

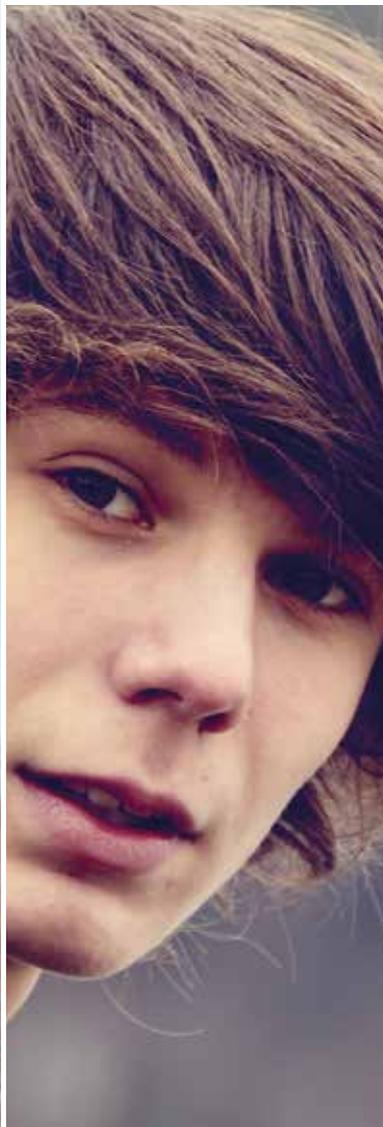


Adolescent mental health care in Europe: state of the art, recommendations, and guidelines by the ADOCARE* network

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BRUSSELS

DECEMBER 2015



COLOFON

***ADOCARE: Service contract SANCO/2013/C1/005 - 512.668919**

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The ADOCARE network of participants (See page 38/39)

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*ADOCARE: service contract with the European Commission to implement a preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems, service contract SANCO/2013/C1/005 - 512.668919.

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FOREWORD

Every adolescent is entitled to grow up to be a healthy and responsible adult who is able to fully participate in society and lead a happy life. Unfortunately, one in five adolescents is affected by at least one psychological problem. Today, young people and their family often cannot find adequate treatment and support, partly because the quality and the availability of Adolescent Mental Health Care (AMHC) fail to meet the needs and demands of young people (WHO, 2005).

In 2009, to respond to this urgent need for adapted, integrated and multidisciplinary care for adolescents with mental health problems, the European network, Action for Teens was created.

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

The overall mission of the ADOCARE project was to improve MHC for adolescents in European member states by:

- Collecting the latest and most relevant information, ideas and insights on AMHC.
- Assessing the quantity and quality of AMHC services in ten participating member states.
- Developing guidelines and recommendations for governments and services to improve AMHC.
- Establishing an innovative, cross-sector, collaborative network of European experts in the field of AMHC.
- Raising awareness and encouraging countries to improve or establish AMHC.

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

The current document comprises the executive summary of the most important insights that were collected throughout the ADOCARE project in answer to the research questions. Based on the research findings, guidelines and recommendations are formulated supporting policy makers (macro level), services (meso level) and professionals (micro level) in their attempt to improve AMHC in their country.



EXECUTIVE SUMMARY

1. INTRODUCTION

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

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

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

Mission and objectives of ADOCARE

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

To achieve this mission, ADOCARE:

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

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

ADOCARE network

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

Awareness-raising and capacity building activities

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

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

Research objectives

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

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

Research method

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

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

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

2. The state of adolescent mental health in Europe

The overall state of adolescent mental health

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

In many adults with a mental disorder, problems started in childhood or adolescence, mostly between age 12 to 24 (Paus et al., 2008). Half of the people who meet the criteria for a major DSM-IV diagnosis at the age of 26, had a first diagnosis

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

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

3. The organisation and typology of AMHC

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

4. The availability and quality of AMHC

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

Availability of AMHC

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

Quality of AMHC

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

5. Strategies to improve availability of AMHC

Balanced care

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

- Primary health care services for persons with common mental health problems. These services conduct case finding and assessment, short psychological and social interventions as well as social treatments and pharmacological treatment.
- General MHC services for persons with more complex problems and consisting of five components: outpatient/ambulatory clinics, community mental health teams, acute inpatient care, long-term community-based residential care and support in work and occupation.

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

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

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

Treatment in primary care

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

Epidemiological and administrative data

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

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

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

The treatment gap

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

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

6. Strategies to improve the quality of AMHC

Quality of care can be considered as a complex and multidimensional construct which is defined according to several inter-related dimensions: access to service, relevance to need, effectiveness, equity, social acceptability, efficiency and economy (Maxwell, 1992). Several strategies to enhance the quality of AMHC emerged from the research conducted by the ADOCARE network of experts.

