KCE REPORTS 170S

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

ORGANISATION OF CHILD AND ADOLESCENT MENTAL HEALTH CARE: STUDY OF THE LITERATURE AND AN INTERNATIONAL OVERVIEW.

APPENDIX

KCE REPORTS 170S
HEALTH SERVICES RESEARCH

Federaal Kenniscentrum voor de Gezondheidszorg
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APPENDIX

MOMMERENCY GIJS, VAN DEN HEEDE KOEN, VERHAEGHE NICK, SWARTENBROEKX NATHALIE, ANNEMANS LIEVEN, SCHOENTJES ERIC, EYSSEN MARIJKE

COLOPHON

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- **The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.**
- **Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.**
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APPENDIX REPORT

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1. APPENDIX 1

1.1. Chapter 1: Definitions

Infant mental health : definition by WHAIMa

The concept of balance between the individual strengths and the environmental conditions of WHO's definition of mental health is supported by the WHAIM on infant mental health, defined as:

"the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system".

Child and adolescent mental health planb

A plan consists of a detailed scheme for implementing strategic actions that favor the promotion of mental health, the prevention of mental disorders and the treatment and rehabilitation of children and adolescents.

Child and adolescent mental health policyc

An organized set of visions, values, principles, objectives and areas for action to improve the mental health of a child and adolescent population.

According to the WHO's Atlas, a Camh policy refers to an easily identifiable section of a country's overall mental health policy or a freestanding child and adolescent mental health policy document (Atlas).

Efficacyd

An intervention's ability to achieve a desired effect in a well defined population group.

Effectivenesse

An intervention's ability to achieve a desired effect in a larger, non-experimental population.

Mental health intervention[f]

A set of activities with the purpose of mental health promotion or mental disorder prevention, treatment or rehabilitation.

Mental health service providerg

Professional, para-professsional, or community-based health or mental health team or institution, which delivers mental health interventions to a population.

Mental health stakeholdersh

People and organizations with some interest in improving the mental health of a population, including consumers, family members, professionals, policy-makers, and children and adolescents themselves.

Valuei

Cultural belief or the moral/ethical standards concerning a desirable mode of behavior or end-state that guides attitudes, judgments and comparison.

Mental Health Promotionj

Is a process of enabling people to increase control over the determinants of their mental wellbeing and to improve it.

Mental Health preventionk

Prevention is a term that refers to all organized activities in the community to prevent occurrence as well as the progression of mental disorders. It

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a WAIMH Handbook of Infant Mental Health, vol 1, p. 25, http://www.waimh.org/i4a/pages/index.cfm?pageid=1

b Mental Health Policy and Service Guidance Package : Child and Adolescent Mental Health Policies and Plans, WHO,2005

c idem

d idem

e idem

f Idem

g idem

h idem

i idem

j WHO Atlas, 2005

k WHO Atlas, 2005

also means the timely application of means to promote the mental wellbeing of individuals and of the community as a whole, including the provision of information and education.

Treatmentl

Includes relevant clinical and non-clinical care aimed at reducing the impact of mental disorders and improving the quality of life of patients.

Rehabilitationm

Care given to mentally ill patients in the form of knowledge and skills to help them achieve their optimum level of social and psychological functioning.

Mental health servicesn

Primary health care

Refers to the provision of basic preventive and curative mental health care at the first point of entry into the health system. Usually this means that care is provided by a non-specialist who can refer complex cases to a higher level.

Community based care

Any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community.

Psychiatric bed

A psychiatric bed is one maintained for continuous (24 hours) use by mentally ill in-patients. The facilities in which such beds are located include public and private psychiatric hospitals, general hospitals and hospitals for special groups such as the elderly and children.

Institution

A facility that may be managed by or sponsored by a social service agency or governmental agency that cares for children who may have mental disorders in addition to their primary reason for being in the institution. These facilities may take care of orphaned or abandoned children, or juvenile delinquents.

Multi-Disciplinary Teamo

refers to a group of people who come from several disciplines. In the case of mental health, those most frequently included are clinical social workers, psychiatric nurses, psychiatrists and psychologists, though occupational therapists, art therapists, child and youth care workers and members of other disciplines may be included. A multi-disciplinary team needs to be distinguished from a multi-sectoral team, as described below. Minimal standards for the composition of multi-disciplinary teams in Belgium may be included in legal acts royal decisions, and decree's, underpinning organization of health services.

Multi-Sectoral Teamp

refers to a team of workers who come from different services sectors, such as acute care, addictions, advocacy groups, child protection, consumers, corrections, education, guardianship, mental health, police, public health and others. A multi-sectoral team may be multi-disciplinary, but could in fact be composed of members of only one discipline, e.g., social work.

Mental Health Financingq

Tax based funding

Money for mental health services is raised by taxation, either through general taxation, or through taxes that are earmarked specifically for mental health services.

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l WHO Atlas,2005

m idem

n idem

o Child and Youth Mental Health Plan, British Columbia, 2003

p Child and Youth Mental Health Plan, British Columbia, 2003

q WHO Atlas, 2005

Social insurance

Everyone above a certain level of income is required to pay a fixed percentage of his or her income to a government- administered health insurance fund. In return, the government pays for part or all of consumers' mental health services, should it be needed.

Private insurance

The health care consumer voluntarily pays a premium to a private insurance company. In return, the insurance company pays for part or all of the consumer's mental health services, should it be needed

2. APPENDIX 2

2.1. Chapter 2: Step 1 Search Strategy

2.1.1. OVID - MEDLINE

2.1.1.1. Part 1:

Date	**2011-01-04**
Database (name + access ; e.g.: Medline OVID)	Ovid MEDLINE(R) 1950 to Present with Daily Update
Search Strategy (attention, for PubMed, check « Details »)	1 Adolescent Health Services/ (3647) 2 Adolescent, Institutionalized/ (91) 3 Child, Institutionalized/ (1556) 4 Adolescent, Hospitalized/ (368) 5 Child, Hospitalized/ (5288) 6 Child Care/ (4199) 7 Infant Care/ (7133) 8 Child Day Care Centres/ (3760) 9 Hospitals, Pediatric/ (6905) 10 Maternal-Child Health Centres/ (1846) 11 Inpatients/ (9028) 12 Outpatients/ (6283) 13 rehabilitation centres/ (5751) 14 Substance Abuse Treatment Centres/ (3623) 15 Ambulatory Care Facilities/ (9604)

16	Outpatient Clinics, Hospital/ (12887)
17	Residential Facilities/ (4043)
18	Assisted Living Facilities/ (599)
19	Group Homes/ (719)
20	Halfway Houses/ (971)
21	Intermediate Care Facilities/ (582)
22	Skilled Nursing Facilities/ (3282)
23	Orphanages/ (229)
24	Home Care Services/ (24410)
25	Foster Home Care/ (2598)
26	Home Care Services, Hospital-Based/ (1402)
27	Health Facilities/ (10085)
28	exp Health Facilities, Proprietary/ (5278)
29	child/ (1172052)
30	adolescent/ (1354123)
31	child, preschool/ (646708)
32	infant/ (550795)
33	infant, newborn/ (433533)
34	*Mental Health Services/ (16234)
35	*Community Mental Health Services/ (10366)
36	*Social Work, Psychiatric/ (1367)
37	*Hospitals, Psychiatric/ (11312)
38	exp Community Mental Health Centres/ (2545)
39	*Emergency Services, Psychiatric/ (1429)
40	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 (96580)
41	29 or 30 or 31 or 32 or 33 (2444866)
42	34 or 35 or 36 or 37 or 38 or 39 (40917)
43	exp *Child Health Services/ (11919)
44	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 43 (43742)
45	40 and 41 (17651)
46	44 or 45 (59366)
47	42 and 46 (1729)
48	limit 47 to yr="1995 -Current" (1060)

Note

2.1.1.2. Part 2 :

Date	2011-01-04
Database (name + access ; e.g.: Medline OVID)	Ovid MEDLINE(R) 1950 to Present with Daily Update
Search Strategy (attention, for PubMed, check « Details »)	---------- 1 *Efficiency, Organizational/ (4683) 2 exp *Hospital Restructuring/ (5082) 3 *Models, Organizational/ (3706) 4 *Multi-Institutional Systems/ (4555) 5 *Organizational Innovation/ (3279) 6 *Organizational Objectives/ (1425) 7 *Public Health Administration/ (8707) 8 *Government Programs/ (1485) 9 *Health Planning/ (10806) 10 *Public Policy/ (13258) 11 *Health Care Reform/ (15842) 12 *Health Policy/ (21919) 13 *health plan implementation/ (974) 14 *health planning guidelines/ (1733) 15 *health resources/ (3378) 16 *health services research/ (10638) 17 *organizational case studies/ (140) 18 *national health program/ (13505) 19 *regional health planning/ (2836) 20 mental disorders/ (102712) 21 psychiatry/ (28213) 22 community psychiatry/ (1517) 23 preventive psychiatry/ (106) 24 20 or 21 or 22 or 23 (125706) 25 Child/ (1172052) 26 adolescent/ (1354123) 27 child, preschool/ (646708) 28 infant/ (550795) 29 infant, newborn/ (433533) 30 25 or 26 or 27 or 28 or 29 (2444866)

	31 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 (118616) 32 24 and 30 (26769) 33 child Psychiatry/ (4317) 34 Adolescent Psychiatry/ (2108) 35 33 or 34 (5313) 36 32 or 35 (31028) 37 31 and 36 (350) 38 limit 37 to yr="1995 -Current" (242)
Note	

2.1.2. Search Strategy EMBASE

2.1.2.1. Part 1:

Date	**2011-01-18**
Database (name + access ; e.g.: Medline OVID)	Embase
Search Strategy (attention, for PubMed, check « Details »)	No. Query Results Results Date #59. #56 AND #57 AND (1995:py OR 1996:py OR 1997:py OR 1998:py OR 1999:py OR 2000:py OR 2001:py OR 2002:py OR 2003:py OR 2004:py OR 2005:py OR 2006:py OR 2007:py OR 2008:py OR 2009:py OR 2010:py OR 2011:py) 1,110 #58. #56 AND #57 1,838 #57. #33 OR #35 OR #36 OR #37 OR #38 43,602 #56. #48 OR #55 95,277 #55. #49 OR #50 OR #51 OR #52 OR #53 OR #54 64,632 #54. 'hospitalized infant'/de 75 #53. 'pediatric hospital'/de 5,951 #52. 'child care'/de 25,720 #51. 'hospitalized adolescent'/de OR 'hospitalized child'/de OR 'child hospitalization'/de OR 'adolescent hospitalization' 7,759 #50. 'early childhood intervention'/de 852

#49. 'child health care'/de	26,596
#48. #46 AND #47	34,838
#47. #30 OR #31 OR #32	2,041,597
#46. #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #45	284,782
#45. 'orphanage'/de	450
#38. 'community mental health centre'/exp	2,602
#37. 'mental health care'/mj	6,620
#36. 'home mental health care'/mj	44
#35. 'mental hospital'/mj	14,002
#33. 'mental health service'/mj	21,885
#32. 'infant'/exp	457,195
#31. 'adolescent'/exp	1,069,866
#30. 'child'/exp	1,501,730
#29. 'institutionalization'/de	6,114
#28. 'deinstitutionalization'/de	2,405
#27. 'institutional care'/de	3,749
#26. 'hospital'/de	121,886
#25. 'health care facility'/de	41,697
#24. 'foster care'/de	2,827
#23. 'respite care'/de	611
#22. 'home rehabilitation'/de	132
#21. 'home care'/de	40,320
#20. 'nursing home'/de	35,106
#19. 'halfway house'/de	921
#18. 'residential home'/de	4,666
#17. 'assisted living facility'/de	680
#16. 'residential home'/de	4,666
#15. 'outpatient department'/de	30,283
#14. 'rehabilitation centre'/de	6,907
#13. 'day care'/de	8,134

Note

2.1.2.2. Part 2:

Date	2011-01-18
Database (name + access ; e.g.: Medline OVID)	Embase
Search Strategy (attention, for PubMed, check « Details »)	No. Query Results Results Date #34. #30 AND #32 AND (1995:py OR 1996:py OR 1997:py OR 1998:py OR 1999:py OR 2000:py OR 2001:py OR 2002:py OR 2003:py OR 2004:py OR 2005:py OR 2006:py OR 2007:py OR 2008:py OR 2009:py OR 2010:py OR 2011:py) 127 #33. #30 AND #32 194 #32. #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #31 114,671 #31. 'government'/mj 16,514 #30. #19 OR #29 28,553 #29. #27 AND #28 17,129 #28. #13 OR #14 OR #15 2,041,597 #27. #10 OR #11 OR #12 OR #25 132,137 #26. #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 100,671 #25. 'mental disease'/mj 77,062 #19. 'child psychiatry'/de 12,712 #15. 'infant'/exp 457,195 #14. 'adolescent'/exp 1,069,866 #13. 'child'/exp 1,501,730 #12. 'mental health'/mj 19,928 #11. 'social psychiatry'/de 2,829 #10. 'psychiatry'/de 38,302 #7. 'health services research'/mj 7,054 #6. 'health care policy'/mj 42,379 #5. 'health care planning'/mj 27,696 #4. 'organizational development'/mj OR 'organizational efficiency'/mj OR 'decentralization'/mj OR 'organizational 16,779

	restructuring'/mj OR 'policy'/mj	
	#3. 'multihospital system'/mj OR 'hospital policy'/mj OR 'interhospital cooperation'/mj	4,627
	#2. 'hospital organization'/mj	6,192
	#1. 'organizational efficiency'/mj	22
Note		

2.1.3. Search Strategy Psychinfo

2.1.3.1. Part 1:

Date	**05/01/2011**
Database (name + access ; e.g.: Medline OVID)	Database: PsycINFO <1806 to December Week 4 2010>
Search Strategy (attention, for PubMed, check « Details »)	1 exp *child guidance clinics/ (422) 2 *child day care/ (1782) 3 *Child Care/ (3073) 4 *child welfare/ (3802) 5 *child psychiatry/ (3867) 6 *adolescent psychiatry/ (2167) 7 adolescent.mp. (86777) 8 child.mp. (208761) 9 children.mp. (328136) 10 adolescents.mp. (95559) 11 exp *community services/ (18019) 12 *psychiatric patients/ (18332) 13 *hospitals/ or exp *psychiatric hospitals/ or exp *psychiatric clinics/ or exp *psychiatric units/ (11351) 14 exp *outpatient treatment/ (3500) 15 exp *hospitalized patients/ (5449) 16 partial hospitalization/ or aftercare/ (2484) 17 infant.mp. (34474) 18 exp *rehabilitation centres/ (707) 19 exp *residential care institutions/ or *halfway houses/ or *hospitals/ or *nursing homes/ or *orphanages/ or *assisted living/ or *group homes/ (20781) 20 ambulatory care.mp. (588)

	21 exp *home care/ (2739) 22 *assisted living/ (282) 23 *nursing homes/ (4411) 24 *home care/ or *home visiting programs/ (3622) 25 exp *community mental health centres/ or exp *community mental health services/ or exp *crisis intervention services/ or exp *mental health services/ (26397) 26 1 or 2 or 3 or 4 or 5 or 6 (13478) 27 7 or 8 or 9 or 10 or 17 (519634) 28 11 or 13 or 14 or 15 or 16 or 18 or 19 or 20 or 21 or 22 or 23 or 24 (53215) 29 27 and 28 (9824) 30 26 or 29 (22280) 31 25 and 30 (1612) 32 limit 31 to (peer reviewed journal and human and (dutch or english or french or german) and yr="1995 -Current") (797)
Note	

