policy, camhs target group by age; also separate camhs initiatives (e.g. FOR-K). Mostly: camhs as part of global mental health care; Flanders: camhs also as part of integrated youth care (youth social and disability care, education, camhs by CGG).
5.Initiative level	Mostly top down	National framework, provincial plan, implementation at level of province or health regions.	Top down with local implementation	Top-down (e.g. federal global mental health care policy) as well as bottom-up (many local initiatives).
6.Level of Governmental policy: inter-sector collaboration	Joint policy (cfr. supra); all these domains are under responsibility of the same Ministry of Health, Welfare and Sports. Close collaboration	BC: Joint responsibilities (no joint policy) of Ministry of Children and Family Development (camhs, youth social and disability care,	Joint policies by Department of Health (health care, mental health care, part of disability care) and Department of Education (education, youth	Flanders: joint policy for integrated youth care (cfr supra); all these domains are under responsibility of the same Ministry of Welfare, Public Health and

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
	with Ministry of Security and Justice. Former Ministry of Youth and Families (2007 until 2010).	juvenile justice). Some camh services under Ministry of Health. Ministry of Education some role in day treatment and school-based programs.	social and disability care), implemented through Children's trusts (2003-2010). Department of Justice also involved. Joint policy recently largely reduced. Camhs partnership: group of local agencies, influencing local camh priority setting in Children's Trusts.	Family. Close collaboration between federal Ministry of Justice and other Ministries (health care or neighbouring sectors). Several joint initiatives of Federal and Federated bodies responsible for health care policy to promote collaboration (e.g. Therapeutic projects).
7.Specialized camhs funding principles; inter-sector mechanisms if available	Specialized camhs funding through health care funding (ZVW and AWBZ); proposal for funding of all joint youth care (cfr supra) through municipalities, together with prevention.	BC: Funding of Specialized camhs partly Ministry Children and Family Development; partly Ministry of Health; little structural joint funding.	Specialized camhs funding responsibility of NHS, in practice joint funding on local level through Children's trusts (2003-2010).	Specialized camhs funding responsibility through health care funding (Federal/ Federated entities); no structural joint funding with other sectors. Funding on basis of projects is common.
8.Camhs Organization	Three tier camhs. Generic first tier; specialized camhs at tier 2 and 3. At tier 2: inpatient and outpatient (or integrated) centres, regionally embedded. Some private practices by child psychiatrists/therapists. Tier 2 actually in transition. Small 3rd tier.	BC: Primary, secondary and third tier camhs. Strong focus on ambulatory community delivered tier 2 with services for children only.	Four tier camhs with strongly developed frontline and specialized camhs at tier 2-4. Tier 2 and 3: universal and targeted ambulatory services; tier 4: multiple modalities often integrated (inpatient, in-outreach, day care…)- Four types of tier 3 and 4 teams: generic/ targeted (particular problems or types of intervention)/ dedicated (specialized camh staff out-posted in other teams)/ tier 4 team.	Tiered system not officially confirmed. Tasks generic tier 1 in camh care not officially confirmed. Focus on care supply by specialized camhs; care offer diverse/ overlapping with different service types; many temporary projects. Tier 2, ambulatory care: CGG/SMM, private practices e.g. child psychiatrists, outpatient clinics, ambulatory rehabilitation centres (CAR/CRA). Tier 3-4, inpatient care: K- and k1/k2 services, NIHDI conventions, outreaching teams (project), Flemish Observation and treatment centres.
9.Gate Keeping within	Formal gate keeping for access to 2nd /3rd tier by	BC: Formal gate keeping by second tier for access third	No formal gate keeping, but formal stepped care model; in	No gate keeping, free access to all tiers (in line with global health