A developmental approach

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

Early detection of mental health problems

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

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

Bio-psycho-social approach

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

Psychosocial interventions are generally considered as the first line of professional treatment (Bohlin & Mijumbi, 2015). Psychosocial interventions refer to a variety of interventions, including help in one's social situation (such as financial support, education, employment, and housing), psycho-education, coaching and counselling, and information or training. Each intervention aims at improving behaviour, overall development or specific life skills and this without the use of medication (Reichow, Servili, Yasamy, Barbui, & Saxena, 2013; Uitterhoeve et al., 2004). Psycho-education is a crucial psychosocial intervention. Especially, psycho-education in parents has proven to be beneficial: it increases parents' knowledge about symptoms and problems, stimulates greater use of appropriate services, strengthens problem solving skills, and induces positive emotions and family interactions (Lucksted, McFarlane, Downing, & Dixon, 2012). Psychotherapy is also an important intervention when treating severe mental health problems. A critical overview of psychotherapies and their evidence-base for children and adolescents is presented in the book "What Works for Whom" (Fonagy et al., 2014).

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

Web-based interventions

A large number of e-health interventions, web-based interventions and mobile applications (i.e., m-health) have recently been developed. Many adolescents daily connect to the internet, so this medium has enormous potential to inform them about mental health care, increase access to care, engage them more actively during treatment (follow-up, planning, additional support, information, etc.), initiate after-care and provide web-based treatment. (Price et al., 2014). These days, several web-based mental health tools for depression, anxiety, and suicide prevention in children, adolescents, and young adults are being developed. However, findings as to their effectiveness are mixed. More research is definitely needed (Boydell et al., 2014; Reyes-Portillo et al., 2014; Ye et al., 2014). During the ADOCARE research, adolescents pointed out that a quality label for websites and apps would be helpful. They find that it is not up to them to determine whether a website or app is trustworthy or not. Another point they made was that professional support is essential to help them interpret the information that is provided on the internet and to guarantee personalised treatment.

Shared decision making (SDM)

As stated in the Convention on the Rights of the Child, adolescents have the right to participate in all decisions that affect them. Adolescents confirmed this during the ADOCARE research: “Young people should be actively involved when decisions about their treatment are being made - nothing should be decided about them without them.” Professionals of the ADOCARE network, on the other hand, argued that an adolescent’s maturity determines to what extent they are involved in treatment decisions.

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

Evidence-based practices (EBP’s)

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

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

Parental involvement

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

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

Continuity, integration, and coordination of care

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

Continuity of care is also closely related to integrated care which is defined as: “*a coherent set of methods affecting funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between different sectors*” (Kodner & Spreeuwenberg, 2002). For adolescents with mental health problems providing integrated care is very important. Young people mostly have multiple needs (psychological, medical,

social, educational, vocational). They require a mix of services provided sequentially or simultaneously by multiple care providers often employed by different facilities in various sectors. In order to provide high quality care, integration of these various levels of care is a must.

Translating continuity of care and integrated care into practice requires strategies at various levels, ranging from macro to micro level (Gröne & Garcia-Barbero, 2001; Kodner & Spreeuwenberg, 2002; Mur-Veeman, Hardy, Steenbergen, & Wistow, 2003; Thornicroft & Tansella, 2003; Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). At macro level, integration is strongly determined by the broader organisation of mental health services and by the way government departments and ministries either opt for a common or separate framework for sectors involved (WHO, 2005). Sadly, legislation and funding systems mostly hinder coordinated care. Collaboration is often based on ad hoc arrangements made by clinicians. Hence, it is important to point this out to governments so that they provide a suitable framework for collaboration. It is their task to highlight the benefits and advantages of working together and to address people’s fears and resistance of change. Collaborative activities such as meetings attended by professionals from various organisations involved in the treatment can be reimbursed. Other strategies are creating local committees to supervise the quality of care and to steer collaboration across services and centralising information on different initiatives on one website (WHO, 2005).

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

The transition from AMHC to adult MHC services

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

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

- When developing and implementing protocols to improve transition, the needs of the adolescent are at the core of every decision made. In order to achieve that, a number of basic rules need to be respected. The time frame and everyone’s responsibility are clearly defined. Adolescents are well-prepared. There is a backup plan in case adult MHC services are unable to accept the transition. Finally, services should be flexible when it comes to the age of clients.
- An adolescent switches to an adult service at a moment his/her condition is stable. Services avoid multiple, simultaneous transitions. Adolescent and adult MHC services collaborate closely, either they work together across services or they provide periods of parallel care. Adult services are actively involved before the adolescent service discharges a case. Services need a standardised record keeping system so they can easily transfer all correspondence and contact information.
- Local adolescent and adult MHC services and voluntary services are mapped and regularly updated (their scope of operation, communication networks and key contacts).
- Professionals truly understand how to get this transition of care right. Training addresses issues concerning referrals to other services, increases knowledge of other services and focuses on self-efficacy and skills.
- Policy plans contain strategies to improve transitional care.
- Four criteria are used to evaluate transition: perceived continuity of care, parallel care, a transition planning meeting, and information transfer.