2.1.3.2. Part 2:

Date	05/01/2011
Database (name + access ; e.g.: Medline OVID)	Database: PsycINFO <1806 to December Week 4 2010>
Search Strategy (attention, for PubMed, check « Details »)	1 *innovation/ (2051) 2 *organizational effectiveness/ (5493) 3 *organizational change/ (5894) 4 *downsizing/ (264) 5 *decentralization/ (152) 6 *government policy making/ (9073) 7 *policy making/ (5122) 8 *health care policy/ (3626) 9 *health care reform/ (540) 10 *welfare reform/ (294) 11 psychiatry/ (16357) 12 community psychiatry/ (613) 13 mental disorders/ (52566) 14 mental health/ (28295) 15 adolescent.mp. (86777) 16 adolescents.mp. (95559) 17 child.mp. (208761) 18 children.mp. (328136) 19 infant.mp. (34474) 20 infants.mp. (38653) 21 newborn.mp. (4892) 22 adolescent psychiatry/ (2973) 23 Child Psychiatry/ (4804) 24 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 (30929) 25 15 or 16 or 17 or 18 or 19 or 20 or 21 (533209) 26 11 or 12 or 13 or 14 (91218) 27 25 and 26 (17236) 28 22 or 23 or 27 (22062) 29 24 and 28 (198) 30 limit 29 to (peer reviewed journal and human and (dutch or english or french or german) and yr="1995 -Current") (107)

Note

2.2. Chapter 2: Step 2 Search Strategy: Grey literature search

Search terms for the grey literature search were derived from algorithms developed for the peer reviewed databases. The following key words were used in different combinations “child adolescent mental health services”, “child adolescent psychiatry”, “mental disorders”, “governmental policy” “policy”, “policy reform”. The search was extended with key words in French (santé mentale, enfants, jeunes, adolescents, psychiatrie infanto-juvenile, pédopsychiatrie, troubles psychique,) and German (Kinder und Jugendpsychiatrie, psychische Erkrankungen, psychische Gesundheit Kindern und Jugendlichen). Both for Google and Oaister the search for new materials was stopped after inspecting the first 10 pages with search results since no new relevant information emerged. In addition to this general search the following list of websites from international organizations was searched:

- World Health Organization: http://www.who.int/en/
- World Health Organization, Regional office for Europe: http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/mental-health/publications
- European Observatory on Health Systems and Policies: http://www.euro.who.int/en/home/projects/observatory
- European Commission, Public Health: http://ec.europa.eu/health/index_en.htm

2.3. Chapter 2: Step 3 Search Strategy

In the third step of the literature review we used a set of free text key words that evolve from step 1 to identify additional studies on the efficacy and effectiveness of integrated systems for child and adolescent mental health care.

Source	Terminology
Eyssen M et al., 2010 (KCE reports 144A)	Case Management Assertive community Treatment Assertive outreach team Community mental health team Shared care Integrated care; services integration Care networks Care programs; care pathways; critical pathways Continuity of care
Shepperd et al., 2009	Wraparound Multi-systemic therapy
Barwick et al., 2005	Mental health liaison team Therapeutic foster care Day treatment programs

The same data sources (including grey literature search) were consulted as in January 2011.

2.3.1. Key-word search OVID MEDLINE

Date	2011-02-16
Database (name + access ; e.g.: Medline OVID)	Ovid MEDLINE(R) 1950 to Present with Daily Update
Search Strategy (attention, for PubMed, check « Details »)	1 *Case Management/ (4360) 2 assertive community treatment.mp. (398) 3 assertive outreach team.mp. (9) 4 community mental health team.mp. (89) 5 shared care.mp. (630) 6 *"Delivery of Health Care, Integrated"/ (4487) 7 *Community Networks/ (2667) 8 *Critical Pathways/ (2167) 9 *"Continuity of Patient Care"/ (5591) 10 wraparound.mp. (124) 11 multisystemic therapy.mp. (93) 12 multi-systemic therapy.mp. (5) 13 case management.mp. (10340) 14 care networks.mp. (359) 15 integrated care.mp. (898) 16 services integration.mp. (62) 17 care program.mp. (3246) 18 continuity of care.mp. (2867) 19 therapeutic foster care.mp. (12) 20 day treatment programs.mp. (63) 21 mental health liaison team.mp. (1) 22 liaison.mp. (4459) 23 (alternative and (inpatient or in-patient)).mp. (1675) 24 treatment foster care.mp. (24) 25 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 (36881) 26 child/ (1177413) 27 adolescent/ (1361222) 28 child, preschool/ (649618)

	29 infant/ (553058) 30 infant, newborn/ (435325) 31 (child or adolescent).mp. (2148055) 32 26 or 27 or 28 or 29 or 30 or 31 (2506688) 33 Mental Health/ or Mental Disorders/ or Community Mental Health Services/ or Mental Health Services/ (139821) 34 Psychiatry/ or Community Psychiatry/ or Forensic Psychiatry/ or Preventive Psychiatry/ (36405) 35 33 or 34 (165023) 36 32 and 35 (37764) 37 Child Psychiatry/ or Adolescent Psychiatry/ (5327) 38 36 or 37 (41446) 39 25 and 38 (915) 40 limit 39 to yr="1995-Current")
Note	

2.3.2. Key-word search Embase

Date	**2011-02-16**
Database (name + access ; e.g.: Medline OVID)	Embase
Search Strategy (attention, for PubMed, check « Details »)	1 #43. #41 AND #42 158 #42. 'comparative study'/exp OR 'controlled study'/exp OR 'experimental study'/exp OR 'quasi experimental study'/exp OR 'control group'/exp OR 'double blind procedure'/exp OR 'experimental design'/exp OR 'nonequivalent control group'/exp OR 'parallel design'/exp OR 'pretest posttest control group design'/exp OR 'pretest posttest design'/exp 4,218,260 #41. #39 AND ([article]/lim OR [article in press]/lim OR [review]/lim) AND ([dutch]/lim OR [english]/lim OR [french]/lim OR [german]/lim) AND [humans]/lim AND [abstracts]/lim AND [1995-2011]/py 471 #40. #39 AND [1995-2011]/py

#39. #28 AND #38	744
#38. #36 OR #37	45,535
#37. 'child psychiatry'/de	12,736
#36. #32 AND #35	35,429
#35. #33 OR #34	252,166
#34. 'psychiatry'/de OR 'social psychiatry'/de OR 'forensic psychiatry'/de	50,808
#33. 'mental disease'/de OR 'mental health'/de OR 'community mental health'/de OR 'mental health care'/de OR 'home mental health care'/de OR 'mental health service'/de	215,619
#32. #29 OR #30 OR #31	2,048,680
#31. 'child'/exp	1,507,441
#30. 'infant'/exp	458,656
#29. 'adolescent'/exp	1,073,050
#28. #4 OR #5 OR #6 OR #8 OR #10 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27	38,091
#27. 'treatment foster care'	28
#26. alternative AND (inpatient OR 'in patient')	2,407
#25. 'liaison'	8,883
#24. 'mental health liaison team'	11
#23. 'day treatment programs'	78
#22. 'therapeutic foster care'	17
#21. 'case management'	10,975
#20. 'continuity of care'	3,484
#18. 'care program'	5,780
#17. 'services integration'	81
#16. 'integrated care'	1,674
#15. 'care networks'	438
#14. 'multi-systemic therapy'	7
#13. 'multisystemic therapy'	114
#12. wraparound	155
#10. 'critical pathway'	533
#8. 'integrated health care system'/mj	3,001

	#6. 'shared care'	890	
	#5. 'community mental health team'		330
Note			

2.3.3. Key-word search OVID PSYCHINFO

Date	**2011-02-16**
Database (name + access ; e.g.: Medline OVID)	PSYCHINFO
Search Strategy (attention, for PubMed, check « Details »)	1 case management/ (2193) 2 case management.mp. (4213) 3 assertive outreach team.mp. (26) 4 community mental health team.mp. (196) 5 shared care.mp. (188) 6 *"Continuum of Care"/ (472) 7 wraparound.mp. (198) 8 multisystemic therapy.mp. (262) 9 multi-systemic therapy.mp. (14) 10 care networks.mp. (85) 11 integrated care.mp. (406) 12 services integration.mp. (75) 13 care program.mp. (1280) 14 continuity of care.mp. (1028) 15 therapeutic foster care.mp. (53) 16 day treatment programs.mp. (148) 17 mental health liaison team.mp. (5) 18 liaison.mp. (3325) 19 (alternative and (inpatient or in-patient)).mp. (600) 20 treatment foster care.mp. (137) 21 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 (12006) 22 adolescent.mp. (87484) 23 child.mp. (209745) 24 children.mp. (329810) 25 adolescents.mp. (96232) 26 infant.mp. (34597)

	27 22 or 23 or 24 or 25 or 26 (522389) 28 *Mental Disorders/ or *Mental Health/ or *Mental Health Services/ (78152) 29 *Community Psychiatry/ or *Psychiatry/ or *Forensic Psychiatry/ (16849) 30 28 or 29 (91915) 31 27 and 30 (16793) 32 child psychiatry/ (4804) 33 adolescent psychiatry/ (2984) 34 31 or 32 or 33 (21512) 35 21 and 34 (559) 36 limit 35 to (peer reviewed journal and human and abstracts and yr="1995 -Current") (249) 37 rct.tw. (984) 38 random$.tw. (96958) 39 (clinical trial$ or clinical stud$).tw. (20087) 40 37 or 38 or 39 (111110) 41 comparative stud$.tw. (9879) 42 controlled stud$.tw. (7141) 43 experimental stud$.tw. (11364) 44 quasi experimental stud$.tw. (854) 45 quasi-experimental stud$.tw. (854) 46 control group.mp. (36834) 47 double blin procedure.mp. (0) 48 experimental design.mp. (13215) 49 nonequivalent control group.mp. (171) 50 parallel design.mp. (83) 51 pretest posttest control group design.mp. (252) 52 pretest posttest design.mp. (577) 53 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 (76413) 54 40 or 53 (173992) 55 36 and 54 (17)
Note	

2.4. Chapter 2: Step 4 Search Strategy

Author	N. Verhaeghe
Project number	2010-25_HSR
Project name	Children Mental Health
Search questions (PICO,…)	What are the relevant financing mechanisms of child and adolescent mental health care services?
Keywords	FINANCING MeSH (Medline) financing, organized/ financing, government/ insurance, health, reimbursement/ reimbursement mechanisms/ fee-for-service plans/ prospective payment system/ single-payer system/ fees and charges Keywords (in title) Budget* Financ* Funding Reimburse* Payment* Commissioning CHILD AND ADOLESCENT MeSH (Medline) Child/ Adolescent/ Adolescent Psychiatry/ Child Psychiatry MENTAL HEALTH CARE SERVICES MeSH (Medline) mental health services/ community mental health services/ emergency services, psychiatric/ social work, psychiatric/ Hospitals, Psychiatric/

Date	07/02/2011
Database (name + access ; e.g.: Medline OVID)	Medline/Pubmed
Search Strategy (attention, for PubMed, check « Details »)	1 Financing, Organized/ (5087) 2 Financing, Government/ (16572) 3 Insurance, Health, Reimbursement/ (7109) 4 Reimbursement Mechanisms/ (9267) 5 Fee-for-Service Plans/ (2141) 6 Prospective Payment System/ (4905) 7 Single-Payer System/ (365) 8 Fees and Charges/ (7630) 9 budget*.ti. (4637) 10 financ*.ti. (11028) 11 funding.ti. (4192) 12 reimburse*.ti. (3825) 13 payment*.ti. (5511) 14 commissioning.ti. (453) 15 Child (1196316) 16 Adolescent (1375027) 17 Adolescent Psychiatry (2159) 18 Child Psychiatry (4401) 19 Mental Health Services/ (21221) 20 Community Mental Health Services/ (15288) 21 Emergency Services, Psychiatric/ (1902) 22 Social Work, Psychiatric/ (2503) 23 Hospitals, Psychiatric/ (20840) 24 1or2or3or4or5or6or7or8or9or10or11or12or13or14 (68439) 25 15 or 16 or 17 or 18 (1939854) 26 19 or 20 or 21 or 22 or 23 (56767) 27 24 and 25 and 26 (216) 28 limit 27 to yr=”1995-Current” (124)

Author	N. Verhaeghe
Project number	2010-25_HSR
Project name	Children Mental Health
Search questions (PICO,…)	What are the relevant financing mechanisms of mental health care services?
Keywords	FINANCING MeSH (Medline) financing, organized/ financing, government/ insurance, health, reimbursement/ reimbursement mechanisms/ fee-for-service plans/ prospective payment system/ single-payer system/ fees and charges Keywords (in title) Budget* Financ* Funding Reimburse* Payment* Commissioning MENTAL HEALTH CARE SERVICES MeSH (Medline) mental health services/ community mental health services/ emergency services, psychiatric/ social work, psychiatric/ Hospitals, Psychiatric/

Date	07/02/2011
Database (name + access ; e.g.: Medline OVID)	Medline/Pubmed
Search Strategy (attention, for PubMed, check « Details »)	1 Financing, Organized/ (5087) 2 Financing, Government/ (16572) 3 Insurance, Health, Reimbursement/ (7109) 4 Reimbursement Mechanisms/ (9267) 5 Fee-for-Service Plans/ (2141) 6 Prospective Payment System/ (4905) 7 Single-Payer System/ (365) 8 Fees and Charges/ (7630) 9 budget*.ti. (4637) 10 financ*.ti. (11028) 11 funding.ti. (4192) 12 reimburse*.ti. (3825) 13 payment*.ti. (5511) 14 commissioning.ti. (453) 15 Mental Health Services/ (21221) 16 Community Mental Health Services/ (15288) 17 Emergency Services, Psychiatric/ (1902) 18 Social Work, Psychiatric/ (2503) 19 Hospitals, Psychiatric/ (20840) 20 1or2or3or4or5or6or7or8or9or10or11or12or13or14 (68439) 21 15 or 16 or 17 or 18 or 19 (56767) 22 20 and 21 (1451) 23 limit 22 to yr=”1995-Current” (617)

Author	N. Verhaeghe
Project number	2010-25_HSR
Project name	Children Mental Health
Search questions (PICO,…)	What are the relevant financing mechanisms of child and adolescent mental health care services?
Keywords	FINANCING Keywords (in title) Budget* Financ* Funding Reimburse* Payment* Commissioning Fee* Charge* CHILD AND ADOLESCENT (in title) Child* Adolescent* MENTAL HEALTH CARE SERVICES Keywords (in title) Mental Health

Date	06/02/2011
Database (name + access ; e.g.: Medline OVID)	Econlit
Search Strategy (attention, for PubMed, check « Details »)	1 Mental Health.ti. (428) 2 Financ*.ti. (37697) 3 Funding.ti. (1123) 4 Budget*.ti (5515) 5 Reimburse*.ti. (246) 6 Payment*.ti. (3692) 7 Commissioning.ti. (6) 8 Fee*.ti. (2217) 9 Charge*.ti. (650) 10 Child*.ti. (6053) 11 Adolescent*.ti. (415) 12 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 (50523) 13 10 or 11 (6413) 11 1 and 12 and 13 (0)

Author	N. Verhaeghe
Project number	2010-25_HSR
Project name	Children Mental Health
Search questions (PICO,…)	What are the relevant financing mechanisms of mental health care services?
Keywords	FINANCING Keywords (in title) Budget* Financ* Funding Reimburse* Payment* Commissioning Fee* Charge* MENTAL HEALTH CARE SERVICES Keywords (in title) Mental Health