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
camhs	Youth care agencies, GPs, primary care psychologists or medical specialists.	tier.	practice strong first tier that provides access to other tiers.	care policy).
10.Target groups within camhs	Compulsory mental health care, Forensic care, Ortho-psychiatric care, Addiction, Mild mental retardation. Camh emergency services universally available.	BC: Day treatment programs, Forensic care, Addiction, Mental Retardation (adolescents); Autism; Aboriginal community. National framework advises focus on transition to adulthood.	Targeted teams exist for children in social care, youth offenders, learning disabilities or mental retardation; less frequent are teams for child abuse, substance misuse, self-harm, eating disorders, ADHD, autism, pediatric liaison. Underdeveloped services to be improved by specific Governmental measures: emergency care, transition to adulthood, learning disabilities, early psychosis intervention.	Forensic care circuit FOR-K (project), Care circuit intensive treatment aggressive behaviour or conduct disorder IBE (project), Autism reference centres, pediatric Liaison, Early parent-child interaction centers. Less frequent: Addiction (1 service), Mild mental retardation (1 service). Camh emergency service organization under development.
11. Local services level: Intra- sectorial collaboration	1.Tier 2 workers can advise and assist at tier 1.	BC: 1.Tier 2 and 3 can advice and support tier one (“collaborative care”). However, not common.	1.Tier 2-4 workers advice and support less specialized tiers.	1. Flexible care provision: intensive/crisis/outreach in FOR-K and IBE (projects). 2. Consultation platforms (Overlegplatformen- Plates-formes de concertation psychiatrique): consulting of regional mental health care organizations to optimize service complementarity. 3.Wallonie: Reference centres for mental disorders: coordination between SSM and other mental health care providers (to be established).
12. Local services level: Inter- sector	1.Youth and family centres (CJG) and school and advice teams (ZATs) can coordinate	BC: 1.Tier 2 and 3 can advice and support primary or specialized services in other	1.Outreach by specialized camh workers directed towards generic services (e.g.	1.Flanders: CGG included in integrated youth care (see before) i.e. regional networking between

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
collaboration	different services at tier 1; the Youth care agency participates in CJGs and ZATs. 2.For the sectors under the joint policy (see supra), Youth care agency coordinates referral to specialized services of different sectors. 3.The sector of juvenile justice directly "buys" specialized camh services. 4.At the disability sector, (inter-sector) case management for children < 4 years by the MEE agency.	sectors. However, not common.	GP practice), specialized services of other sectors, or at the patient's home. Services can be ad hoc or by "dedicated team" workers out-posted into other sectors. 2.Sometimes regular local area inter-sector meetings. 3.The Team around the child-family-school (TAC-TAF-TAS) is a "virtual", flexible multi-agency team with a lead professional and staff from social care, health care, camhs, education etc; team changes as needs change.	services and single central entrance for intensive services. 2. CGG/SMM staff can support staff of other agencies. 3.Outreach to school teachers by CRA/CAR. 4.Flanders: Centres for expertise networks (SEN) for autism or mental retardation with behavioural problems.
13. Patient level: Intra-sectorial collaboration	1.At tier 2, some centres provide integrated in- and outpatient services.	BC: 1.Tier 2 and 3: Case managers. 2.At tier 3, integrated comprehensive camhs (inpatient, outpatient, outreach)	1.At tier 4 some integrated comprehensive camhs offer (inpatient, outreach, day care…).	1.Financing of child psychiatrists for diagnostic services to GP or medical specialist (Nomenclature n° 109410). 2.Generic Outreaching teams (project): K-service, CGG/SMM, home care service.
14. Patient level: Inter-sector collaboration	1.At tier 1 inter-sector care offer (e.g. CJG, ZATs). 2.Direct collaboration between specialized camhs and specialized services in other sectors: ad hoc.	BC: 1.Tier 2 and 3: Case managers for care coordination within or between sectors. 2.Collaboration between camhs and educational sector in Youth Day treatment programs. 3.Some camh care provision in youth custody services. 4.Other types of collaboration between specialized camhs and youth care or specialized education ad hoc (poorly	1.At tier 1: inter-sector care offer (e.g. Children's centres); inter-sector collaboration in youth offending teams (YOTs).	1.At tier 1: some generic inter-sector care offer (e.g. Kind&Gezin-ONE-Kind und Familie). 2.CAR/CRA: multidisciplinary care offer encompassing educational support, mental health care. 3.Outreach to youth social care sector by CGG (Flanders, project). 4.Financing of child psychiatrists for consultation with other care giving agencies (Nomenclature n°