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

Bridges to the real world

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

Outreaching

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

Ethical considerations

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

Gender disparities

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

Training and education

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

Results of the ADOCARE research show that the profession of adolescent psychiatrist is recognised by law in only 5 out of 10 participating member states (Finland, Germany, Hungary, Italy, and Lithuania). The profession of adolescent psychologist isn't formally recognised as a separate profession anywhere. It is important to note that, across Europe, the education and training programmes of mental health professionals differ significantly and abide by different standards (Union Européenne des Médecins Spécialistes, 2014). This means they are difficult to compare. A common EU model for the education and training of professionals and teams in AMHC might be helpful without neglect of the local education needs. The European Federation of Psychiatric Trainees (EFPT) and the Union of European Medical Specialists (UEMS) each formulated recommendations for training programmes for psychiatrists in general and child and adolescent psychiatrists in particular.

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

Youth friendly MHC services and staff

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

- Actively involve young people in service design, care delivery (e.g., peer support, group therapy, self-support groups), evaluation and monitoring of a service (Bielsa et al., 2010). In some services, adolescents are involved in the development of the service charter on confidentiality, opening hours, treatment programme, rights of adolescents, ethical aspects and so on.
- Be easy to access so adolescents experience few barriers. This implies drop-in services, convenient opening hours, access without the permission of parents, low cost or free services, reduced waiting times, convenient location near public transport, availability of e-health tools, an appealing and welcoming environment, discrete entrance, positive image.
- Invest in activities/communication that raise awareness (leaflets, posters, website, etc.) and strengthen mental health literacy. Adolescents often do not know what to do or where to go to when they need help.
- Provide clear information on legal (confidentiality) and economic (affordability) aspects. Amongst other things, it should be clearly explained what adolescents can expect when they are under 18 and they reach out to a service unbeknownst to their parents.
- Make an effort to guarantee continuity in therapeutic relationships with professionals for instance by minimizing staff turn-over. Adolescents are in a turbulent phase in their life. Hence, professionals should try to provide stability.
- Engage good role models (i.e., adolescents who experienced similar problems in the past) as they have a beneficial effect on the well-being of adolescents.

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

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

Quality Indicators

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

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

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

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

Structural quality indicators	<p>The service is accessible: adolescents have access to health care, in time, irrespective of income, physical location, and cultural background. There are no waiting lists; the service is affordable and easy to reach.</p> <hr/> <p>Resources are used in a cost effective way.</p> <hr/> <p>Services are sustainable in terms of facilities, workforce and equipment.</p> <hr/> <p>Professionals are capable and skilled and follow trainings on adolescent related topics on a regular basis.</p> <hr/> <p>The service has an improvement plan that is implemented and the progress that is made is followed up.</p> <hr/> <p>Structural requirements are implemented to ascertain the patients' dignity and basic needs.</p>
Process quality indicators	<p>The provided care is appropriate in the sense that the interventions are relevant to adolescents' needs and are based on established standards.</p> <hr/> <p>There is a balanced use of psychosocial, medical and other interventions.</p> <hr/> <p>There is continuity and coordination of care (i.e., uninterrupted, coordinated care across programmes, practitioners, organisations and levels over time).</p> <hr/> <p>There is collaboration with other services in order to provide integrated care.</p> <hr/> <p>Services are able to be innovative.</p> <hr/> <p>Professionals have a positive attitude toward adolescents. They act in a respectful, honest, supportive, friendly and trustworthy manner.</p> <hr/> <p>Services and professionals apply the principles of shared decision making during practice.</p> <hr/> <p>Services and professionals empower adolescents by teaching them how to cope with their problems and by encouraging them to ask for help when they are confronted with problems in the future.</p> <hr/> <p>Services address ethical principles and respect the human rights of adolescents.</p>
Outcome quality indicators	<p>The provided treatment has a positive impact on the symptoms of adolescents, on their everyday life (e.g., days at school, coming home before midnight, fighting behaviour, etc.) and on their quality of life.</p> <hr/> <p>The positive effects resulting from the provided treatment are preserved in the long run (e.g., after one year).</p> <hr/> <p>The desired outcomes are achieved within a reasonable time frame.</p> <hr/> <p>The level of dropout is reduced to a minimum.</p> <hr/> <p>Professionals are satisfied with their work. There are low staff turn-over rates, the number of sick-leave days among professionals is low and the incidence of burn-out is low.</p>