Date	06/02/2011
Database (name + access ; e.g.: Medline OVID)	Econlit
Search Strategy (attention, for PubMed, check « Details »)	1 Mental Health.ti. (428) 2 Financ*.ti. (37697) 3 Funding.ti. (1123) 4 Budget*.ti (5515) 5 Reimburse*.ti. (246) 6 Payment*.ti. (3692) 7 Commissioning.ti. (6) 8 Fee*.ti. (2217) 9 Charge*.ti. (650) 10 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 (50523) 11 1 and 10 (28) 12 limit 11 to yr=”1995-Current” (19)

Author	N. Verhaeghe
Project number	2010-25_HSR
Project name	Children Mental Health
Search questions (PICO,…)	What are the relevant financing mechanisms of mental care services?
Keywords	Financing Mesh (CRD) financing, organized/ financing, government/ insurance, health, reimbursement/ reimbursement mechanisms/ fee-for-service plans/ prospective payment system/ single-payer system/ fees and charges Keywords (in title) Budget* Financ* Funding Reimburse* Payment* Commissioning Mental health care services mental health services/ community mental health services/ emergency services, psychiatric/ social work, psychiatric/ Hospitals, Psychiatric/

Date	25/01/2011
Database (name + access ; e.g.: Medline OVID)	Centre for Review and Dissemination (CRD)
Search Strategy (attention, for PubMed, check « Details »)	1 Financing, Organized/ (26) 2 Financing, Government/ (91) 3 Insurance, Health, Reimbursement/ (260) 4 Reimbursement Mechanisms/ (160) 5 Fee-for-Service Plans/ (86) 6 Prospective Payment System/ (43) 7 Single-Payer System/ (4) 8 Fees and Charges/ (108) 9 budget*.ti. (99) 10 financ*.ti. (333) 11 funding.ti. (40) 12 reimburse*.ti. (106) 13 payment*.ti. (63) 14 commissioning.ti. (5) 15 Mental Health Services/ (452) 16 Community Mental Health Services/ (229) 17 Emergency Services, Psychiatric/ (13) 18 Social Work, Psychiatric/ (8) 19 Hospitals, Psychiatric/ (82) 20 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 (1217) 21 15 or 16 or 17 or 18 or 19 (722) 22 20 and 21 (19) 23 limit 22 to yr=”1995-current” (19)

2.5. Chapter 2: Selection Countries

2.5.1. Long list of countries

To enable a well balanced selection of foreign countries a long-list was assembled based on a grey literature search and expert consultation. The grey-literature search strategy, as described in Appendix 1, was used as starting point. In addition, during sifting of the peer reviewed literature, it was looked for information of the countries in the long-list.

Experts in the field of mental health policy and/or organization for children and adolescents from different countries were contacted by e-mail, and were asked to send available relevant information or/and names of key persons concerning the organization and policy of camh care for their country.

Experts were selected from own networks and from expertise networks in European and WHO and IACAPAP (International association for child and adolescent psychiatry and allied professions) collaborative groups. Following Experts replied:

- England:

  Dr. Anne York, Consultant Child and Adolescent Psychiatrist, and Clinical Team Leader South West London & St George's Mental Health NHS Trust, Honorary Senior Lecturer, St George's Medical School, London

  Dr. Steve Kingsbury, Consultant Child and Adolescent Psychiatrist, CAMHS Hertfordshire Partnership Trust
- Canada

  Prof. Dr.S. Kutcher, Associate Dean of International Medical Development & Research with Dalhousie University's Faculty of Medicine; , Director of Sun Life Financial Chair in Adolescent Mental Health, Director of the World Health Organization Collaborating Centre in Mental Health at Dalhousie.
- Italy:

  Dr. G. De Girolamo , psychiatrist, director of the IRCCS (Italian Research Hospital) Fatebenefratelli di Brescia.
- The Netherlands:

  Prof. Dr. R. Vermeiren, Kinder- en Jeugdpsychiater, Directeur patientenzorg Curium-Leiden University Medical Center, Leiden; Brekelmans C, senior policy advisor, GGZNederland
- Iceland:

  Prof. Dr. H. Hannesdottir, Landspitali University Hospital,
- Sweden:

  Prof Dr. P.-A.Rydelius, Karolinska Institute, Astrid Lundgren Children's Hospital, Stockholm, and

  Prof Dr. U. Wallin, Scientific Secretary oft he Swedish Child and Adolescent psychiatric association, MPedical Centre (MC-huset), S:t Lars omradet, Lund Sweden
- Australia:

  Prof. Dr. P. McGorry, University of Melbourne, Centre for Youth Mental Health
- France:

  Dr. V. Garcin, Child and Adoelscent Psychiatrist, head of the Child and Adolescent Department of the EPSM Lille Métropole, Armentières-Tourcoing

The results from the pre-assessment were summarized in table 2.1.

Table 2.1. Long-list countries

Country	main or dominant system	Governmental CAMH Policy	CAMHS system	info available/ Language (E/F/G/D)	Scientific evidence (peer reviewed)	Interagency-intersectoral collaboration
United Kingdom	Beveridge	Every Child Matters	Community mental health care	lot/E	yes	Child care, foster care,
Ireland	Beveridge	Headstrong/Jigsaw	Community systems of care	some/E	poor	yes
Germany	Bismarck	Regions (länder)	Reform of inpatient care	few /G	poor	
France	Bismarck	Maisons des jeunes	Maisons des jeunes	few /F	poor	
Switzerland	Bismarck	Confederation		no	poor	
Austria	Bismarck			?		
Netherlands	Bismarck/Beveridge mixed	Circuit jeugdzorg	Integrated youth care	lot/D	limited	Yes : youth care
Denmark	Beveridge			poor/Danish		
Iceland	Beveridge			poor/ IC/ E	poor	
Norway	Beveridge		Community mental health care	poor	fair	
Sweden	Beveridge			poor	poor	
Finland	Beveridge			poor	poor	
Italy	Mixed	Decentralised (federal, Regional, local)		poor/ mostly Italian	ongoing	
Canada	Beveridge (NHIS)	Governmental camhs plan/ Provinces and regions		lot, E/F	yes	case management
Australia	Beveridge	National CAMH plan: Headspace-Provinces	Schoolbased, juvenile justice	some/E	yes	

2.6. Chapter 2: Experts of selected foreign countries

The following experts of the selected foreign countries participated in the review of a preliminary draft per country; and some of them gave a generic, overall appraisal of the system in their country.

The Netherlands: Wijnands Y, Head of Department General Youth Policy, Ministry of Health, Welbeing and Sports; Rietveld A.A, President of the Board of Directors, Accare Univerity Centre for child and adolescent psychiatry, Assen; Menting J,Board of Directors at Yulius Mental Health, Dordrecht; Brekelmans C, senior policy advisor, GGZNederland

Canada: Waddell C, Children's Health Policy Centre, Simon Fraser University, British Columbia; Kutcher S., Associate Dean of International Medical Development & Research with Dalhousie University's Faculty of Medicine, Director of Sun Life Financial Chair in Adolescent Mental Health, Director of the World Health Organization Collaborating Centre in Mental Health at Dalhousie.

England: York, A, Consultant Child and Adolescent Psychiatrist, and Clinical Team Leader South West London & St George's Mental Health NHS Trust, Honorary Senior Lecturer, St George's Medical School, London; Kingsbury, S, Consultant Child and Adolescent Psychiatrist, CAMHS Hertfordshire Partnership Trust; Rees D, Independent Development Consultant; Kelvin R., Professional Advisor for Camhs, Dept of Health; Hewson, L., Child psychiatrist, Camhs clinical and service development advisor, Trustee at Bradford Couselling Service

2.7. Chapter 2: Methodological framework

2.7.1. Methodological framework : analysing literature, grey literature and international experience.

The framework consists of seven dimensions, each with several criteria, for analysing data retrieved from peer reviewed literature. This framework is documented on WHO guidelines (WHO: improving Health systems and services for mental health, 2009; http://www.who.int/mental_health/policy/services/mhsystems/en/index.html ; WHO Atlas: child and adolescent mental health resources: global concerns, implications for the future, 2005, Atlas : Child and Adolescent Mental Health Resources ; Mental Health Policy and Service Guidance Package : Child and Adolescent Mental Health Policies and Plans, WHO, 2005, MENTAL HEALTH POLICY AND SERVICE GUIDANCE PACKAGE CHILD AND ADOLESCENT MENTAL HEALTH POLICIES AND PLANS WHO, 2005 ,) British Medical association (BMA,2006 : CHILD AND ADOLESCENT MENTAL HEALTH A guide for health care professionals), practice parameter on child and adolescent mental health care in community systems of care (Winters and Pumariga, 2007) and expert reports (Kutcher et al, 2010; Saxena et al, 2007; Bachmann et al, 2009; Stroul et al. 1997, 2002; Williams & Kerfoot, 2005).

The first five dimensions (A1 to A5) can be used to study care organization and financing. The last two dimensions are to be used to help us draw lessons for the Belgian context.

2.7.2. A1.Population

Definition of the population subjected to the study : information available concerning :

- population definition and mental health needs
- group magnitude
- geographical/demographical characteristics
- assessment instruments population characteristics
- assessment population mental health needs
- assessment health care planning and adaptation

2.7.3. A2.Stakeholders

(individuals, groups, agencies, professions involved in health care policy making, planning, organizing and delivery)

Health policy level,

- Governmental
- Region
- Local
- Public insurance

- Private insurance
- Other financing agencies,
- diverse lobbies,
- religious, philosophical or political inspired

Health service level, providers, :

- education,
- child welfare,
- juvenile justice,
- handicapped/disabled people,
- general healthcare
- paediatric healthcare
- mental health care agencies/services
- mental health care professions,
- mental health care professional training, professional quality…)

Consumer level

- Formal versus informal care
- how are families and contexts involved, values and cultures

consumer advocacy

2.7.4. A3.Mental health care models, organizational models

- Historical background, development of the camhs
- Governmental policy plan for camhs or not
- Health care plans, models/implementation
  - Tiers system
  - Systems of care
  - Community soc
- School based services
  - Integration of target groups
  - Organisation of access to health care systems
  - Continuity of care
  - Transition to adulthood
  - Interconnectivity between services
- Key components
  - Promotion
  - Prevention
  - Cure and care : acute, chronic, urgency – in/outpatient
  - Rehabilitation

2.7.5. A4.Financial models (financing mechanisms, economical mechanisms)

- National model of health security organisation
- Cost of camhs
- Financing of camhs: (partially or fully integrated with general health financing or not)
  - Fee for service
  - Tax-based Government
  - Social insurance
  - Private insurance
  - Consumer/patient
- Consumer/patient (child/adolescent) equity risk
- Cost of interconnecting / inter-sectorial cooperation
  - including sectorial spread of cost
- Cost of implementing change, initiating and supervising processes of change

2.7.6. A5.Processes of Change

- Motivation of change for health policy makers
- Motivation of change on health service level
- Method of introducing change
- Evaluation of process of change
- Pitfalls

2.7.7. B1.Efficacy

(data concerning system efficacy, health care organisation quality (effectivity and efficiency))

- Evaluation and monitoring systems

Mental health information system, data sharing : since multi-agency working and inter-connectedness depends on common language and sharing information

2.7.8. B2. Applicability and adaptability

Strengths and weaknesses, opportunities and threats of systems, in the Belgian context

3. APPENDIX 3

3.1. Chapter 3: Evidence tables

3.1.1. Evidence tables: Systematic reviews

Study	Time-frame	Included study designs	Risk of bias	Patients/subjects	Interventions vs comparators	Main results	General conclusion
Browne, G. et al, 2004 [1]	1990-2000	23 Reviews of RCT's or quasi-experimental studies	Low	School-age children with mental health problems	Mental health-services programs (non-clinical) for school-aged children: universal programs (provided to all children) and early intervention population-based services (provided only to children at risk)	Programs developing protective factors, more effective than programs reducing existing negative behaviours; Young children benefit more than older children; Programs addressing specific cultural or gender-adapted problems have greater effect then broad unfocussed interventions (e.g. suicide); Integrated programs involving more than the single domain of family, school or community are more likely to have positive results.(skills acquisition, risk reduction); Effect sizes decrease over time, suggesting need for follow-up and reinforcement of positive interventions; Methods that are associated with lower effectiveness: fear-inducing tactics; programs that deliver information only in a non-interactive way; Long-term programming more effective than short, intensive initiatives; Certain behaviours and attitudes proved more resistant to change (substance abuse, unsafe sex, oral hygiene); Peer mentoring promotes academic and social behavior in early intervention programs, but is less reliable for general competencies and skill maintenance.	Favourable interventions -Universal services to enhance protective factors -Tailored, long-term timely interventions for high-risk children -Holistic programs instead of focusing on a single problem behavior. - Research about, intersectoral programs is inconclusive
Litell et al., 2009[2]	1985-2003	8 RCT's	Low	Children and adolescents (10-17 years) with social, emotional, and behavioural problems, at risk of out-of-home	Multisystemic Therapy compared with any counterfactual condition, including 'usual services' (in juvenile justice or child welfare), other treatment	Setting: Country (6 USA; 1 Norway, 1 Canada) and Service (6 juvenile offenders; 1 problem behaviours; 1 psychiatric emergencies) Results indicate trends for lower rates & length of incarceration, less arrests or conviction rates but (due to study heterogeneity), the pooled	Available evidence does not support the hypothesis that MST is consistently more effective than usual services or other

				placement: (1) abused, neglected, and dependent children be at risk of foster care or other out-of-home placements in child welfare settings; (2) children with mental health problems at risk of psychiatric hospitalization; (3) delinquents at risk of incarceration or placement in residential treatment settings;	conditions (e.g., individual therapy), and no treatment.	results were not statistically significant	interventions for youth with social, emotional, or behavioural problems. However, it is not appropriate to conclude that MST has no effects. In sum, evidence about the effectiveness of MST is inconclusive.
Macdonald and Turner (2008)[3]	1966-2007	5 RCT's (ten citations) conducted in the USA	Low	Children and adolescent (0-18 years) with severe medical, social, psychological and behavioural problems at risk of or being placed in out of home care in restrictive settings: Studies on children and adolescents with emotional and behavioural problems: 1 study about adolescents in psychiatric hospitals; 2 studies out-of-home placements because of abuse or neglect; 2 studies on delinquent adolescents (12-17 years) with histories of chronic delinquency	Therapeutic foster care programme providing individualised, community- and foster family based intensive services to children and adolescents, designed to prevent multiple placements and/or as an alternative to restrictive institutional placement options Comparator: no treatment, wait-list or regular foster care	*Behavioural problems* (e.g. occurrence of problem behaviours; days on the run): No clear significant results *Antisocial behaviour* (e.g. criminal referrals, general delinquency; incarceration): mixed results, some studies indicate small to large significant effects ($p<0.05$) on – some – of the outcomes, other studies do not show significant effects Psychological functioning: no significant results *Educational, training & employment outcomes* (e.g. school attendance, job training, suspensions): 2 studies without significant results, 1 study with significant ($p<0.05$) results on school attendance & homework completion Interpersonal functioning: not significant *Placement stability* (e.g. runaway; time in placement): statistically significant (but mostly not-meaningful) or insignificant results *Other placement outcomes*: significant results for living at home at 1 year; days in treatment at 1 and 2 years. Non-significant results at days in regular foster care, sheltered care or living at home.	The results of individual studies illustrate that therapeutic foster care is a promising intervention for children and adolescents experiencing mental health problems, behavioural problems or delinquency, the evidence-base is not robust