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
		documented)		109432/109454). 5.Liaison from K-services to pediatric wards. 6.Care path coordinator in FOR-K (project). 7.Care coordinating role for Thuisbegeleiding, SAP/SAI, Frühhilfe/ Familienbegleitung. 8.COS (Flanders) and Autism reference centres: diagnostic and care coordinating role for developmental disorders (0-7 yrs) resp. autism. (9. previous Therapeutic projects (2007-2010))
15.Needs assessment & Monitoring at level of Government	Some role for VIR, a central inter-sector monitoring system of youth at risk at the municipality level. (Mental) health care supply mostly driven by market principles rather than centrally planned.	BC: No instruments to assess systematically camh needs.	Uniform assessment system for generic tiers (Central assessment system CAF) & uniform information sharing system for all tiers: better communication between staff, easier central data collection.	No specific instruments for camh care.
16.Outcome measurement	Not specified	Performance measurement recommended in the BC camhs plan.	Camhs outcome research consortium (CORC): systematic use of 5 outcome measures e.g. HoNOSCA. NHS Information centre: central camhs data collection under development.	Not specified
17.Workforce training & training requirements	Legal underpinning for training of health professions exists within youth social care sector. For camh professionals mainly responsibility of professional associations	BC: Development of Training standards and packages ongoing (lead by professional organizations).	Legal underpinning for training of health professions; “core” and “specific” workforce training defined for generic respectively specialized camh workers	Not legally specified
18.Knowledge development	Knowledge centres develop evidence based guidelines and good practices e.g.	Evidence based guideline development e.g. CADTH, Simon Frazer University.	Knowledge centres, good practice development (NICE, Child and maternal health	VVGG (Vlaamse vereniging geestelijke gezondheid, vzw); IWSM (Institut Wallon pour la

Key point	The Netherlands	Canada (Br. Columb.)	England	Belgium
	Netherlands youth institute NJI, Trimbos, National knowledge centre for child and adolescent mental health care		observatory (ChiMat))	Santé Mentale, asbl); other.
19.Main criticism by stakeholders	Large organizational and cultural differences between camhs, youth social care and care for youth with mild intellectual disabilities hamper practical implementation of joint policy. Government proposed adjustments; but these are heavily debated.	Fragmented service supply between and within Provinces and regions.	Difference between policy guidelines and final implementation, e.g. for partnerships across agencies; variable policy implementation across area's; cultural and knowledge differences between sectors; lack of capacity for evidence based practices.	Beyond the scope of this report

7. DISCUSSION

7.1. No reform without global framework

Based on our literature review and international evaluation, it is clear that any reform in the field of camhs should primarily be based on a global vision or framework on how these services should be organized.

Such a framework could be based on international consensus (e.g. WHO framework[10]), including its values, but also the current set of values that is hold by the community itself. This should be reflected in a camh policy that contains clear plans and identifiable goals to realize and evaluate this policy, to organize service provision, and to offer high standard patient care. The WHO guide[10] on developing camhs can be considered as an internationally agreed consensus document guiding national camhs policies and plans.

Integration of care and continuity of care are recognized as key concepts in organizing camhs. These concepts are reflected in the WHO model[10] that states that a range of services should be available to meet the needs of seriously emotionally disturbed children as outpatients, in partial care programs and in hospital settings. The question arises how camhs organization can facilitate the implementation of these aspects of care provision.

Several theoretical and philosophical models to implement such a framework are set out in literature; the model that is most prominent in the scientific literature is the Systems of care, and associated community-based interventions and services. This model and the interventions aim to implement the core values promoted by the WHO-framework, providing integrated care as close to the communities as possible. They involve multifaceted, multi-level processes simultaneously at the global policy system level, the local health organization level and the practice level, including individual patient treatment and care level.

Evidence, based on scientific research and (clinical) practice could help to set priorities in organizing camhs. However, any reform should take into account the specific socio-demographical, political and cultural reality of the country.

The model should be designed to meet the current needs of the target population, but should be flexible enough to adapt to the continuously evolving and changing needs of the target population. Therefore a camhs framework should have the potential to act as a navigation system.

Our literature review does not reveal clear evidence on what is efficient camhs organization and how it relates to better outcome. This might partially be due to methodological shortcomings, lack of large scale international research, different outcome measures and the difficulty to assess complex and continuously evolving organizational structures in clinical and sociological contexts.