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

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

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

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

Strategies in a school setting

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

- Provide basic training to teachers in mental health. Teachers are constantly present in the life of adolescents. They are in a position to detect problems at an early stage and they can give valuable support. Therefore, it is important that teachers receive basic training in mental health promotion, in mental health problems and in ways to prevent and recognise these problems.
- Engage mental health professionals at school. During the ADOCARE research, it was pointed out not to burden the teachers unnecessarily with providing support and care to adolescents given their high workload. Besides, some mental health problems require experienced professionals. In these cases, teachers should be able to rely on mental health professionals working in the school setting (e.g., school nurse, school counsellor, school psychologist). These professionals can advise teachers on how to manage students with mental health problems, they can provide direct support to adolescents or they can refer the student to an expert.
- Collaborate with external mental health professionals. In some cases, the support provided by teachers and school mental health professionals is not sufficient and thus an external professional needs to be engaged. School mental health professionals should have the opportunity to collaborate with mental health professionals working outside the school setting. For instance, community mental health clinicians can be placed on-site in schools. A recent study shows that this formula has a positive influence on suspension rates, school attendance, and emotional and behavioural symptoms in adolescents as perceived by parents and teachers (Ballard, Sander, & Klimes-Dougan, 2014).
- Organise classes on mental health. Adolescents do not only need to know how their body works, they also need to understand how their mind works (ADOCARE, 2015). Classes, integrated in the curriculum, should focus on mental health issues such as building resilience, respecting others, teaching social skills, managing difficult situations, promoting help-seeking as a personal strength, promoting family involvement, expressing emotions, and developing personal strengths (Vidal-Ribas, Goodman, & Stringaris, 2015). These classes can either be given by care teachers or health educators, but it is also an option to invite a mental health professional as a guest speaker. Meeting a professional in the classroom possibly lowers the threshold for adolescents to visit a professional later on when needed. It is highly recommended that classes on mental health adopt an innovative approach based on interaction. As such, the main focus lies on acquiring knowledge, attitudes and skills simultaneously. During the ADOCARE research adolescents pointed out that classes on mental health may evoke bullying and teachers should be very much aware of this.
- Organise health care check-ups. Generally, prevention and screening programmes are regarded favourably within the school context. Such programmes require: gathering and screening of data, using the results in a multidisciplinary school

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

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

8. Policies and legal frameworks related to AMHC

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

Challenges regarding adolescent mental health policy

- Develop a clear vision on AMH. In most countries AMHC is no priority because policy makers are not aware of the mental health needs of adolescents. It is imperative to consider adolescents as a specific target group with distinctive needs. Understanding the needs of adolescents and informing policy makers are a shared responsibility of the EU Commission, lobby groups, researchers, professionals and adolescents and their families.
- Develop and implement specific AMH policies and plans. The WHO developed a guidance package for policy makers. It describes the successive steps to take and helps policy makers develop and implement AMH policies and plans (WHO, 2005). During the policy making process, it is highly recommended to closely involve adolescents and their parents as they know best what their needs and pitfalls are. Of course, attention should also be paid to evaluation. These evaluations need to be scientifically sound and are preferably published so that other countries may benefit from the work carried out. For the evaluation of policies and plans, there are easy to use checklists developed by the WHO (2009).
- Implement clear legislation on the rights of young people. The Universal Declaration of Human Rights and the Convention on the Rights of the Child are good sources of inspiration for the development and design of new policies, legislation and frameworks for action. Moreover, governments are advised to draw up clear legislation on the following topics: how adolescents can claim help without their parents’ permission, the right of youngsters to co-decide in their own treatment plan, the rights and duties of parents, restraining order procedures (although they should be kept to a minimum), the registration and access of patient records, and the use of e-health.
- Define a core package of basic services available for adolescents across the EU member states (WHO, 2002). Countries are stimulated to move the balance of care away from established institutions and to advocate better community-based systems of support and treatment (Knapp, McDaid, Mossialos, & Thornicroft, 2006). All over Europe, investment in MHC services exclusively developed for adolescents is urgently needed. The age range of these services should be broad and flexible and should preferably span from the age of 9 to 25.
- Allocate sufficient financial resources to AMH. Policy plans need to state clearly how much of the gross national product is allocated to mental health in general and how much is spent on AMH in particular. As recommended by the WHO (2005), the budget for child and AMHC services equals the budget spent on adult mental health. During the ADOCARE research it was stated that increased funding for prevention, mental health promotion, and targeted treatment for adolescents actually saves money in the long term. Mental health problems can be intercepted early on. In doing so, clients do not develop complex mental health problems in adulthood requiring expensive long term treatment.
- Stimulate cooperation between sectors and professions. As referred to earlier, it is a good idea for governments to work out a generic framework to facilitate collaboration and integration between sectors, services and professions.





GUIDELINES AND RECOMMENDATIONS

The present guidelines aim at supporting policy makers (macro level), services (meso level) and professionals (micro level) in their attempt to improve AMHC in their country. It does so by outlining concerted actions. Adolescence in this text spans the ages 12 to 24. The recommendations and actions proposed are the result of a two-year research process. The following groups were consulted on several occasions in a differentiated manner: policy makers, professionals and experts in the field of AMHC, teenagers and young people as well as their families and organisations which represent this age group and their families. In addition we reviewed the most recent literature on MHC in general and AMHC in particular.

The recommendations concern ten areas European countries need to focus on to improve AMHC:

- Availability of AMHC services
- Quality of AMHC services
- Accessibility of AMHC services
- Personalised treatment
- Integrated care
- Transition of adolescents from AMHC services to adult MHC services
- Training of professionals
- Prevention and mental health promotion
- Policy and legal frameworks
- Research

1. AVAILABILITY OF AMHC SERVICES

Recommendation: Each country is committed to pursue a balanced care model.