Neil and Chris-tensen (2009)[4]	1987-2008	27 RCT's (20 individual school-based programs)	Mode rate	Children and adolescents (5-19 years)	Structured school-based program that aims to prevent the symptoms or incidence of anxiety or to build resilience Comparator: no intervention (14 RCT's); wait-list (9 RCT's); attention control, (4 RCT's)	21 of the 27 studies reported a significant improvement in participants' symptoms of anxiety either post-test or follow-up or both 13 RCT's collected follow-up data: 8 with significant effects, 5 without *Indicated programs*: 4 and 6 out of 8 with significant anxiety reductions at post-test and follow-up respectively; *universal programs*: 11 and 6 out of 16 with significant anxiety reductions at post-test and follow-up respectively; *selective programs*: 2 and 1 out of 3 with significant anxiety reductions at post-test and follow-up respectively;	Overall support for prevention interventions for anxiety Quality of the studies reviewed was quite poor (no double-blinding, no details randomization process, withdrawals & drop-outs)
Painter et al., (2010).[5]	Not speciifie d	8 RCT's & follow-up studies of RCT's (13 papers)	High	Adolescents with serious clinical problems (General description, lacking specificity about type of problems and age-range)	Multisystemic therapy: 4 juvenile offenders; 1 mal-treating families as alter-native for parent behaviour training; 1 for substance dependent delinquents; 1 alternative to psychiatric hospitalization for suicidal or psychiatric distressed youth 1 compared with usual services for youth with severe emotional disorders	Positive impact of Multisystemic therapy on: (1) peer relationships; (2)school attendance; (3) performance; (4) behaviour problems and/or psychiatric symptoms; At 4-year follow-up: no long-term effects of psychiatric symptoms	Review with weak methodology (No clear research question; no search dates; quality assessment and data abstraction not described; all included studies are performed by the founders of multisystemic therapy)
Shepperd et al., 2009[6]	1966-2007	7 RCT's	Low	Children and adolescents Aged 5-18 years with a serious mental health condition or non-specific emotional or behavioural disorders.	Mental health services providing specialist care, beyond the capacity of generic outpatient provision, which provide an alternative to inpatient mental health: Multi-systemic therapy (2 RCT's); Intensive home-based crisis intervention (1 RCT); Intensive home treatment (2 RCT's); Intensive specialist outpatient treatment (2	Too much heterogeneity to pool study results. *Multisystemic therapy*: majority of findings not significant; Significant results ($p<0.05$): externalizing symptoms ↑; days out of school↓; consumer satisfaction ↑; out-of-home placement↓ Intensive home based crisis intervention: Out-of-home placement not significant; Short term & 6-month follow-up: mixed results favouring control or intervention; Intensive home treatment: findings not significant *Intensive specialist outpatient treatment:*	Most RCT's are underpowered studies with multiple testing and unclear primary outcome Too few evidence to draw conclusions

					RCT's);	findings on behavioural and psychological outcomes not significant	
Suter & Burns (2009)[7]	1986-2008	3 RCT's and 4 quasi-experimental studies (studies that did not use random assign-ment)	Low	Children and adolescents (3-21 years) with severe emotional and behavioural disorders and/or significant functional impairment (i.e. those at risk of out-of-home placements): Settings: 2 studies in child-welfare; 3 studies in mental health; 1 study in juvenile justice; 1 study in juvenile justice and mental health	Team-based planning process labelled as wraparound or adhering primary principles of wraparound Comparator: no treatment, wait-list or conventional services Intervention group had access to similar services as the comparator group, primary differences were assignment of a wraparound facilitator, development of a wraparound plan, availability of flexible funds to pay for non-traditional services (e.g. respite, recreational services)	Effect sizes individual outcome measures ranged from a medium negative effect (-0.38) to a large positive effect (1.09). Random effects mean effect size across 7 studies was 0.33 ($p<0.05$), which falls within the range of small to medium effects. On average, children receiving wraparound was better off than 63% of those receiving conventional services ($p<0.05$) Significant effects ($p<0.05$) found on following individual outcomes: mental health outcomes, overall youth functioning	Overall this meta-analysis support the view that wraparound can potentially yield better outcomes for children and adolescents with severe emotional and behavioural disorders. However, the studies do not provide unequivocal support for efficacy due to high attrition, lack of single treatment manual and heterogeneity of target populations. Effectiveness of wraparound is shown to some degree by studies included in this review that were performed in real-world settings

3.1.2. Evidence tables: (Quasi-)experimental studies

Reference	Risk of bias	Design and study duration	Setting & target population	Sample size & characteristics	Intervention	Results	Comments
Ahrens C., et al. 20078	High	Quasi-experimental pre-post design comparing length of inpatient treatment and forensic treatment or incarceration for the year before and after a Program of Assertive Community treatment (PACT) enrollment (April 1998-May 2000)	Psychiatric hospitalization and forensic treatment for adolescents with severe ad persistent mental illness, aged 15-21 years,	15 participants (15 first consecutive adolescents admitted to PACT who met study criteria : 15-21 years of age, received PACT, primary axis I diagnosis of psychotic disorder, bipolar disorder, or obsessive-compulsive disorder, 4 or more functional limitations upon initial screening.) 12 males, 3 females, mean age 16,8 years, 3 African Americans 12 Caucasian; 13 participants diagnosed having psychotic disorder (3 schizophrenia and 10 schizoaffective disorder), 2 persons diagnosed having bipolar disorder	Program of Assertive Community treatment (PACT), providing a highly individualized array of long term services(comprehensive assessment; medication prescription, delivery and monitoring; monitoring of symptoms and medication side effects, illness management and recovery skills, intensive clinical case management, health monitoring ad 24 hours crisis intervention) and rehabilitation services (supportive psychotherapy, psycho-education, vocational rehabilitation, substance abuse counselling ad assistance with independent living skills).	Significant drop of mean number of days of psychiatric hospitalization in the year after enrolment in the PACT (8,73 days) compared to the year before enrolment (66,20 days). The average frequency of hospital admissions for psychiatric treatment did not differ significantly. 2 patients accounted for all incarceration time or forensic treatment; Combined time in institutions (psychiatric or forensic and incarceration) dropped significantly from a mean of 104,1 days in the year before enrolment in the PACT to 24,1 days in the year after enrolment.	Pilot study; small sample size
Atkins, M et al, 20069	High	The research design was a nested model, in which classrooms within schools	Kindergarten through 4th grades of three public schools located in high-poverty	2 cohorts,(1 year time between), children met DSM IV criteria for one or more disruptive behaviour disorder (DBD) based on the	Random assignment in cohort 1 to experimental condition of Positive Attitudes towards learning in school-program (PALS), a	60 of the 75 families of cohort 1 agreed to enrol in the program, 30 of 55 families agreed to enrol in the clinic-based program. PALS school service units were correlated significantly and	Parents who were randomly assigned to receive services by PALS staff, were significantly

	were randomly assigned to either the experimental school-based intervention or referral to clinic	communities in a large Midwestern city, in which 97% of students were from minority families receiving free or reduced lunches.	DBD Rating scale. Parents and teachers were paid $10 an hour for completion of research measures, which were collected at intake, 2 months into each school year, and one month before completion of the school year. Cohort 1 (n= 279, 17 class rooms), cohort 2 (n = 52, of two schools,).From cohort 1 147 children (n=83 intervention program, n= 64 clinic program) obtained clinical cut-off scores, 75 families of the intervention condition and 55 of the clinic condition participated;	school-based program, or to neighbourhood mental health clinic, based on teacher referral and parent follow-up rating. The PALS staff was trained on a variety of contingency-based classroom behaviour management programs, which were summarized in a treatment manual provided to each staff member. All PALS families received family services by home visit or by attendance at twice-monthly parent groups	negatively with parent IOWA-Connors total scores, indicating improved behaviour, but not with teacher IOWA-Connors total scores nor with teacher SSRS Academic Competence scores. PALS family service units also were correlated significantly with parent IOWA-Connors total scores but not with teacher IOWA-Connors total scores nor with social Skills Rating System (SSRS) Academic Competence scores . When PALS school service units and family service units were entered as simultaneous predictors of parent-reported IOWA-Connors scores in a multivariate regression analysis, controlling for pre-test scores, school service units remained a significant whereas family service units did notIn cohort 2, PALS school service units were correlated significantly with parent IOWA-Connors total scores, indicating reduced disruptive behaviour, and were significantly and positively correlated with teacher SSRS Academic Competence scores. However PALS school service units were also significantly and positively correlated with teacher IOWA-Connors total scores, indicating worsening behaviour. Pals family service units were not correlated significantly with disruptive behaviour as rated by parents or teachers or with academic competence as rated by teachers.	more likely to enrol their child in services as compared to those who were assigned to receive clinic-based services, and PALS services were maintained across two school years for 80% of families. In contrast, only two of 34 families who agreed to receive services in the clinic received any services across the 2 years, and each of the two children who received clinic services received one session of a medication evaluation with no follow-up. Correlational data; Disruption of the program, with no control group for cohort 2

Bickman et al, 199710	Moderate	Randomized longitudinal experimental design with random assignment to Systems of care condition (experimental condition) or usual care in the community (control condition)	Children's services from community agencies in Stark County, Ohio, Baseline data collection from 1993 to 1995, and follow-up interviews at 12, 18, and 24 months after baseline	Children 9 years and older, serious emotionally disturbed, not mentally retarded or emergency. Sample size = 350 families	Random assignment to the Systems of care condition or usual care in the community. Systems of care: Child and Adolescent Service System Program : This framework calls for a child-centred and family-focused system offering a comprehensive and coordinated network of mental health and other necessary services (initial assessment, treatment plan, coordination of delivery of services, use of home based treatment and case management)	Outcome scores at six months follow-up: The average youth in the sample showed fewer symptoms and higher functioning over time and those in the Systems of care did not experience more gains than their counterparts who received traditional care. No significant difference between groups was found at follow-up. No significant difference in outcome was measured for subgroups (such as dysthymia, severe emotional disturbance)	
Bickman, L., Noser,K., and Summerfelt, T. (1999).11	Moderate	Randomized experimental five-wave longitudinal design with 350 families, interviews at 6,12,18,and 24 months after baseline data collection. (between Sept 1993- June 1995)	Evaluation of Stark County Ohio Systems of care (CASSP) for children 0 to 20 years with serious emotional disturbance (SED) and/or DSM mental health diagnosis and current placement or risk of placement outside family	419 youths, selected from 1300 families referred to the evaluation. 350 persons accepted to participate. Recruitment trough the Department of human Services or C&A. exclusion criteria: less then 5 years old, no SED, to low IQ, not a county resident, already receiving mental health care, a sibling in treatment at C&A, or considered	Random assignment by computer program to Systems of care (experimental group) or usual care in the community (control group) after baseline data collection	Baseline characteristics for experimental group (EG) and Control group(CG) were identical for demographic attributes, functioning, symptoms and family factors. Average age : 11,1 (5-17)104 of the 171 families of the EG and 98 of the 179 families of the CG completed wave 5 data collection. The families in the EG received more services and had quicker access to care then those in the CG. There was no evidence for differences in clinical outcome between the EG and the CG or non treated youth.	The authors conclude that systems reform does not improve clinical outcome, indicating that reform also must occur at the treatment or service level tot affect outcome. Other explanations may be that assumptions that underlie the systems reform may be

				emergency.			inaccurate, and laboratory-like interventions are not always proven effective in community treatment.
Burns et al. 199612	High	RCT with 12 months follow-up	USA, Robert Wood Johnson Foundation Demonstration project in North Carolina Region characterized by mountainuous terrain Children with a DSM-III_R diagnoses and severe functional impairment and unstable residential placement Youth residing in Buncomb or Haywood counties; at least 8 years old; not being a sibling of an enrolled study participant	Age ranging from 8 to 17 years; 77% white; approx 50% female 8% refusal rate Follow-up: 89%	Intervention: multiagency treatment team led by a case manager (n=82) vs regular care (n=85), team led by youth's primary clinician from the mental health centre	Self-reported activities by case-managers and primary clinicians: significant more activities (outreach, assessment, monitoring, advocating, crisis intervention, clinical treatment, documentation) in intervention group (p<0.05) Youth in the intervention group were more likely to be still in the program after 1 year (which is considered to be desirable) (p<0.05) Control group youth were at 1 year more represented in inpatient treatment settings whereas the intervention group youth were more represented in treatment foster care, mental health centres outpatient settings, family physicians (p<0.05) Effects on outcomes like CAFAS, family burden, number of symptoms inconclusive	No power calculation, multiple measurement, no intention to treat, ..
Cheng, T.,	High	Randomized	Youth aged 12	88 (of a total of 403)	Random assignment to	88 families participated. There was	Relying on self

et al., 200813		controlled trial The study lasted for 2 years (start May 2000, to may 2002)	to 17 year of age, Presenting to Emergency Department (ED) of a large urban hospital with peer assault injury	Adolescents aged 12-17 presenting to a large urban children's hospital, residence in the surrounding metropolitan area (20 miles), ED presentation with an interpersonal assault injury excluding sexual assault, child abuse, sibling fights, or legal intervention; mental and physical ability to participate in telephone assessments.	intervention condition or control group. Intervention group received intensive case management services by telephone or in person for 4 months by a masters-trained counsellor (counselling, assessment of family needs, facilitating service use, responsible for referral and coordination of needed services). Follow up on a weekly or monthly base was provided. Participants in the intervention and control groups received usual care from clinicians in the ED as well as a list of community resources.	a 57% follow-up rate (n=50). Drop outs for follow-up seemed les likely to be enrolled in school, employed, or living with their biological father compared to those who completed follow-up; Mean age was 14 years, predominantly male African American. The intervention and control group showed at baseline no differences except on the CBCL attention subscale (intervention group showing higher scores). There was no significant program effect on service utilization per parent and youth report. The intervention and comparison group families who did not receive services cited similar barriers to service utilization. The most common reason for those not receiving their most desired service was that the situation improved on its own and services were unnecessary (30%). At follow-up, no intervention families reported fights or fight injury in the last 3 months, whereas 8% of youth and 14% of parents in the comparison group reported youth fighting in the past 3 months (Table 3). With limited sample size, there was no statistically significant program impact on reported fighting, fight injury, or weapon carrying.	report
Evans, M, et al.	High	Random assignment of	children with serious	296 children and their families were referred	(1) Home Based Crisis Intervention (HBCI):	The average age was 12.3, (58% older than 13 years, considered as	

199714	children with serious psychiatric problems to 3 models of intensive in-home services as alternatives to hospitalization. Design: positive controlled three-group randomized study-design, 3 times of data collection: at intake, at discharge ad 6 months post discharge. Duration: 26 months	emotional, behavioural problems, presenting at two emergency service settings in the Bronx, New York, aged 5-17 years, living at home, and experiencing a psychiatric crisis that would require hospitalization; child and parents willing to receive intensive in-home crisis services.	and randomly assigned to the 3 conditions. The measures administered at intake included the Client Description Form (CDF), the Supplemental Assessment Form, the Child Behaviour Checklist (CBCL; Achenbach, 1991), the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), and the Piers-Harris Children's Self-Concept Scale (Piers, 1984). Instruments to measure family characteristics included the Emergency Services Assessment, The Supplemental Form, the Inventory of Socially Supported Behaviors (ISSB), the Parent/Child relationship Scales, Family Adaptability and Cohesion Scales II (FACES II), the Parental Self-Efficacy Assessment and the Martin Acculturation Index.	short-term intensive in-home services to a family with a child with imminent risk of being admitted to an inpatient program. 4 counsellors trained in the Homebuilders model 24/7 response capacity, 4-6 weeks, focusing on strengths and needs. (2) Enhanced Home-based Crisis Intervention (HBCI+): same as HBCI with additional support in- and out-home services for families (respite care, parent advocate); additional training and technical assistance opportunities for staff, and a small amount of service dollars for the family ($100 per family). (3) Crisis Case Management (CCM): short term intensive model of crisis care based on the existing standard New York crisis model: more caseload, less time, focusing on assessment of strengths and needs and coordinating service delivery and referring to other services and supports.	adolescents, 42% children); 53% boys, 47% girls. 59% of the children were Hispanic, 34% African American, 5% White, and 2% other minority children. Spanish was the primary language of approximately one fifth of the children (18%). Regarding DSM-III-R or DSM-IV diagnosis, 37% of the children had disruptive behaviours diagnoses, 21% adjustment disorders, 17% mood disorders, 11% psychotic disorders, 9% anxiety disorders, and 5% other disorders No outcome results after discharge or at follow-up are presented. No differences between the three conditions are presented.	

