REFERENCES

Child and adolescent mental health in Europe

Research on best practice

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This snapshot looks at the Child and Adolescent Mental Health in an Enlarged European Union: Development of Effective Policies and Practices (CAMHEE) project. This European Commission (EC) funded project aimed to provide a set of guidelines for effective mental health policies and practices. One element of the work was to map research on best practice with the specific objective of analysing community based child and adolescent mental health (CAMH) activities, specifically focusing on successful examples of deinstitutionalisation. The research uncovered predominant service areas, the most frequently targeted client groups, philosophies and ways in which services are structured, budgets, financing and other aspects of service provision. The most problematic issues identified by the research were political passiveness and a lack of transparency in some settings.

Moving up the European policy agenda

It is stated that European citizens have a right to a good mental health. This especially should be true for our youngest generation, upon whom rest our future hopes for strong social cohesion, productivity and better health. Through the enlargement of the European Union (EU) in 2004, as well as in preparations for a World Health Organization (WHO) European Region Ministerial conference on Mental Health in 2005, the importance of CAMH began to be addressed through the concerted efforts of the EC, WHO and national authorities of EU member states. Recommendations of a pre-conference on Child and Adolescent Mental Health in Luxembourg in September 2004, as well as the final Declaration and Action Plan approved in the Ministerial Conference on Mental Health in Helsinki in January 2005, put a clear emphasis on the urgent need for the development of effective CAMH policies and practices in an enlarged Europe. Most countries that joined EU in 2004 and 2007 have had to contend with major problems in the field of CAMH, revealed by strikingly high rates of poor mental health among children and young people.

There remains a concern that in many countries in central and eastern Europe financial and human resources are still largely invested in services that contribute to traditional patterns of social exclusion, institutionalisation and stigmatisation of children, youth and parents at risk. This creates and reinforces the vicious circles of a culture of dependence, learned helplessness, exclusion and a lack of tolerance. Many new EU member states acknowledge that they need to undergo a complicated transition to a system based on principles of participation, the involvement of families and communities and strong primary care involvement. Moreover, there needs to be an emphasis placed on mental health promotion and the concept of citizenship as basic prerequisites. for the good mental health of children and their parents.

The CAMHEE initiative: mapping best practice

In January 2007 a new EU-wide initiative in CAMH emerged in Lithuania, through the creation of the CAMHEE project supported by the EC’s Public Health programme. As noted above, CAMHEE had the objective of providing a set of recommendations and guidelines for effective CAMH policy and practice in EU, with a special emphasis on new EU member states. It was conducted in light of the Declaration and Action Plan endorsed by WHO European Ministerial Conference on Mental Health in 2005.

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Further information on the CAMHEE project is available at http://www.camhee.eu/
The general approach was based on the understanding that new EU member states have to make proactive concerted efforts to develop effective approaches to CAMH promotion. They need to evaluate the new situation, and identify opportunities for action, as well as gaps to be plugged, by drawing on the rich experience of EU15 countries. One element of the work was to map research on best practice, with the objective of analysing community based CAMH activities, specifically focusing on successful examples of deinstitutionalisation of children with disabilities and other risk factors.

A bespoke questionnaire was developed and disseminated to health, social care and educational organisations that had some responsibility for CAMH. This research was conducted between May and July, 2008. Sixty-four questionnaires were completed by experts in Lithuania, Bulgaria, Norway, Germany, Belgium, Latvia and Greece. Forty-seven organisations were from new member states. Data were analysed using the Statistical Package for Social Sciences (SPSS) and Microsoft Excel. Descriptive statistics were applied to the data analysis.

**Survey results**

Approximately two-thirds of participant organisations indicated that their main service domain comprised of primary and secondary prevention (66%), psychosocial care (64%) and the provision of educational services (61%). Families were most frequently targeted, with 92% of organisations providing services to families. Emotional and conduct disorders were the most frequently targeted problems (70% and 69% respectively) reported by respondents. Providing services to victims of abuse and individuals with poor parenting skills was also noted as an important activity (62%).

79% of respondents emphasised that teamwork was the overarching service provision philosophy. Community-based service provision was the second most essential issue, with two-thirds of organisations surveyed mentioning its significance. More than half indicated using client involvement (58%), a risk management approach (53%) or individual engagement-based care (53%). The most popular way (81%) of service structuring was to offer training to non-medical clientele to implement interventions, as well as increasing the competence of professional staff, including psychologists.

A considerable number of organisations (71%) had an agreed procedure for arriving at case-formulation through contributions from their staff members and other sources. Only one third of organisations used data such as the average number of sessions, duration of care episodes or costs to indicate their involvement with specific cases.

The majority of organisations (65%) surveyed offered their services for free; almost one-third (31%) stated that they had a mixed system of charging; less than 5% fully charged for services. When pricing their services, only 16% applied market prices, while one-third used their own price lists. The remainder employed a variety of strategies for setting prices.

Projects, rather than maintenance grants, are the main source of financing (58%), which raises questions about the sustainability of some services. The respondents identified two key sources of funding: local government (26%) and central government (20%). 22% supplemented public funds with their own income, largely generated through fees paid by service users, as well as membership subscriptions, donations and the time of volunteers.

The majority of the organisations are autonomous (60%), while one-third are integrated into other services (33%). When integrated, organisations usually noted that they held a special position, having been founded by an institution (for example, a municipality or hospital) but enjoying extensive autonomy. One of the organisations described its functioning as separate and autonomous but dependent on specialist care units for service provision.

Despite the fact that research participants were identified as ‘best practice’ examples (and respondents also stressed their achievements instead of problems), the questionnaires revealed several challenges. First of all, participants remain inactive in the sphere of policy development; less than one-third (31%) stated they had taken a proactive stance. This fact may signal a discrepancy between services provided and priorities in national mental health policy. Gaps in legislation, coupled with unclear mandates for different actors in the field, have created uncertainty, with overlapping services on the one hand and serious gaps in service provision on the other.

Though human rights violations for individuals in residential mental health institutions represent significant challenges for new EU member states, approximately one fifth also indicated deinstitutionalisation as an essential element of their future activities. A similar trend was identified when analysing targeted problems: institutional stigma turned out to be the least interesting issue for respondents, with only 23% being active in this area.

Secondly, we encountered a significant lack of evaluation culture, evidence based service evaluation and monitoring. 85% of organisations chose to carry out an internal evaluation of services provided, whereas only 51% were subject to any external evaluation. External evaluation is likely to be more objective, critical and show the real state of the affairs. Organisations in ‘old’ member States more often acknowledge the importance of such evaluation, unlike the situation in eastern and central Europe where they remain committed to internal evaluation. This situation reflects different democratic traditions, attitudes towards clients, quality of services and a lack of constant verification of compliance with national mental health policy.

Interestingly, several organisations from new member states claim to use informal conversations instead of any official complaints mechanism, implying that unregistered complaints do not appear in the records. This may hide dissatisfaction with services provided. Sharing experience of best practices and moving towards a better culture of evaluation and evidence based decision making process would help to identify strengths, weaknesses and challenges for the development of evidence based and sector wide national CAMH policies in both the current enlarged EU and candidate countries.

It is hoped that the outputs of the CAMHEE project, allowing for the exchange of positive experiences and facilitating cooperation across countries, will provide a new impetus and support for better mental health promotion, mental disorder prevention and treatment for children and adolescents. However, negative factors, like the apparent lack of external evaluation and political passiveness of some research participants in new EU member states, allow us to presume that this is only the tip of the iceberg and that there is much more to do. Child and adolescent mental health requires much more academic, political and social awareness, as well as support and incentives for further development.