Obviously, as becomes clear from the international overview, political inspired government decisions are important factors in determining the values guiding camhs implementation, and values could serve easily as legitimating the decisions. However, Rosenblatt's[68] warning that changes in the political climate, in elected officials and their staffs, and in funding agency priorities rapidly can create and disband reforms in human service delivery, could even be observed during the course of the writing of this report.

7.2. Aspects of camhs organisation

As suggested by the WHO consensus model[10] and the Systems of care philosophy[82], a comprehensive care offer should contain several levels from broad and easy accessible frontline services to intensive and highly specialized services.

In these models, as well as in the three countries studied in-depth, the importance is stressed of a well-developed frontline or first tier, providing general advice or support and primary mental health care. While there are in Belgium several services and professionals delivering this type of care, there is no clear health policy recognizing and supporting that this is or should be their task and that people should address these services for first line help and support.

There is however increasing evidence to suggest that intervention during the early stages of a disorder may help reduce the severity and/or persistence of initial or primary disorder and prevent secondary disorders. This implies that camhs not only deliver prevention, diagnostics, treatment, cure and care for short term consequences of mental illness in children and adolescents, such as impaired social functioning, poor educational achievement, substance abuse, self harm, suicide and violence, but also acts preventive for the long term consequences i.c. the development of adult mental disorders, and sustains the development of a healthy society.[132, 133]

It should also be mentioned that in all countries studied, a strong accent has been put on prevention of child and adolescent mental health problems and disorders.

In the English as well as in the Dutch camhs framework, the most specialized tier of care (at the other rear end of the continuum) provides a diverse array of services for the most severe problems, including inreach and outreach, full hospitalization function, day care and care coordination facilities, offered in an integrated way. Lack of inpatient capacity in England has been documented.

A camhs model and subsequent policies offering a comprehensive and integrated care will have to deal with several risk groups or special groups of the target population that are at the borders of the camhs offer and therefore, are at risk to be deprivated of the care they need. Camhs policy should be designed to include these groups in the general camhs provision. The models studied in the international comparison show, in a varying degree, services focused on specific disorders, such as autism spectrum disorders or learning disability. The WHO Atlas[3] states that the stimulus for disorder specific services often can be traced to parental advocacy, the dissemination of new knowledge, or the influence of the pharmaceutical industry.

Examples of inter-sector integration of care as proposed by WHO and the Systems of care philosophy can be observed in the examples of the three countries studied in depth. Initiatives at the governmental level range from joined policies between different ministries that are involved with children (England) to clustering of competences and accountabilities related to children and families (British Columbia, the Netherlands in former cabinet).

These initiatives appear highly volatile, often changing with government changes after elections. At the health services level care integration ranges from statutory defined collaboration at the frontline level (England) to integration of camhs in the youth care (the Netherlands). Supposed that effects were investigated and/or available- which is almost not the case-, most initiatives are idiosyncratic which makes them difficult to compare or transpose to other care systems.

7.3. Camhs and Education are facing common challenges and could look for integrated answers

Mental health needs of children and adolescents are often first present in other systems than the mental health system.[3] School or education settings, along with families, are among the most important settings that constitute the environment in which children and adolescents develop.

Literature review has indicated that mental health services delivered within a school venue are highly accessible. These services can range from minimal support services provided by school counselors to more integrated programs of prevention, identification and treatment. Programs focusing on protective factors, tailored (cultural and gender adapted) long-term timely interventions for high risk children, anxiety prevention programs and programs focused on resilience building, delivered within school contexts have proven to be effective. This evidence of moderate quality underlines the importance of re-evaluating how such programs, as far as not implemented yet, can best be organized in the context of the Belgian education settings and school communities. This reflection should be done at the services level (camhs providers, schools) as well as at the policy level and may urge for joint policies between education and health care.

7.4. Rethinking funding strategies to allow for change

In the literature review as well as in the international overview it appears that the funding mechanisms for camhs are often complex and not transparent. This makes any reform process hazardous. A global overview, not only of the financing mechanism (as described it this report) but also of the magnitude of the budgets involved, could help to make critical decisions in the design of a new camhs framework. With respect to this, the WHO[10] documents important under-financing of camhs, compared to financial resources allocated to other population groups. England, Canada and Norway documented substantial increases in funding resources in order to enable reforms.