					The length of the service duration is also 4-6 weeks, also available on emergency basis 7 days a week, 24 hours a day, $15,00 available per family		
Fisher, P. et al, 200515	High	RCT: Random assignment to EIFC (Early Intervention Foster Care Program) intervention (intervention group IG) or regular foster care (comparison group, CG), providing services as usual, in accordance with standard policies	All 3-6 year old foster children in need of a new foster placement of the Oregon Department of Human services Child Welfare Division, Lane County	90 children, (47 to IG, 43 to CG) No significant group differences on prior placements, total time in foster care prior to entering the study or CBCL internalizing or externalizing scores were fond	Intervention derived from Oregon Social Learning Centre Parent Management training program). The EIFC intervention is delivered via a team approach to the child, foster care provider, and permanent placement resource (birth parents and adoptive relatives or nonrelatives). Before receiving a foster child, the foster parents complete intensive training. After placement, the foster parents work with a foster parent consultant and are given extensive support and supervision through daily telephone contacts, weekly foster parent support group meetings, and 24-hour on-call crisis intervention. The children receive services from a behavioural specialist working in preschool or	54 of the 90 children were places in a permanent placement during their time in the study. Permanent placements failed for 9 (36%) of the children in the CG, and for 3 (10%) of the children in the EIFC group The failure rate for children with more than one foster placement during the study was 13.95 times higher than that for children with only one foster placement. The number of foster placements prior to the study was significantly related to failed permanent placements for children in RFC but not for children in EIFC, as indicated by the significant interaction between condition and foster placements prior to study.	The data presented do not allow for an in-depth examination of mechanisms that might account for the effectiveness of the EIFC intervention. Limited sample size

					day care and home-based settings. In addition, the children attend weekly therapeutic playgroup sessions where behavioural, social, and developmental progress is monitored and addressed.	
Garner, et al, 201016	B. Moderate	Quasi-experiment. Participants staying at least 1 week in a residential treatment were randomly assigned to either a control condition (standard care) or one of three assertive conditions (assertive care, AC) Participants were recruited between January 2004 and September 2006	Participants were recruited from Chestnut Health Systems (CHS), which is a publicly funded treatment organization located in the Midwest To be included, adolescents had to (a) meet the DSM-IV diagnostic criteria for dependence on alcohol, marijuana, and/or another drug in the past year; (b) be between 12 and 17 years old at intake; (c) stay at least 7 days in residential treatment; and	324 patients were randomized. 86 were assigned standard intervention, 234 received one of the assertive conditions. Most adolescents were male (63%), Caucasian (70%) and between 15 and 16 years (61%). 80% was involved with school, but also 86 % reported having current involvement with the criminal justice system. 68% reported marijuana dependence and 26 % reported alcohol dependence; 24% reported marijuana abuse and 32% alcohol abuse, and co-occurring psychological problems (80%)	In addition to receiving the same procedures as adolescents in the standard condition (SC), adolescents assigned to one of three assertive conditions (AC) also were assigned a clinician for 90 days following discharge. Clinicians were responsible for initiating continuing care services, by meeting the adolescent in their home, school or other convenient setting as soon as possible following discharge. The three AC conditions were Assertive continuing care (ACC), contingency management (CM) or both ACC and CM. Adolescents assigned to ACC received community adapted	Predictors of continuity of care: Continuity of care was significantly higher among adolescents assigned to AC compared to SC., even after controlling for substance-related problems (p< .10) and number of days in residential treatment (p< .001) Predictors of recovery status at 3 month follow-up: 34% were classified as being in recovery at 3 months post discharge. Continuity of care was proven to be a significant predictor of 3 month recovery status (p< .05)	

	(d) be discharged to live in the community (vs. jail or prison) in 1 of the 10 catchment counties. Adolescents were excluded from study participation if (a) there was evidence of a psychotic or an organic state of sufficient severity to interfere with the understanding of study instruments, continuing care procedures, or the informed consent process; (b) the adolescent was deemed dangerous to self or others during residential treatment; (c) the adolescent provided evidence of a pathological gambling disorder; or (d)	reinforcement approach procedures (A-CRA), and case management procedures. A-CRA is a behaviour therapy based on operant conditioning and social skills training. Adolescents assigned to the CM condition could earn draws (varying value) for providing alcohol/drugs free urine specimens and for completing verifiable pro-social activities. Adolescents assigned to the ACC+CM condition received both procedures.	

			the adolescent was already participating in another research study.				
Glisson, C. et al, 201017	Moderate	Randomized trial: 2x2 factorial design: 2 factors : (a) random assignment within each county to Multisystemic therapy (MST) or usual services, and (b) random assignment of the counties to the ARC Organizational Intervention condition	Delinquent youth in 14 rural Appalachian counties of eastern Tennessee, that were referred to the juvenile court between October 2003 and September 2007.	N= 615 (69% male, 91 % Caucasian, 9-17 years)	The ARC Organizational Intervention Model is designed to implement effective mental health services. It incorporates manual guided activities within 12 intervention components and provides 3 strategies (1) organizational tools (team work, goal setting, feedback systems), (2) principles of effective service systems (mission-driven, results-oriented, participation based); (3)service provider behaviours and attitudes (flexibility, openness, engagement).	A multilevel, mixed-effects, regression analysis of 6-month treatment outcomes found that youth total problem behaviour in the MST plus ARC condition was at a nonclinical level and significantly lower than in other conditions. Total problem behaviour was equivalent and at nonclinical levels in all conditions by the 18-month follow-up, but youth in the MST plus ARC condition entered out-of-home placements at a significantly lower rate (16%) than youth in the control condition (34%).	Hypotheses formulated, Clear selection criteria, Manualised or protocollized interventions, therapist adherence measures
Harrington, R. et al, 200018	Moderate	Open study with two randomized parallel groups	Two health districts in the north of England	Parents of 3 to 10 years old children with behavioural disorder, referred to CAMHS; N = 141 Subjects were randomized to community treatment (n=72) or hospital treatment (n=69);	Each service used its routine intervention for behavioural disorders for the age group. In one of the two districts this was the videotape modelling parental group education programme of Webster-Stratton and	There was no difference between groups for attendance, in both conditions , and location did not influence attendance rate. No significant differences between the hospital and community condition were found in the mean overall cost per child, per primary carer, or in total	This finding contrasts with that of Cunningham and colleagues in Canada, who reported that children with behavioural problems treated

				Measurements were completed before treatment, 3 months after treatment start, ad at one year. Mean age of children: 6.9 years 79%boys	colleagues. The other district used a programme of parental education groups with parallel child groups. In both districts the interventions were provided by various professionals, including community psychiatric nurses, psychologists, social workers, and psychiatrists.		in the community had better outcomes than those referred to a specialised clinic. It is, however, difficult to interpret the results of that study because outcome data were obtained on less than a third of randomised subjects. - small sample size - - different kinds of community services
Henggler, S. et al. 199719	High	Pilot study of a randomized field trial	Emergency psychiatric hospitalization at the Medical University of South Carolina; adolescents, referred for emergency psychiatric hospitalization	26 adolescents, referred for emergency psychiatric hospitalization, aged 12-17 years, presence of symptoms of suicidal ideation, homicidal ideation, psychosis, or threat to harm to self or others due to mental illness; existence of a non-institutional residential environment	Participants could be randomized to the hospitalization condition or to the experimental condition, receiving MST (multisystemic therapy) by an MST therapist and a child psychiatry fellow, at home	Out of home placement was prevented for 53 % of the participants (n=8) in the MST experimental condition. Days of hospitalization for youths in the MST condition was higher than expected (87 days versus 194 days in the hospitalization condition), and the savings in days was partly offset by a higher than expected use of other out-of-home placements (a.o. juvenile detention)	The study reports having underestimated the clinical resources needed to assure safety and address clinical needs (in comparison with experience with substance abuse and juvenile offenders), ad having overestimated

							the quality and quantity of community resources available to meet the short-term respite needs
Henggeler et al. 2002 20and 199921	Moderate	RCT with 12 months follow-up (Henggeler 1999), and a second evaluation at 4-years (henggeler 2002) Multimethod data collection (self-report; parent report; biological measures; archival)	Adolescents recruited from Juvenile Justice Charleston County, South Carolina Inclusion: 12-17 years Diagnosed with substance abuse/ dependency Residence in Charleston county Residence with at least 1 parent Exclusion: Already involved in substance treatment	423 adolescents screened; 140 met inclusion criteria; Of these 118 (84%) agreed to participate Demographics at entrance: Average age: 15.7 79% male 50% Afr Am; 47% Caucasian Low income (median family income: $15.000-$20.000) 72% met DSM criteria psychiatric diagnosis T1 (pre-treatment): 118 T2 (post-treatment): Intervention: 100% Control: 93% T3 (6 months) Intervention: 93% Control: 90% T4 (12 months): ? T5 (4 years): 68%	MST-therapy (n=58) MST model views caregivers as key to achieving desired outcomes, interventions typically focus on the family and the family's interface with key social systems MST therapists: master-prepared clinicians supervised by Child psychiatrists Home-based model Low case-load (4-6 families/therapist): average 46h contact over 130 days 24/7 availability Usual care (n=60) Referred by their probation officer to receive community-based substance abuse	Drug use: Self-reports: T1 versus T2 in favour of MST ($p<0.05$) for alcohol/marijuana and other drugs T1-T3: NS T5: NS Urine screens: T1 – T2: NS T1-T3: NS T5: MST group higher rates of marijuana abstinence (55% versus 28%) ($p<0.05$) but not for cocaine Criminal Activity: Self-reported delinquency: T1 – T2: NS T1-T3: NS Aggressive crimes: significant reduction at T5 for self-reported crimes & conviction rates ($p<0.05$) No differences at T5 in property crimes Out-of-home placement: Substantially ($p<0.05$) fewer days in out-of home placements for youth	No primary outcome defined Low sample size Report of low treatment adherence therapists intervention group Attrition at T4 is unclear

				38 dropouts at T5: 19 refused; 13 not found; 4 could not be interviewed; 2 died baseline differences (p<0.05) self-reported alcohol & marijuana use, other drug use (higher in MST) T5 sample at baseline: MST-> older & more marijuana use	treatment (i.e. weekly attendance group meetings), additional residential and inpatient services as needed	in MST (19 adolescents for 569 days) compared to usual care (16 adolescents for 1051 days) during the T1 to T3 period	
Holden et al. 2007 22	High	RCT (study date unclear) Structured interviews at program entry, 6months and 12 months	Connecticut (USA) launched a Title IV-E waver demonstration program in July 1999 to evaluate whether the well-being of children approved for residential mental health services could be improved, and LOS ↓ by providing case rate payments to a community agency Target: children	432 children considered for inclusion: 263 children not eligible (67% too acute; 11% severe physical & develop. disabilities; 10% too old; 3% residence outside region; 9% unknown) 10 refused to participate 159 children (of which 2 did not participate) Random allocation: Intervention (n=78) & Comparator (n=79) Characteristics: Male: 53% White (46%), African American (24%);	Intervention: community agencies were required to organize collaborative networks of children's mental health service providers and coordinate care among the community and residential services with their local agency partners. Flexible, incentive oriented funding arrangements were used: risk corridor for 110% of the case rate and full retainment funding if actual expenditures fell between 90-100% Comparator: State services as usual	Dropout: 8% at 6 months; 6% at 12months; Services received: Intervention group provided more (p<0.01) crisis stabilization; family therapy; family preservation; family support services; behavioural aides; respite care; after school programs; transportation services; use of flexible funds Intervention: more intensive (i.e. nbr of service units per month) services in the area of case management; family support & transportation (p<0.05) Comparator: more intensive services in the area of residential treatment, inpatient hospital stays, medication monitoring (p<0.05)	No power calculation No primary outcome defined No clear description intervention No blinding of patients, caregivers, assessors Intention to treat analysis?

		with moderate mental health acuity levels, aged 7-15 (target 11 or older for the study) years, authorized for residential care placement. Exclusion of certain behaviours (e.g. suicide attempts); conditions (IQ<65)	Hispanic (24%) Average age 12.1y 58% referred from within child welfare programs; 14% from probation departments; 12% from caregivers; other Primary presenting problems: physical aggression (85%); self-injuries (75%); withdrawal/depression (66%) Most frequent diagnosis: depression (68%); oppositional defiant disorder (46%); posttraumatic stress (31%); ADHD (28%)		Placement status: Placed at home: Intervention: entry (20%) → 38% at 12 months (p<0.05) Comparator: entry (22%) → 14% at 12 months (p<0.05) % days placed at home during first 12 months: Intervention (38%); comparator (14%): p<0.05) Clinical outcomes: No significant differences across time when comparing intervention with comparator. Both groups showed improvements at a similar rate Costs: Intervention: $51618 Comparator: estimated at (data less complete) $62000	
Jusczak et al. 200323	High	Retrospective cohort study between 1989 & 1993 aims to identify the differences in low-income adolescents utilization of health, mental health and urgent care services on the basis of access	Network of 11 federally funded community health centres in low-income neighbourhoods: most patients are low income patients 3 senior high school based health centres with combined	3469 visits made by 451 students over 3 years Group 1: students enrolled in Community Health Networks attending a school with School based health centre without using it: Y1: 86 Y2: 101	School-based health centre: comprehensive health services, mental health services (substance abuse group & individual counselling), social services (e.g. food, shelter) Community health network:	Average reported visits per year: Group 3 (5.3) >Group 1 (3.3)>Group 2 (3.1) Reasons for visit: Group 3 (26% accessed mental health) >> 3% in groups 1 & 2 (p<0.001) Adolescents were 21 (CI: 15-29) times more likely to come for mental health visits at school based	Schools not randomly selected Limited relevance for Belgium Risk of Bias in schools without school base health centres where to a lesser extent support is given to students