Proposed actions at macro level:

- When establishing balanced MHC, the following types of services are considered necessary:
 - Primary health care services for persons with common mental health problems. These services are responsible for case finding and assessment, short psychological and social interventions as well as social treatments and pharmacological treatment.
 - General MHC services for persons with more complex problems. General MHC services comprise five components: out-patient/ambulatory clinics, community mental health teams, acute inpatient care, long-term community-based residential care and support in work and occupation.
 - A series of specialised MHC services in each of the five categories of general MHC services to provide more intensive/expert interventions (e.g., autism, schizophrenia, eating disorder, addiction, severe depression and suicidality).
- A balanced care model implies that both community and hospital care are available and provided in a pragmatic and balanced way. This means that in countries with many residential services, the number of beds will need to decrease in favour of more community-based care and mental health promotion.
- The evolution towards more balanced care goes hand in hand with a more important role for primary care in mental health. Mental health interventions and treatments and non-specialised primary health care for adolescents are integrated. Examples of the latter are concerns about sexual health, career options, general health, bereavement support, campaigns to stop smoking.
- Services are linked in a regional network, they develop a joint mission and strategy and make sure their services are complementary. There is neither overlap nor are there gaps.
- Governments make sure the principles of stepped care are applied.

Proposed actions at meso level:

- The guiding principle in the choice of treatment and interventions is stepped care:
 - Appropriate non-specialised care is provided first.
 - Adolescents are only referred to more specialised care when this appears necessary.
 - Professionals (especially primary care workers) but also parents acknowledge that not all mental health problems require specialised care and that much can be done within primary care or community-based care.

Proposed actions at micro level:

- General practitioners and other primary care professionals are trained to recognise AMH problems.
- They are able to use short term interventions and are aware of assessment tools to decide whether more specialised care is required.
- They apply the principles of motivational interviewing and shared decision making to determine treatment and decide whether referral is needed.

Recommendation: Availability of AMHC services is guaranteed for all adolescents that need care.

Proposed actions at macro level:

- Countries need to obtain a clear view on their availability of MHC services for adolescents. It is essential to identify the treatment gap. This is defined as the absolute difference between the prevalence of mental health problems among adolescents and the percentage that receives appropriate treatment.
- Once the required number of MHC facilities and professionals per 100,000 adolescents is defined, governments need to take action to close the potential treatment gap.
- Availability of each of the three types of health care services is guaranteed (primary health care services, general MHC services, and specialised MHC services). Balanced care is equally available throughout the country.

2. QUALITY OF AMHC SERVICES

Recommendation: Each country has youth friendly services tailored to the needs of adolescents.

Proposed actions at macro level:

- Governments make sure that the three types of health care services needed to achieve balanced care operate in such a way that adolescents feel welcome and understood. Services are youth friendly.

Proposed actions at meso level:

- Services apply their age range (12 to 24) in a flexible way.
- Services are easy to access so that adolescents experience few barriers. This means :a welcoming and attractive environment, drop-in services, convenient opening hours, access without the permission of parents, low cost or free services, reduced waiting times, convenient location near public transport, discrete entrance and a positive image.
- Services provide clear information on legal (confidentiality) and economic (affordability) aspects.
- Young people and their parents are actively involved in service design, care delivery and procedures of a service. For instance, adolescents can be involved in the development of a service charter which addresses issues such as confidentiality, opening hours, treatment programme, rights of adolescents, ethical aspects.
- Services engage good role models in care delivery (i.e., adolescents who experienced similar problems in the past) as they have a beneficial effect on the well-being of adolescents. Examples are peer support, group therapy, self-support groups.
- Services guarantee continuity of care so that adolescents are preferably treated by the same team of professionals.
- Services reach out to adolescents in order to prevent drop-out of adolescents in need of help, to offer support and treatment.

Proposed actions at micro level:

- Youth friendliness is an important characteristic for staff working in AMHC. Besides their clinical competencies, professionals have a positive attitude towards the life and lifestyle of adolescents. They respect their target group and are highly motivated and honest. They are easy to connect with and they develop an empowering helpful relationship.

Recommendation: AMHC services adopt high quality standards.

Proposed actions at macro level:

- Governments define a set of quality standards that AMHC services should meet. Relevant indicators are amongst others the accessibility of a service, the capability and skills of professionals and the balanced use of psychosocial and medical interventions. For the selection of indicators we refer to the User-generated Quality Standards for Youth Mental Health in Primary Care (Graham et al., 2014) and the Service Standards (seventh edition) (Thompson & Clarke, 2015).
- Governments develop evaluation instruments to assess the quality of AMHC services. The same instruments are preferably used across services, regions and countries, to allow comparison.
- The evaluation is carried out by an independently funded research organisation. Services that do not comply, are offered assistance to improve their quality of care.

Recommendation: When providing care, ethical considerations and values are taken into account.

Proposed actions at macro level:

- An ethical committee is in place to provide feedback to professionals on ethical dilemmas.

Proposed actions at meso level:

- Services abide by the ethical principles of autonomy, beneficence and equity that are stated in the Belmont Report (Michaud et al., 2010).
- Ethical issues concerning confidentiality in treatment, the right of adolescents to access their patient record and to participate in their treatment are clearly outlined in a service charter. This charter is developed in collaboration with adolescents.