It is clear that the type of financing influences care provision, and this holds also true in the domain of camhs. Financial integration of funds from different sources might be desirable to facilitate integrated care provision. In fact, in the domain of mental health care and possibly also in the broader literature, only limited evidence is available on how this could best be performed. A reason might be that such research poses substantial methodological challenges.

In Belgium, the use of “project financing modes” is common in the domain of camhs. This implies that specific financial means are provided for a limited amount of time to support innovative approaches, which certainly appears to be an interesting approach. Nevertheless, maybe due to the lack of global framework for camhs, the central authorities are often reluctant to transform these budgets into more fixed financing mechanisms, which in turn often hampers the further development or broader implementation of these approaches when they appeared to be effective.

7.5. Without monitoring and feed-back any reform will soon lose track

The international literature[134] and experiences in foreign countries, especially England, stresses the need for the availability of an efficient monitoring and feedback system for camhs. The Child and maternity health observatory (ChiMat) in England provides the loco-regional authorities, national government, as well as the individual provider with many tools to optimize camhs provision, while the Camhs outcome research consortium (CORC) gathers and validates extensive data on outcome measurement, direct available to service providers as well as to commissioners. In the Netherlands, the VIR (Verwijs Index Risicojeugd) is introduced as a compulsory tool to register, communicate between professionals, and monitor care services offered to youth at risk. This compulsory monitoring system should allow broad inter-agency collection of data. Existing monitoring systems in Belgium lack the power to provide useful data for a global camhs reform.

The introduction of such a monitoring system has proven to have many advantages in the models studied: the system allows for a continuous view on the population dealt with in the care system and it allows different types of service providers to report the data concerning their specific interventions in a universal (online) platform that is sufficiently tailored to their particular type of work, but remains sufficiently generic for other types of service providers to report their activities.

7.6. A global camhs framework will not stand without a qualitative camhs workforce.

Based on international recommendations and examples of neighbouring countries there appears to be a need for specific training for all professionals involved with camhs. In Belgium for most of the involved professions, there is a lack of dedicated training as it comes to child and adolescent mental health care, in their basic curriculum. Mandatory specialist vocational training for all professionals involved should be considered. These trainings should be based on current international standards. By analogy to other (medical) professions, the need for a continuous life-long training should also be stressed. This continuous education should also be made compulsory for professionals working in camhs.

Furthermore, foreign examples such as in the Netherlands (NJI, Kenniscentrum KJP) and in England (ChiMat, CORC) have shown great efforts to provide specific knowledge centres and databases for camhs. These efforts could be facilitated through international collaboration.

Besides service- and knowledge development and workforce training, strong camh leadership will be required to implement the local plans and adapt the offer to evolving population needs. That leadership may require a thorough camh experience as well as organizational and executive skills.

7.7. Limitations of the current study

First of all it has become clear that the organization of child and adolescent mental health services occurs in a very complex field, entangled with many issues such as general youth policy, legal position and children's rights, justice, education, (general) health and many other aspects influencing children's and adolescents' development and mental health. Studying this organization interferes with many domains as well, e.g. the field of evidence based interventions and treatment, of organization knowledge and of health economics. Therefore, for feasibility reasons, we had to narrow our scope, and this study can only give a broad overview of some aspects of camhs organization, without giving many details.

Secondly, In the course of this study we were confronted with a quickly changing reality in some countries studied, as a consequence of changing government cabinets, taking office after elections, and ongoing reforms also in the field of camhs policy.

Third, it became very obvious in the course of the study that literature results were limited twofold: at the one hand we were confronted with limitations in the literature: most studies focus on models for service delivery for severely emotional and behavioural disturbed children, or deal with a limited aspect of camhs. Models focusing on the continuum of services or at the primary care are less prominent. Laboratory-like experiments do not predict necessary results in a more clinical environment, and clinical health services research has to deal with many methodological challenges. At the other hand, peer reviewed literature is seriously biased by overrepresentation of US based studies. Research conducted in countries with a health system, financing mechanisms and budgets comparable to the Belgian system is virtually absent, reducing the relevance for the Belgian context. The examples from international comparison are also almost idiosyncratic implementations that are not easily applicable to a different context.

Internationally agreed definitions and consensus on outcome parameters, and comparable inter-sector data gathering, through a shared monitoring and feedback system, could enhance understanding of the complex reality of child and adolescents development, and children's and adolescents mental health needs.

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