		to and use of a school-based health centre as compared with a community health network	student population of 3900 serving an urban inner city population in grades 9-12. 912 students visiting healthcare providers in school based health centres or community health network Inclusion: school confirmation matched at least 1 y Exclusion: Students without confirmed school Control group: ±50% of those meeting criteria for age & zip-code randomly selected from a geographic area in the city without school based health centres	Y3: 114 Group 2: control group enrolled in a community health network and attending schools without school based mental health centre Y1: 44 Y2: 59 Y3: 62 Group 3: adolescents visiting a community health network and also used services in the school based health centres Y1: 140 Y2: 121 Y3: 105	Health services, mental health services (limited to individual counselling)	health centres than at community health networks	regarding health Measurement error possible for medical record screening Mental health services were available at al sites (but not to the same extent: community health centres offer only individual counselling)
Kjobli & Sorlie, 200824	High	Quasi-experimental pre-post design with randomly selected	Norway, suburban municipality close to Oslo;	271 employees: 1st assessment: 266 (RR=98%)	Intervention: Community wide Early Intervention for children at risk for developing behavioural problems,	Baseline comparisons: 2 significant differences in respondents: Intervention group: 3.4 years more experience & 3.3 years older	Assessment soon after intervention

	intervention and comparison area	Teachers in elementary schools (≥0.5FTE) to evaluate intervention for children aged 3-12 years Intervention group included 3 schools; comparison group included 4 schools Pre-assessment (t1) at start school year 2004/2005 Post-assessment (t2) 9 months later, 3 months after intervention ended (June 2005) Prevention of contamination: main stakeholders were informed that intervention would be implemented	Mean age: 43; Mean experience: 11 years Intervention: Lost-to follow up 22 Complete data: 106 Control group: Lost-to follow up 29 Complete data: 109 During the study period 64 children were exposed to 1 or more intervention modules; multiple interventions were given to 27 children Mean age:7.7 years (86% boys)	concerning competence and skills in regular health services, early and targeted interventions for at risk children, across-service coordination. Includes 6 predefined intervention modules offered to children at elevated risk, their parents or their teachers. Intervention implemented in multiple settings (e.g. home & school) Intervention modules: brief component promoting (universal); teacher & pre-school consultation (selected/ indicated); social skills training (selected/ indicated); parent counselling (selected); parent management training (indicated); parent management group training (selected/indicated)	1477 students in intervention and 1490 in control group; Average school size intervention (500)> control (374) group Outcomes: Intervention group – staff reported: Problem behaviours: improved only marginally ($p<0.005$) Prevalence of learning inhibiting incidents↓ ($p<0.005$) Aggression incidents↓ ($p<0.005$) No changes in classroom climate Student relations↑($p<0.005$) Significant change in 4 of 8 outcomes in intervention group, however the effects were to be considered small to moderate in effect	Risk for detection bias (measurement not blinded)

			everywhere after evaluation period (if desired)				
Magiati et al. 200725	HIGH	Prospective outcome study (including patients between July 1998 & April 2000); follow-up for 32-27 months	UK, Inclusion criteria. age (CA) 22–54 months. Independent professional diagnosis of autism/ASD; No additional major medical diagnoses. • Native language: English • Living within 3 hours' travel of Central London. • Enrolled in either EIBI (early intensive behavioural interventions) home-based programmes or specialist autism-specific school-based nursery provision for a minimum of 15 hours per week Receiving no	63 initially include, 19 subsequently excluded not meeting inclusion criteria 44 children; 28 intervention group (1 girl); 16 Nursery group (4 girls) No statistical differences detected between intervention & control group. Exception: parents in intervention group: higher educational level (p=0.04)	Intervention (Early intensive behavioural home-based therapy) versus comparator (Nursery at school) More hours of interventions (3.4h intervention & 2.2 comparator: p<0.001) Average hours per week: Intervention: 32.4 Comparator 25.6 (p<0.001)	No significant group differences in outcome in cognitive, language and play skills, autism severity or daily living skills when accounting for differences in IQ-levels	No power calculation No blinding assessors No randomization Contamination with other treatments: more intervention children followed diets & biological interventions (p<0.001); more comparator children followed extra educational support (p<0.001)

			other intensive intervention.				
Mears et al. 200926	High	Quasi-experimental design with pre-post test evaluation (baseline & 6 months) 2 intervention groups (state custody foster care & parental custody and 1 control group (traditional foster case management) Intervention not randomized	Nevada Division of Child and Family Services 126 participants aged 5-18 years with severe emotional disturbance Parental custody: Either being discharged or at least 6 months active State custody foster care: First 12 youth served by 4 wraparound facilitators Traditional foster care: n=30	126 patients (48 youth in parental custody; 48 in foster care custody; 30 in traditional case management foster care) Average age:12.3 No differences in 3 groups regarding age, gender, ethnic origin No significant differences on any outcome test at pretest	Wraparound: small caseloads from 10 to 12; trained in wraparound, supervision of their work Care givers in traditional case management received no special training or supervision	Degree of impairment (CAFAS): Improved functioning at post test ($p<0.001$) Other tests 'Parent's reported problem behaviours (CBCL)'; 'Restrictiveness of Living Environment (ROLES)'; 'School and community behaviour indicators' not significant Number of placements significant lower ($p<0.001$) in comparison group); no effect for other variables (number arrested, law enforcement contacts; reports of abuse or neglect; absences from school; disciplinary actions at school No significant movement from special education classes to regular education classes or vice versa	High risk of bias: Performance bias, Selection bias, detection bias
Ogden & Hagen 200627	Moderate	RCT with weighted randomization (6/10 MST; 4/10 comparator)	Norway Participants referred from municipal Child Welfare services.	Intervention (n=46); control (n=29) 3 MST & 3 controls dropped out (8% attrition)	MST: Low caseload (3-6/therapist) 24/7 availability Therapist contacts family daily or weekly	Placement out of home: Living at home at time of follow-up (approximately 6 months): MST: 33/46 or 72% Comparator: 15/29 or 52% P<0.07	Low sample size No power calculation No primary

		Three sites, MST treatment delivered by 4 MST teams (each 3 or 4 therapists & a clinical supervisor Inclusion criteria: Problematic behaviour 12-17 years Motivated parents Exclusion criteria: Ongoing treatment other agency Substance abuse without other behavioural problem Autism, acute psychosis, imminent risk of suicide Home treatment has a high risk for harm	Average age: 15 All have Norwegian background	Comparator: Regular child welfare services	For patients that were living at home at intake (n=61): MST: 31/39 or 80% Comparator: 12/22 or 55% P<0.05 Parent reports: MST children rated as having lower behavioural problems (p<0.05) Youth reports: Adolescents in MST group scored lower (p<0.05) on the self-report delinquency scale Teacher reports: At follow-up 51 were attending school: only 29 reliable teacher assessments were collected Clinical significance: MST: Intake: 9% in normal behavioural category Follow-up: 38% in normal behavioural category Comparator Intake: 14% in normal behavioural category Follow-up:21% in normal behavioural category	outcome defined
Schmidt et	High	Non-	Setting:	Intervention:	Total symptom score:	Home treatment

al., 200628	randomized controlled study. Allocation to intervention depends on patient/parent motivation	Manheim, Germany: outpatient unit of the Child and Adolescent Department of the Central Institute of Mental Health Inclusion: Aged 6-17 with heterogeneous psychiatric disorders (disorder that is present in at least in 5% of children) that require hospital admission (severity disorder score – SGKJ ≤5) IQ≥85 Informed consent Place of residence≤30km of institution Exclusion: self-endangering behaviour and severe disorders requiring continuous	Baseline assessment (t1) 76 patients were included in the intervention group of which 6 dropped out (e.g. inpatient admission) 35 patients in control group At end of treatment (t2) 1 year after treatment (t3) 59 patients Average age:10.9y 60% of lower social class Average 3.4 psychosocial risk factors	Home treatment during 3 months with on average 20 personal contacts(≥2 hours per session) and 4 telephone consultations as alternative to inpatient care. Performed by psychiatric nurse or medical students under supervision of a child psychiatrist Comparator: Adolescents previously admitted for inpatient treatment between may 1993-may 1998 Selected based on age, sex, diagnosis, degree of psychosocial impairment	T1 vs t2: ↓ in symptoms from 12 to 8 (p<0.001) Intervention (t2) vs control (t2): intervention group less effective than control (p<0.001) T2 vs t3 : further : ↓ in symptoms from 8 to 4.6 (p<0.001); Significant more improvements in intervention than in control group T1 vs t3 : sizeable improvement in intervention and control group Global level of psychosocial functioning: T1 vs t2: ↑ in functioning from 4.5 to 5.8 (p<0.001) Intervention (t2) vs control (t2): intervention group less effective than control T2 vs t3: improvement from 5.8 to 6.3 (p<0.001); Significant more improvements in intervention group than in control group T1 vs t3 : sizeable improvement in intervention and control group Level of functioning: T1 versus t2: significant improvements, but low absolute values, school performance NS Intervention (t2) vs control (t2): no difference but one (school performance improvement only seen in control group) T2 vs t3: only significant improvement for autonomy T1 vs t3 : sizeable improvement in intervention and control group	appears to be effective when patients are motivated and care is given by highly skilled staff. Also inpatient treatment has shown to be effective. However: No randomization: selection bias Severity of psychopathology higher at baseline in control group. Social class lower in intervention group Attrition Bias No intention to treat analysis Only limited blinding for outcome measurement

			monitoring			Global rating of behavioural changes by child, parents, therapists: T1 vs t2: most children (46%), parents (50%), therapists (51%) report moderate improvements, nearly no responses of deterioration or no improvement Intervention (t2) vs control (t2): treatment effects in intervention group superior as rated by patients and parents T2 vs t3: stability Blind evaluation effectiveness of treatment: symptoms, level of functioning, psychosocial evaluation, global: T1 vs t2: improvement in all areas Intervention (t2) vs control (t2): control group > intervention group Comparison intervention given by nurses vs medical students: Outcomes intervention nurses(n=38)> medical students (n=32)	
Schoenwald et al. 200029	Moderate	2*3 mixed factorial design with yoked pairs (randomly assigned) T1 (within 24 h) T2 (shortly after comparison youth was	Adolescents approved by independent source for emergency psychiatric hospitalization at Medical University of South Carolina	134 met inclusion criteria 116 agreed (3 dropouts) 113 adolescents and their families: MST (n=57); hospitalization (n=56) 13 years on average 65% male 64% Afr Am; 34%	Intervention: MST intervenes directly in social systems in which youth are embedded Training of clinicians in psychiatric crisis Teams included psychiatrists for supervision of master-prepared therapist (assisted with bachelors	Out of home placements (foster care; therapeutic foster care; shelters; orphanages; group homes; residential treatment centres; psychiatric or substance abuse hospitals; detention centres; boot camps; reception & evaluation centres; jails; prisons) Acute crisis stabilization: hospitalization T1-T2	Power calculation? Low sample size No types of blinding described No primary outcome

		released from hospital) T3 (at completion of home-based MST: 3-4 months) Telephone survey was administered to caregivers monthly from T1 to T3	Inclusion: 10-17 years Symptoms of suicidal, homicidal or other behaviour due to mental illness Residence in Charleston county Medicaid or not insured Availability of non institutional residence Exclusion: Already involved in MST Autism	White Intake: 32% with suicidal ideation, plans or attempts; 15% homicidal; 11% psychotic; 42% judged by psychiatrist as a significant threat to harm others or themselves	for administrative assistance) Caseloads of 3 per therapist Comparator: hospitalization	MST prevented in 75% of the cases hospitalization. 14 patients were hospitalized: 2.2 days on the unit Comparator: 100% hospitalized with on average 6 days in hospital Acute crisis stabilization to MST treatment completion: hospitalization T2-T3 During the ±3.5 months after hospitalization, 27 were hospitalized (16 in MST and 11 in comparator group): proportion and mean days NS Referral to MST treatment Completion: hospitalization T1-T3: Mean days hospitalized: 2.39 in MST and 8.8 days in comparator group (p<0.05) Out-of home placements T1-T3: Comparator group counted twice as many out-of home placements (excluding hospitalization from the counts): p<0.05: 906 versus 508 days	
Solhkhah et al., 200730	High	Within-group design (6 years: 1996-2002). Control group: retrospective analysis of patients on waiting list	Setting: St.Luke's-Roosevelt Home and Community-Based Services (New York County)	Intervention group: 169 children (115 boys); average age: 11.98 Average stay in intervention group: 12 months Control group: same	Intervention: Systems of care (alternative to hospitalization): 6 different wraparound services: 1) ICC or Individualized Care Coordinator; 2)	Maintenance in community: Intervention: 81% versus control: 30% (p<0.001) Corrected treatment failure (corrected for longer period of intervention observation): Intervention: 3 patients/month;	Weak design with high risk of bias

			Inclusion: Aged 5-18 with DSM-IV Axis 1 psychiatric disorder and NY criteria for severe emotional disorder (=functional limitation last 12 months); Viable living environment in community; parents are willing to participate Exclusion:	subjects as intervention group. Retrospective chart review period on wait list. Average time on wait list: 3.5 months	respite care; 3) family support services; 4); skills building; 5) intensive in-home services; 6) 24-h crisis response by on-call child psychiatrists ICC (social worker) meets 6/month; assessment, in-home treatment and family support; coordination of care with local community agencies. Comparator: Wait list patients	control: 33 patients/month Inpatient psychiatric hospitalization rate Intervention 3%; control 41% (p<0.001)	
Sheidow et al. 200431 Based on RCT Schoenwald et al. 200029	Moderate	2*3 mixed factorial design with yoked pairs (randomly assigned) T1 (within 24 h) T2 (shortly after comparison youth was released from hospital) T3 (at	Adolescents approved by independent source for emergency psychiatric hospitalization at Medical University os South Carolina Inclusion: 10-17 years Symptoms of	115 of 156 families (74%) were receiving Medicaid: 13 years on average	Intervention: MST intervenes directly in social systems in which youth are embedded Training of clinicians in psychiatric crisis Teams included psychiatrists for supervision of master-prepared therapist (assisted with bachelors for administrative assistance) Caseloads of 3 per	The average programmatic savings was $1.617 per youth during the treatment period (p<0.01) The impact of MST on Medicaid spending in the 12 month follow up period was less advantageous at savings of $400 per youth: NS ICER were calculated but are not presented here since the effects on which they are based were NS	Power calculation? Low sample size No types of blinding described Additional publication: Huey, S et al. Journal of the American Academy of

		completion of home-based MST: 3-4 months) T4 (6 months after T3) T5 (12 months after T3) Telephone survey was administered to caregivers monthly from T1 to T3	suicidal, homicidal or other behaviour due to mental illness Residence in Charleston county Medicaid (not insured from original RCT excluded) Availability of non institutional residence Exclusion: Already involved in MST Autism		therapist Comparator: hospitalization		Child and Adolescent Psychiatry 43: 183-190.2004.
Sundell et al. 200832	Moderate	RCT (2004)	Sweden Child welfare in 27 local authorities from Sweden's 3 largest cities (Stockholm; Goteborg; Malmo) and 1 town (Halmstad) MST treatment delivered by 6 teams (each 3 or 4 therapists & a clinical supervisor) Inclusion	168 families invited; 156 (93%) accepted) Average enrolment of 146 days: Intervention (n=79); Received intervention: 55 Prematurely terminated: 20 Allocated intervention	MST: Implementation supervised by Charlston MST team Comparator: Social services determined intervention: most commonly individual counselling (1-2 h a week) (n=20) or family therapy (n=16)	No statistical differences found in child behaviour; self-reported delinquency; alcohol & drug consumption; youth social competence; school attendance; parenting skills; mother's mental health	Low sample size No power calculation No primary outcome defined Short-term effectiveness of MST in Sweden not confirmed: Different with USA: MST not