3. ACCESSIBILITY OF AMHC SERVICES

Recommendation: MHC services are highly accessible for adolescents.

Proposed actions at macro level:

- Governments and the media take action to overcome stigmatising attitudes toward mental health problems and the use of MHC. A recurring theme is that mental health issues are a normal part of life and that searching for help is no sign of personal weakness. Actions should particularly target boys as their mental health literacy is less developed and they are less willing to look for help.
- The knowledge of young people regarding mental health and MHC should be increased. This can be done by providing attractive, easy-to-navigate and read websites and by targeting mental health literacy through the school curriculum.

Proposed actions at meso level:

- Services provide online information on the support they give. The communication style appeals to youngsters and is very matter of fact. Concerns related to confidentiality are addressed in a transparent way.
- Services reach out in order to stay in touch or establish contact with the most vulnerable adolescents. This group hardly ever accesses help on a voluntary basis.

Recommendation: Mental health treatment is integrated as much as possible in non-specialised primary health care.

Proposed actions at meso level:

- General practitioners are stimulated and trained to recognise mental health issues at an early stage. During this type of intervention they assess different areas of life (home environment, education, employment, eating patterns, activities, drug use, sexuality, addictive behaviour, suicide/depression, signs of injury and violence) and they make sure the severity of psychological problems is not underestimated.
- Youth clubs can provide information on mental health and offer basic support to adolescents with mental health problems.

Recommendation: The internet can make MHC more accessible for adolescents.

Proposed actions at macro level:

- Web-based interventions are encouraged to increase access to mental health care, to inform adolescents about care, to engage adolescents more actively during treatment and to make sure care after treatment has been completed.
- Governments assign quality labels to websites, tools and apps so adolescents know that they are dealing with a reliable and youth friendly website.

Proposed actions at micro level:

- Professionals are aware of reliable internet-based interventions for adolescents.
- Internet-based interventions are preferably supplemented by professional support. The idea is to help adolescents interpret the information they find online and to guarantee a personalised treatment.

4. PERSON-CENTRED TREATMENT

Recommendation: Support, coaching and treatment is offered in a person-centred way and actively involves the adolescents.

Proposed actions at micro level:

- During assessment, professionals take the adolescent's bio-psycho-social functioning into account. They focus on the client's psychological problems as well as on his strengths and competencies.

- During treatment, professionals involve young people in the decision making process by applying the principles of shared decision making. Professionals clearly state that there are choices to be made, provide detailed teen-oriented information about the different options and support adolescents in exploring preferences and making choices.

Recommendation: Every adolescent receives an effective combination of bio-psycho-social treatments.

Proposed actions at macro level:

- In countries where the biomedical paradigm is the exclusive or dominant treatment model, governments take action to stimulate the use of the bio-psycho-social paradigm. This can be done for example by reimbursing psychosocial interventions in addition to pharmacological treatment.

Proposed actions at micro level:

- Psychosocial interventions are regarded by professionals as the first line of treatment. Most common are psycho-education and psychotherapy, but other interventions might be beneficial such as creative art workshops in which adolescents can express their feelings (music, writing, dancing, painting, etc.) or sports activities. An overview of current evidence-based interventions is available in the book "What works for whom" (Fonagy, et al., 2014).
- Psychosocial interventions do not only focus on cure and care, but also on resilience and strengthening one's competence.
- Medication for serious mental health disorders may be necessary, but it is offered in combination with psychosocial interventions. Professionals are sensitised about the possible overuse of medication and rely on guidelines when prescribing.
- Treatment, coaching and counselling strategies which have proven to be effective are given priority but one needs to keep an open mind for new developments. Guidelines are used as they provide an overview of existing evidence-based treatments (e.g., the Mental Health Gap Action Intervention Guide of the WHO, NICE, etc.). Professionals also resort to protocols on how to implement evidence-based interventions in a standardised way.
- Treatment outcomes are systematically monitored so as to determine whether interventions are efficacious.

Recommendation: Adolescent mental health problems are approached from a developmental perspective.

Proposed actions at micro level:

- Caregivers take into account how the adolescent has developed so far and what developmental issues and crises are influencing the current situation. The idea is to fully grasp the problems at hand and to determine the need for help and support.
- Caregivers acknowledge that the needs of adolescents are subject to constant change. The care plan must follow suit.

Recommendation: Every care plan builds bridges to normal life.

Proposed actions at meso level:

- Recovery and inclusion in society are primary objectives in every treatment plan. Professionals support adolescents in their education, in finding housing and employment and in building trusting relationships with others, so they fully assume their role as citizens. Therefore, collaboration with other sectors is essential.
- When and if possible care is offered in the natural environment of the adolescent. When hospitalised, professionals develop a strategy so that the adolescent has a perspective to go home.
- Supported employment and supported education are important aspects of care for adolescents with severe and enduring mental illness. This requires a systematic collaboration of mental health services with employment and education services (Ellison et al. 2015).

Recommendation: Parents are involved if possible.

Proposed actions at macro level:

- Countries develop legislation on the rights and duties of parents in case their child needs AMHC

Proposed actions at micro level:

- At the start of treatment, parents are informed. Adolescents are encouraged to involve their parents if this has a positive effect on their well-being.
- Parents should receive support when they are experiencing problems themselves or when a dysfunctional relationship is at the heart of the adolescent's problems. A good overview of existing family-based interventions is available for professionals (Kaslow et al., 2014).

5. INTEGRATED CARE

Recommendation: Governments create a common framework spanning all sectors.

Proposed actions at macro level:

- Strategic alliances and care networks are organised at a local level. The aim is to link different levels of specialisation (e.g., primary, secondary and tertiary care services) as well as similar levels of care across sectors (e.g., housing, employing, justice, etc.).
- Local committees are created to steer networking across services.
- When professionals involved in the treatment of adolescents collaborate across sectors, there ought to be a financial incentive. To encourage collaboration, the benefits of working together should be highlighted, or job mobility encouraged across sectors.
- Information on current initiatives is available on one centralised website.

Proposed actions at meso level:

- Multidisciplinary teamwork is the standard, the general practitioner is included as a team member.
- Joined care planning is initiated. The team of professionals shares a common care plan and feels jointly responsible for its implementation.
- Venues for cross-sector discussion and interaction are provided.
- Intensive case management is established. One professional is appointed who has the final responsibility for each case.
- Consensual agreements are drawn up outlining each partner's role and responsibility and referring to procedures and rules that should be followed in case of discharge, transition or conflict.
- A common infrastructure for collecting and sharing patient information between different care providers within or across sectors is established.
- Joined training is organised for professionals of different sectors. That way competencies are transdisciplinary.

6. TRANSITION OF ADOLESCENTS FROM AMHC SERVICES TO ADULT MHC SERVICES

Recommendation: Governments, MHC services and professionals improve the transition of AMHC services to adult MHC services.

Proposed actions at macro level:

- Policy plans contain strategies to improve transitional care. Within the context of the Milestone project, guidelines for policy makers are developed to assist them in making informed and evidence-based decisions to improve health systems.
- Local adolescent and adult MHC services and voluntary services are regularly mapped and updated (i.e., their scope of operation, communication networks and key contacts).
- Mental health professionals are trained on how to optimise transition of care. Such trainings need to tackle negative attitudes concerning referrals to other services, increase knowledge of other services, and improve self-efficacy and skills. Similarly, within the context of the Milestone project, training packages for clinicians across the EU are being developed and will be implemented.

Proposed actions at meso level:

- Services develop and implement protocols to improve transitional care in line with the needs of adolescents. Within this protocol, the time frame and everyone's responsibility are clearly defined. There is a backup plan in case adult MHC services or the patient in question are unable to accept the transfer.
- Services are flexible when it comes to the age of clients. Adolescents who are not ready for transition to an adult service, remain in the care of the adolescent service.

- Services try to avoid multiple, simultaneous transitions, as one transfer already requires a lot of preparatory work.
- The adolescent and the adult MHC service co-manage the transition for a certain period of time.
- Active involvement of the adult service is required before the adolescent service is allowed to discharge a patient.
- Adolescent and adult MHC services use a standardised record system and transfer all correspondence and contact information.
- The transition to adult services is an important quality indicator when evaluating care. Within the context of the Milestone project, specific outcome measures are being developed and validated.

Proposed actions at micro level:

- Adolescents are well-prepared by professionals in the weeks prior to the transition and the transition occurs when the adolescent's condition is stable

7. TRAINING OF PROFESSIONALS

Recommendation: The education of mental health professionals working with adolescents is tailored to that specific group.

Proposed actions at macro level:

- During their education, adolescent mental health professionals receive training on specific adolescent-related topics, such as normal adolescent development, assessment of mental health problems in adolescents, how to communicate with adolescents, shared decision making, evidence-based psychosocial interventions, how to work within an integrated network of services, transitional care, and policies and legislation regarding AMHC.
- Uniform standards are set up for the educational curriculum of adolescent psychiatrists and psychologists in Europe.

Proposed actions at meso level:

- Interdisciplinary training sessions and postgraduate courses are mandatory for clinicians in AMHC services.
- Learning networks are set up to stimulate continuous education on the work floor (cf., ImROC).
- Services organise intervision and supervision on a regular basis.

Recommendation: Professionals who occasionally encounter young people with mental health problems are trained in AMH issues as well.

Proposed actions at macro level:

- It concerns general practitioners, hospital nurses, school nurses, youth workers, public health workers, social workers, and teachers. They receive courses on AMH issues during their basic education.
- Helplines or websites are available. Professionals can consult these in case they have questions or concerns related to AMH.

8. PREVENTION AND MENTAL HEALTH PROMOTION

Recommendation: Countries have an action plan to prevent mental health problems and to promote well-being in adolescents.

Proposed actions at macro level:

- Action plans include interventions to reinforce protective factors (e.g., encourage adequate help-seeking behaviour, support parents in the raising of their child, create good school environments, increase mental health literacy, etc.) and interventions to address risk behaviours (e.g., bullying, poverty, parental violence, substance abuse, etc.). These actions particularly target vulnerable young people and their families.
- Strategies and interventions that appeared successful in other countries are highly recommended.
- The media can play an important role in de-stigmatisation and the distribution of information.