		criteria: conduct disorder 12-17 years Motivated parents Exclusion criteria: Ongoing treatment other agency Substance abuse without other behave-oural problem Autism, acute psychosis, imminent risk of suicide Home treatment has a high risk for harm	not received: 4 Included in follow up after 7 months (n=76) Could not be located at follow up: 3 79 cases analysed Control (n=77) Received intervention: 48 Prematurely terminated: 16 No intervention: 13 Included in follow up after 7 months (n=73) Refused: 3 Could not be located at follow up: 1 77 cases analysed Average age: 15 47% not from Swedish heritage			implemented with sufficient fidelity (empirically illustrated) In-home services are quite frequent in usual care: child welfare compared to juvenile justice in US Norway Implementation by Ministry Child & Family Welfare, in Sweden up to local initiatives
Vostanis et al., 200633	High	Nonrandomized (organizational) case-control cluster evaluation	UK. Early intervention to children <12 years who present with a	Children consecutively referred to each of the FSS & the comparison group over a period of 6 months FSS-A:	Family support service A: open referral system; brief-solution focused therapy (Level 1 Service) Family support service	First assessment (within 2 weeks of referral): C-C group higher on total HoNOSCA, total clinical, behavioural & impairment HoNOSCA, Time of follow-up (within 2 weeks of	accessibility: FSS >> specialist CAMHS FSS with social services:

	broad range of behavioural problems Exclusion: Self-harm; anxiety or depressive disorders; ADHD; autism; learning disabilities; eating disorders	45 agreed FSS-B: 48 agreed Comparison: 40 agreed, 32 in follow-up Comparison of 3 groups: Gender not different; Age & ethnicity differed – FSS-A younger and more diverse -(p<0.05) Referral pathways differed: FSS-A: health visitor FSS-B: social worker C-C: GP Mean response time first assessment: FSS-A: 19.6 days FSS-B: 41 days C-C: 132.4 days	B: same interventions as FSSA but only referrals processed by Social Services (Level 2 Service) Comparison service C: Area with the same local authority where the only option for primary care agencies is to refer direct to specialist CAMHS. Children matched for age and reason for referral. Directly referred to specialist CAMHS (Level 3). Each referral is a low priority referral	intervention; at 5 months for group C): FSS-A: 5 home visits; FSS-B: 6.8 home visits; Group C: 2.1 appointments specialist CAMHS (p<0.001) Changes between 1st assessment & follow-up : FSS-A: total scores; clinical total; symptomatic problems; social problems improved (p<0.05); All SDQ scores improved: total difficulties; conduct; emotional; hyperactivity (p<0.05) FSS-B: improvement in most HoNOSCA scores (p<0.05); Also all SDQ scores improved (p<0.05) Group C : improvement in most HoNOSCA scores (p<0.05); total and conduct SDQ scores improved (p<0.05). Changes in group C were less clinically relevant Association between type of service and outcome score: Children with behavioural problems are more likely to complete a treatment with positive outcomes at a level 2 service than at a specialist service predominantly targeting more severe disorders	significantly more positive outcomes Selection bias; detection bias; Most of subjects specialist CAMHS did not yet completed treatment FSS have an important role within a comprehensive CAMHS but the specificity of the intervention and target group requires further research

3.1.3. Evidence tables: Observational studies

Reference	Risk of bias	Study objective	Design and study duration	Setting & target population	Sample size & characteristics	Data collection	Results	Comments
Hernandez et al. 2001[34]	High	To compare practice-level variables between well developed Systems of care and traditional service systems The hypothesis that SOC principles at the organizational level, compared to a traditional service organization, is associated with greater implementation of SOC at practice level of service delivery is tested	Mixed method design, qualitative data of different sources are used to rate different domains in a quantitative way Two separate cases are studied with each having a comparator	Sites: Organizations that implemented SOC for at least 5 years Controls: matched to SOC sites based on geography, demographics, economic characteristics, rate of child enrolment, child referral patterns, willingness to participate Samples of families: Inclusion: at least having a clinical DSM-IV Axis I diagnosis; a clinical problem indicated by the child behaviour checklist or adolescent functional assessment scale; history of multiple system services; history of out-of-home placements; participation in special education for SED AND 2-12 months care Random sample in Canton/Youngstown;	Pair 1: Canton (SOC)-Youngstown (Control) Age, gender NS More white people in Canton compared to Youngstown (p<0.05) Pair 2: Santa Cruz (SOC) – Austin (Control) Race and gender NS Santa Cruz (average age: 13.6) treated children that were relatively older than children in Austin (average age: 10.1) (p<0.05)	5 or 6 individuals (0.9 inter-rater reliability tested on 15 cases) with professional training in a human service discipline and field experience carried out data collection: Document review; interviews (between 3 to 7 per case) with target child, informal support caregiver, representatives of different systems serving the child; The reviewers rated, based on the qualitative information, 4 domains including sub-domains (11 child-centred and family focused; 11 community based; 10 cultural competence; 2 impact)	Canton-Youngstown: Mean overall rating higher in SOC site (p<0.05); Overall ratings on all 4 domains higher in SOC-sites (p<0.05) 4 sub-domains with non-significant differences (early intervention, restrictiveness, agency culture, appropriateness of services), all other domains with significant (p<0.05) higher ratings for SOC-sites (individualization, full participation, case management, access; integration and coordination, awareness; sensitivity and responsiveness; informal support; improvement) Santa Cruz-Austin: Mean overall rating higher in SOC site (p<0.05); Overall ratings on 3 domains higher in SOC-sites (p<0.05); no significant difference for impact 3 sub-domains with non-significant differences (early intervention, improvement appropriateness of services), all other domains with significant (p<0.05) higher ratings for SOC-sites	Selection bias (willingness to participate) Small sample size Non-random samples No blinding of raters for intervention or control Transformation from qualitative data to quantitative data not supported with examples, however high inter-rater reliability demonstrated

				convenience sample				
Pandiani et al., 2001[35]	Moderate	Examining the relationship between 'variation in the degree of service system integration' and 'variation in 4 service system outcomes	Observational study using existing databases	Vermont (State in USA): 10 community mental health service areas. Each area was served by a community mental health centre children's program, ≥regional office of the state child protection & juvenile justice agency, special education programs in each of the 62 school districts. Number of children ≤18 years ranged from 7.00 to 33.000 Per capita income ranged from $16.200 - $26.300 98.6% White 4 years of measurement (1993-1996)		Existing data sources Independent variable: Caseload Segregation/integration Ratio (CSIR): Measures degree to care is given by each of multiple child-serving agencies in a local SOC Measures amount of caseload overlap (0: no child is served by more than 1 agency → 100: all children served by all agencies) This is an essential attribute of Systems of care Dependent variables: Referral for intensive residential treatment Hospitalization Incarceration Maternity Controlling for: Per capita income	Descriptives: Caseload Segregation/integration Ratio varied from 12 to 57 (p<0.001) but was consistent over time Referrals intensive residential treatment: ranges from 1.3 to 3.7% (p<0.001) with a significant decrease over time (p<0.003) Incarceration rates young men: ranges from 2 to 17% (p=0.035) with a significant increase over time (p=0.03) Rates of hospitalizations of young people served by SOC: ranges from 1.5 to 3% (NS); no change over time; Maternity rates young women: ranges from 3 to 16%(NS); no change over time; Relationships: CSIR with Referrals intensive residential treatment (r=-.39; p<0.015) CSIR with Incarceration rates (r=0.34; p<0.036)→ counter-intuitive result CSIR not significantly related with hospitalization rates or maternity rates	Lack of theoretical framework variable selection Limitations existing databases
Rivard & Morrisey 2003[36]	HIGH	Which factors promoted coordination of activities over time, after the initial opportunities	observational design using 2 time points: 1991 (Wave 1) 1993 (wave	North Carolina Children's initiative funded by the Robert Wood Johnson's Foundation Mental Health Services	1 respondent from each organizations was surveyed (program director or supervisor appointed by the	Survey of 1 key informant Dependent variables: Coordination of activities (The extent to which activities are	Only 15% of dyads were in the same service sector (e.g., dyad composed of two mental health agencies), thus indicating that the vast majority of dyads represent different sectors (e.g., mental health agency and a child welfare agency)	The findings suggest that after two years of project implementation, dyads that coordinated in

		and structures were created to stimulate organizations to work together.	2)	Program: integrating services across public service agencies Wave 1 (1991): 63 organizations Wave 2 (1993): 74 organizations	administration as a resource person): response rate of 98% Dyad analysis of 63 agencies that had client referral at either Wave 1 or Wave 2: 978 dyads identified (50% of all possible dyads)	well coordinated between one agency and another: 0-4) Independent variables: Awareness of the goals and services of other agencies Satisfaction with other agencies Formalization of interagency arrangements Helpfulness in goal attainment Influence in shaping mental health policy Geographic proximity Client referral or information exchange Same service sector Primary service area	In examining factors associated with greater coordination, after two years of project implementation, the strongest associations were found in dyads with stable referral or information linkages (p<.001), which perceived their relationships as facilitating their own agency's goal attainment (p<.001) and influencing the direction of policy and programming for children's mental health (p<.01)	stronger ways were becoming more interdependent, and were beginning the shift from individual goal attainment to systemic goal attainment. High risk of bias: Evaluation by persons in charge of interagency collaboration Relatively small sample size
Slade 2002[37]	HIGH	have school-based mental health programs increased adolescents' access to mental health counselling services; do school based programs complement or substitute for mental health counselling	Secondary data analysis cross-sectional data	National representative survey of students in grades 7-12 drawn from 132 geographically, ethnically and economically diverse middle and high schools → in-home survey sample students interviewed in summer 1995 Administrators of 132 schools in the study were asked	Of the 18924 in-home interviews 449 were excluded (missing info on key variables:): sample size 18475 3075 observations do not have a parent interview (e.g. family income; health insurance status) indicator	Service use measures: Single question: "In the past year, have you received psychological or emotional counselling?" (if yes, locations are asked for) Service availability: The availability of "emotional counselling" at school is reported by a school administrator Measures of mental health status and	Students not in special education: Adolescents in schools that offer on-site counselling: 1.6 percentage point increase of receiving counselling at school relative to schools that do not report counselling present at school (p=0.04). Availability of school-based counselling is not associated with either lower or higher level use of mental health counselling outside schools (p=0.753). Minority students significantly less likely to use counselling services outside school	Insufficient details to know if the sample is representative as the authors say Poor quality measures: e.g. instrument does not specify what types of services comprise psychological or emotional

		services offered outside of school; are these impacts concentrated among students from racial minority backgrounds?		about service availability (impossible to determine if administrators refers to specialized mental health care workers like psychologists, social workers or counselling given in school-based health clinics)	variables were created and entered in analysis as explanatory variables 2642 of the respondents are from oversampled groups like Chinese students, students with limb impairments (part of sampling strategy used for the data on hand): sample weights used in analysis 74/132 report to have school based services	service need: Self-reports symptoms + parent perception of child functional status Socioeconomic status and health insurance: Family income & mother's educational attainment used to measure socio-economic status and ability to afford mental health care. Both are reported by the parents.	Greater use of school-based counselling among Medicaid enrolees, the uninsured Students in special education: School counselling programs do not have a significant impact on use of mental health counselling outside school (p=0.302) but do have an effect on school-based use of counselling (p<0.05)	counselling Probability of using MH counselling increases when schools offer on-site counselling; no differences regarding race; no impact (in either way) on service used outside schools (school based centres and community centres run in parallel) Uncertainty quality of measures used
High	Stroul, Manteuffel 2007[30]	To assess "sustainability" of systems of care after federal funding disappeared. Sustainability is defined as the maintenance of systems of care over time, including the	Mixed method design:	First 37 communities funded to develop and improve SOC through a federal program Phase I 'graduated communities: sites with grants awarded in 1993 (n=4) & 1994 (n=22). Federal funds have been terminated for at least 4 years	Of the 148 total respondents, 140 (94.6%) completed the survey. 1 community was excluded since only 1 out of 4 respondents responded	web survey. Designed based on review, focus groups and analysis of site visit reports with the intention to compare the status of elements of SOC during and after the grant funded period: Dillman approach Telephone interviews (structured template)were	Sustainability of services: 31 items tested, only 3 reached significance (p<0.05): All sites (n=139 in 36 sites): flexible funds & transportation services decreased Phase II sites (n=42 in 11 sites): behavioural/therapeutic aide services increased Sustainability of philosophy: 10 items tested, only 3 reached significance (p<0.05): All sites: individualized care	In-conclusive results Self-constructed survey No appropriate techniques (e.g. transcription, second analyst) used to analyse data from

	services, infrastructure, goals and philosophy Systems of care is defined as a comprehensive spectrum of mental health and other necessary services and supports which are organized into a coordinated network to meet the multiple and changing needs of children with SED and their families	Phase II 'nearly graduated' most were in the final year of federal funding (n=11) 4 key informants were identified for each site: Current or former director of SOC; mid-level or high-level position representative in children mental health system; family member involved in SOC; representative of partner child serving agency (welfare, education justice)	conducted with: the current/former director of SOC OR the representative of the mental health system 2) family member Telephone interviews with state children's mental health director in each state that had one or more soc community included in the sample	approach; interagency coordination in planning decreased Phase I sites (n=97 in 25 sites): individualized care approach; interagency coordination in planning; family involvement in system policy decreased Sustainability of goal achievement: 9 items tested, only 2 reached significance (p<0.05): Phase I sites: ensuring that services in the service array have sufficient capacity decreased Phase II sites: reducing the number of children in settings more restrictive than necessary increased Factors with most positive impact on sustainability (qualitative results): Inclusion of key stakeholders; Interagency partnerships; Local commitment to the Systems of care approach; Existence of ongoing leadership; Provision of training; Existence of a constituency to advocate systems of care; Presence of a Bchampion^ with the power to focus energy and resources; Infusion of the Systems of care into the larger service system; Existence of positive evaluation data on system effectiveness; State commitment and involvement; Existence of formal policies supportive of systems of care; Engagement of political and policy leaders; State financial support; Increased utilization of Medicaid for financing	telephone interviews Multiple testing

services

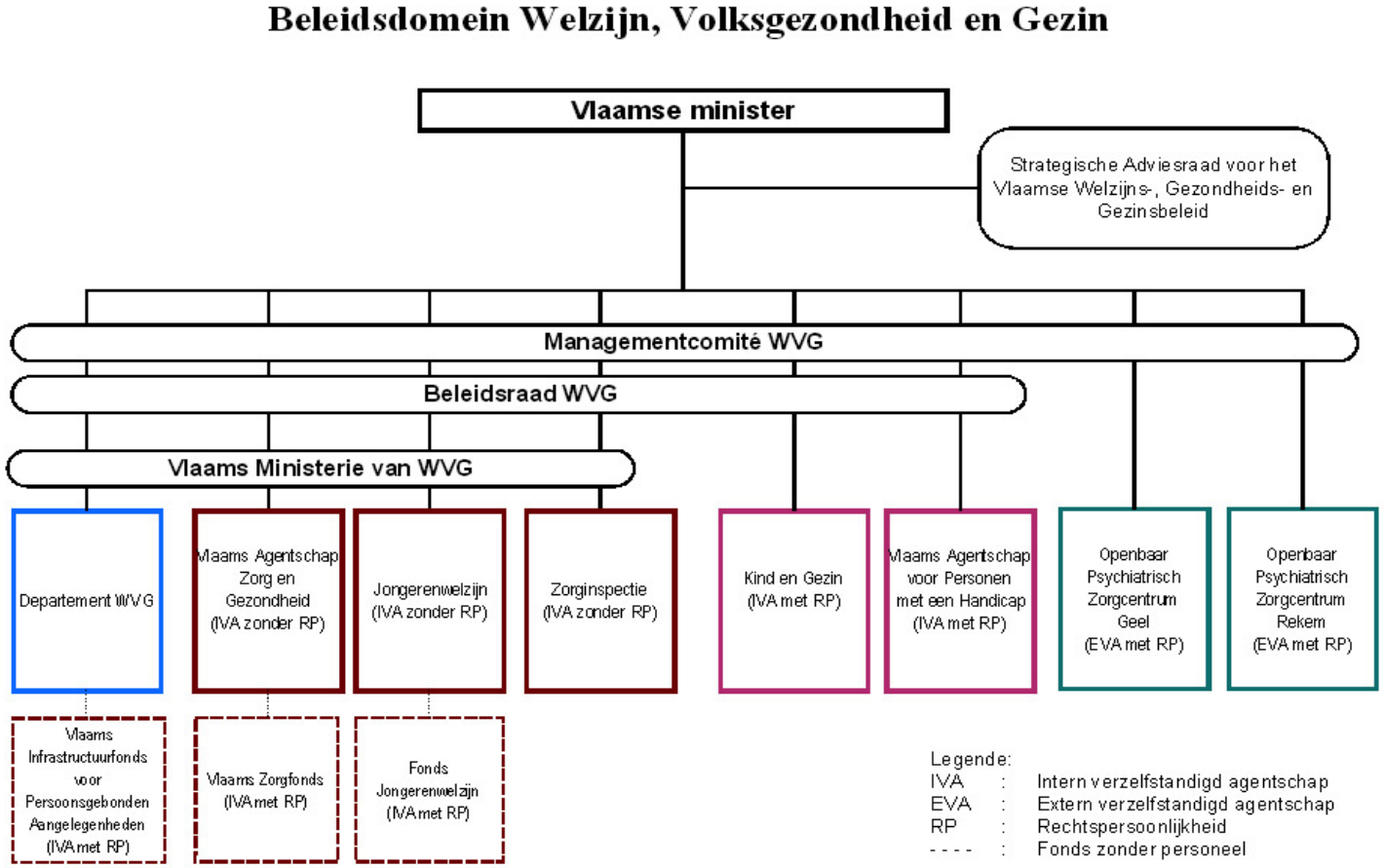
4. APPENDIX 4

No Appendix to chapter 4.