Proposed actions at meso level:

- Health workers reach out to vulnerable adolescents who tend to remain out of view. They visit places where they frequently hang out (e.g., stations, squares, parks, public sport venues, pubs), and invite them to visit their service or give support onsite when needed.
- Certain programmes support the personal development and inclusion of these vulnerable adolescents. We think in this respect of special events or group activities (e.g., cleaning nature to protect the environment, small restorations of public buildings, assistance to the poor, neighbourhood parties, fund raising, etc.). This is a good way to empower adolescents as they learn to successfully engage, take responsibility, build social relations, etc.
- Parents obtain support on how to cope with mental health issues in their child. Websites can help parents identify mental health issues and show them what actions they should take in the best interest of their child.

Recommendation: Schools are a key setting to promote mental well-being.

Proposed actions at macro level:

- Teachers receive basic training in adolescent mental health, mental health promotion, and how to prevent and recognise mental health problems.
- Classes on mental health are integrated in the curriculum of adolescents. Classes focus on issues such as building resilience, respecting others, social skills, dealing with difficult situations, expressing feelings, promoting help-seeking behaviour and empowering youngsters.
- Health care check-ups can be organised in a school setting to detect students who are in need of MHC. Within the context of the "Saving and Empowering Young Lives in Europe" (SEYLE) project a school-based professional screening procedure was developed. However, screening programmes have a detrimental effect when a country has insufficient MHC services. They might create demand for help which is not available.

Proposed actions at meso level:

- Mental health professionals (school counsellors) are engaged at school to provide advice to teachers and/or to offer direct support to adolescents.
- Schools can collaborate with mental health professionals working outside the school setting. For example, external professionals can drop in at the school once a week.
- Classes on mental health can be given by care teachers or health educators, but it is also an option to invite a mental health professional as a guest speaker. In addition, classes are preferably given in an interactive manner to increase knowledge and work on attitudes and skills. Teachers should be attentive to possible signs of bullying which may be evoked by such classes.
- Schools pay special attention to risk behaviours strongly associated with mental health problems. Examples are substance abuse, sensation seeking, excessive use of media, self-injury, delinquent behaviour and truancy. In those cases, the school counsellor tries to establish contact with the adolescent to find out what is going on.
- Schools develop an action plan to address bullying. This is important to prevent mental health problems.

9. POLICY AND LEGAL FRAMEWORKS

Recommendation: Countries develop and implement specific policies and plans on adolescent mental health.

Proposed actions at macro level:

- When designing new policies, legislation and frameworks for action, the Universal Declaration of Human Rights and the Convention on the Rights of the Child are a reference.
- Governments need to acknowledge that improving the quality of AMHC is a key priority and that adolescents have distinctive needs.
- The WHO developed a guiding package for countries describing the successive steps policy makers need to take in order to develop and implement AMH policies and plans (WHO, 2005).
- When policies and plans are being developed, adolescents and parents are closely involved. Policies are evaluated. For instance, by using the WHO checklist for evaluating a mental health policy (WHO, 2009). Results should be exchanged with other European countries to learn from one another.
- Governments draw up clear legislation stating how adolescents can claim help without their parents' permission, the right of youngsters to co-decide in their treatment plan, the rights and duties of parents, restraining order procedures (although they should be kept to a bare minimum), registration and access of patient records and the use of e-health.

Recommendation: Governments allocate sufficient financial resources to AMH.

Proposed actions at macro level:

- In policy plans it is transparent which percentage of the gross national product is allocated to mental health in general and how much is spent on AMH in particular.
- The amount of funding spent on MHC is distributed more evenly between adult MHC on the one hand and child and adolescent MHC on the other hand. By increasing funding for AMH, mental health problems can be detected at an early stage. This prevents complex mental health problems in adulthood that require more expensive, long term treatment.
- Governments make efforts to increase financial resources in order to obtain high quality AMHC.

10. RESEARCH

Recommendation: Epidemiological data are crucial to raise awareness and to support policy makers.

Proposed actions at macro level:

- Governments invest in well-developed data registration systems to collect administrative data. Good examples of standardised assessment instruments are the InterRAI Community Mental Health and the InterRAI Mental Health. Implementing such systems requires time to enter data and train users.
- Epidemiological research can be organised in a collaborative approach across EU countries (cf., the European Study of the Epidemiology of Mental Disorders, ESEMeD study).
- Research particularly focuses on AMH in specific and vulnerable target groups (such as refugees, adolescent Roma, etc.).
- Data on adolescent issues that are collected by other sectors such as dropout rates, youth crime, and sexual abuse are worth studying as well.

Proposed actions at micro level:

- Research centres make sure that epidemiological findings are communicated in a clear and lively fashion to policy makers and the general public so that results are used.





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WE THANK ALL THE PARTICIPANTS FOR THEIR CONTRIBUTION TO ADOCARE

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