5. APPENDIX 5 BELGIUM

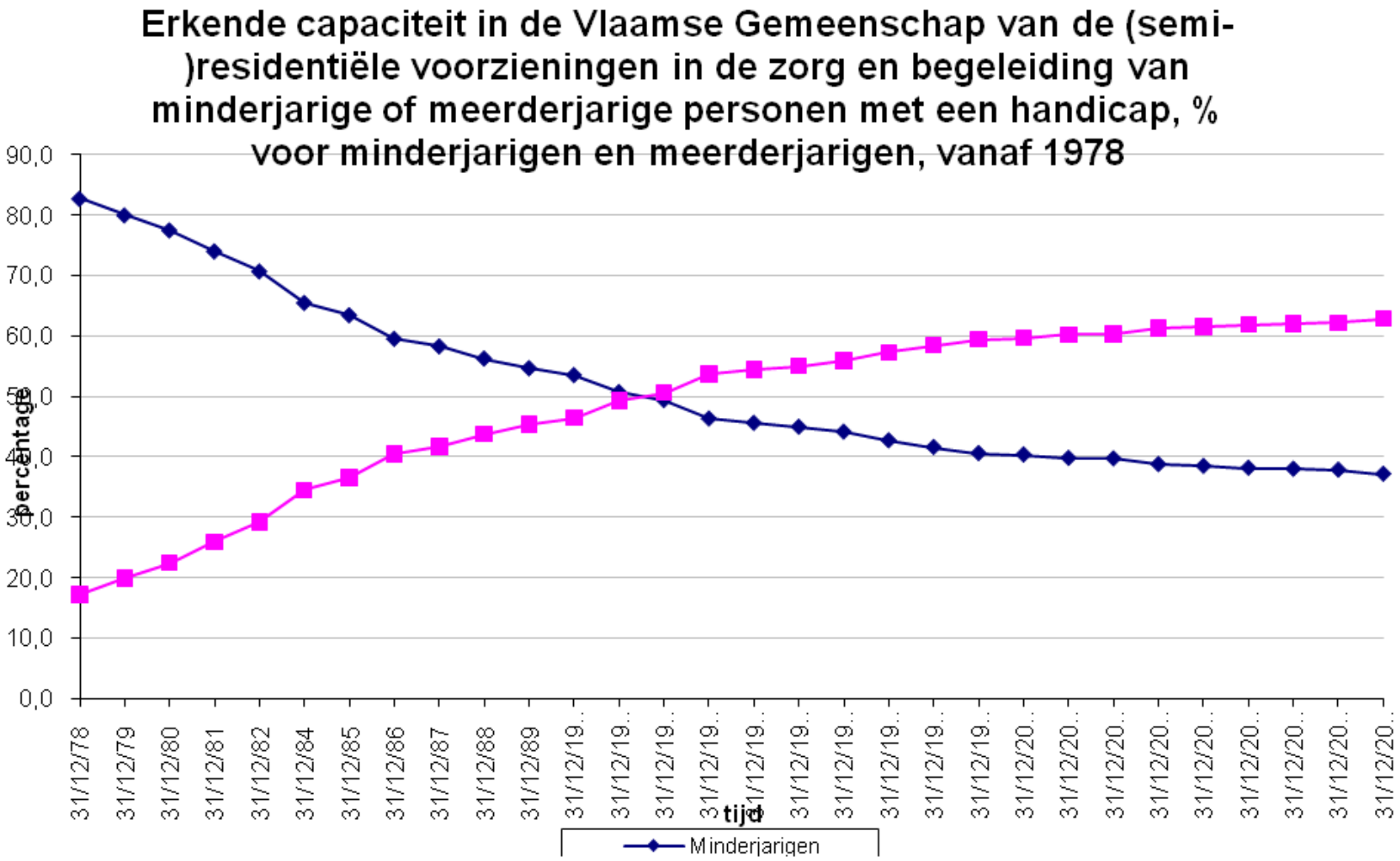
5.1. Belgium: tables and figures

Figure 5.1: Overview of the policy domains of the Minister of the Flemish government, accountable for Wellbeing, Public Health and Families



5 *(http://wvg.vlaanderen.be/welzijnengezondheid/voorstelling/organogram/index.htm)*

Table 5.1: Capacity of (semi-)residential services for disabled persons in Flanders; adults versus minors, evolution 1978-2008.



(Source: VAPH)

Table 5.2: Flanders: number of youth in youth social care (2004-2008)

NAAM	**Evolutie van het aantal jongeren dat tijdens het jaar begeleiding kreeg via de BJB, naar leeftijd**	
DIMENSIES	**Ruimte**	Vlaamse Gemeenschap
	Tijd	vanaf 2004
	Leeftijd	0-4 jaar 5-9 jaar 10-14 jaar 15-19 jaar 20-21 jaar
BRON	WVG, Agentschap Jongerenwelzijn	
Voor meer informatie		laatst gewijzigd 18/11/2009

1. Aantal

	2008	*2007*	*2006*	*2005*	*2004*
0-4 jaar	2.330	1.893	1.709	1.609	1.554
5-9 jaar	4.452	3.810	3.553	3.289	3.124
10-14 jaar	6.129	5.317	5.027	4.824	4.739
15-19 jaar	10.053	8.806	8.422	8.096	7.860
20-21 jaar	384	397	377	320	337
onbekend	2	2			
totaal	23.350	20.225	19.088	18.138	17.614

2. Percentage

	2008	*2007*	*2006*	*2005*	*2004*
0-4 jaar	10,0	9,4	9,0	8,9	8,8
5-9 jaar	19,1	18,8	18,6	18,1	17,7
10-14 jaar	26,2	26,3	26,3	26,6	26,9
15-19 jaar	43,1	43,5	44,1	44,6	44,6
20-21 jaar	1,6	2,0	2,0	1,8	1,9
onbekend	0,0	0,0	0,0	0,0	0,0
totaal	100,0	100,0	100,0	100,0	100,0

Tot en met 2007 zijn de gegevens afkomstig van het oude registratiesysteem BJ96; vanaf het jaar 2008 zijn de gegevens afkomstig van het nieuwe registratie- en opvolgingssysteem DOMINO.
Aantal jongeren: hier worden alle verschillende jongeren geteld die gedurende het begeleidingsjaar voorwerp geweest zijn van een maatregel in het kader van de bijzondere jeugdbijstand. (doorstroom)

Figure 5.2: the Regions and Communities in Belgium (http://www.belgium.be)

The 3 communities

The 3 regions

Table 5.3: Evolution of K- beds and k(day)-k(night) places in Belgium (2000-2011).

K- bedden AZ	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Vlaanderen	129	135	135	135	135	126	139	139	164	164	164	164
Brussel	23	53	63	63	63	63	63	60	60	75	75	75
Wallonië	20	20	20	20	20	35	35	35	35	35	35	35
België	**172**	**208**	**218**	**218**	**218**	**224**	**237**	**234**	**259**	**274**	**274**	**274**
k-1 plaatsen AZ	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Vlaanderen	20	14	14	14	34	40	43	52	55	55	55	55
Brussel		23	23	23	23	23	23	23	23	28	28	28
Wallonië							5	11	11	11	11	11
België	**20**	**37**	**37**	**37**	**57**	**63**	**71**	**86**	**89**	**94**	**94**	**94**
K- bedden PZ	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Vlaanderen	123	143	143	173	189	209	209	207	207	207	207	207
Brussel	40	37	37	37	45	45	45	45	45	45	45	45
Wallonië	204	205	205	205	205	205	205	205	205	190	190	190
België	**367**	**385**	**385**	**415**	**439**	**459**	**459**	**457**	**457**	**442**	**442**	**442**
k1- plaatsen PZ	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Vlaanderen	14	17	17	39	23	23	23	27	34	34	34	34
Brussel	10	33	33	33	37	37	37	40	50	50	50	50
Wallonië	56	56	56	56	56	56	56	56	56	46	46	46
België	**80**	**106**	**106**	**128**	**116**	**116**	**116**	**123**	**140**	**130**	**130**	**130**
k2- plaatsen PZ	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Vlaanderen	42	44	44	42	42	42	42	42	42	42	42	42
Brussel					4	4	4	1	1	1	1	1
Wallonië	20	20	20	20	20	20	20	20	20	20	20	20
België	**62**	**64**	**64**	**62**	**66**	**66**	**66**	**63**	**63**	**63**	**63**	**63**
	AZ: Algemene ziekenhuizen											
	PZ: Psychiatrische ziekenhuizen											

Source: Federal Public Service (FPS) Health, Food Chain Safety and Environment; Department of Mental Health, June 2011.

5.2. Bottom-up initiatives and Good Practices

5.2.1. Flanders

Stent[18] platforms and Bijpass model: link to special youth care : introducing input of camhs in special youth care services through introduction of consultation, wraparound, network tables ad careful defining needs of necessary intensity of care through the use of instruments (Casii – izika : defining severity of care) Stent platforms are active in each Flemish province. The Bijpass-model was developed at the Antwerp university, Capri (JansensA.,, 2010).

Capa[19]: developed in England (see chapter 6.4, and Appendix 8); introduced in Ghent. Aims to tailor services to the patient's needs and empower them into their choices. Introducing Stepped care models (core and specific offer).

Registration models that are useful to integrate all types care facilities (mental health care, general health care, social care) over sectors and ages to monitor on individual lifetime level as well as on services and policy level : RAI instrument (initially developed for geriatrics) could serve as an example for life-time intersector monitoring of care providing and need.

Positive Parenting Program® (Triple P)[20]: Australian early intervention and support for parents of young children empowering them in their parenting skills; implemented in many countries, as in several services for Belgium.

Friends program[21]: an internationally adopted evidence based prevention (in educational settings) and early intervention program (in camhs settings) for depression in children >8 years and in adolescents; introduced for over five years in Ghent[22]

Flemish early psychosis projects, financed by the Flemish Government (VDIP, for young people between 14 and 35 years)

5.2.2. Walloon region

Source : document de travail IWSM 18-3-2011

Collaboration between youth care and camhs[23]

Le Toboggan

L' entretemps: (service d'aide à l'integration, approach transversal) [24]

S'Acc'Ados et Passado[25], initiatives of the Centre Chapelle-aux-Champs

Collaboration between AWIPH and camhs

Les cellules Mobiles d'intervention CMI, based on Carminati's model: for persons with mental retardation and severe behavioural problems

Aim is to work as much as possible in the environment of the child, and to work in a network of care facilities[26].

18 http://www.stentproject.be/

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

20 http://www.triplep.net/

21 http://www.friendsinfo.net/

22 Mommerency et al , 2009 Een groepsprogramma voor angst en depressive, tijdschrift voorgedragstherapie, , 42, 1, 5-33

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

24 (www.lentretemps.be)

25 (www.passado.be)

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

5.3. Social care and youth welfare in the German speaking community

Social care in the German speaking part of the country[27] is organised by the German community government (DG), under the responsibility of the Minister of Family, Health and Social Affairs. The DG is also responsible for ambulatory specialist mental health care, services for disabled persons, and education.

Social care encompasses:

5.3.1.1. General social services

First line support in the domain of welfare, including teleservices[28].

5.3.1.2. Youth social care or "Youth care"

- the Jugendhilfedienst (JHD)[29] and the Jugendgerichtsdienst (JGD) corresponding to the Flemish Youth care committees and the Flemish social services of the Youth court, respectively.
- ambulatory support services on a voluntary or not-voluntary basis (OIKOS)
- Youth homes[30] to provide educational services, on a voluntary basis (OIKOS, SIA)

5.3.1.3. Child and family agency

Like Kind&Gezin and ONE, the German speaking Child and family agency (Dienst für Kind und Familie DKF)[31] provides general social and preventive medical care for new-borns and infants, the child and its family. It also supervises services professional child nursery and crèches for children under the age of 12 years. There are also supporting services for parents and children in case of family crisis, eventually in collaboration with JHD or JGD. The DG has also foster care services but no own adoption service or SOS Children team.

5.4. Disability care in the German speaking community

DPB (agency for disabled persons of the German speaking community; Dienstelle für Personen mit Behinderung DPB) services related to child and adolescent mental health care[32]:

- "Frühhilfe Ostbelgien" and "Familienbegleitung" are 2 support services for parents; (SAP/SAI) of young children <6 yrs and >6yrs respectively for all types of disabilities, e.g. ASS, other mental disorders… They can also provide case-management;
- "Freizeitvermittlung" provides mediation for leisure time activities, especially for children and adolescents with all types of disabilities;
- "Kurzaufenthalte" provides temporary relief for the family caregivers in short stay host centres for all types of disabilities.

27 www.dglive.be

28 http://www.dglive.be/desktopdefault.aspx/tabid-299/

29 http://www.dglive.be/desktopdefault.aspx/tabid-300/537_read-3830/

30 http://www.dglive.be/desktopdefault.aspx/tabid-352/718_read-15323/

31 http://www.dglive.be/desktopdefault.aspx/tabid-295/469_read-2910/

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

6. APPENDIX 6 THE NETHERLANDS

6.1. General overview

6.1.1. Country profile

The Netherlands is a constitutional monarchy with a parliamentary system[33]. It has a total population number of 16.6 million (2011). The territory of the Netherlands is about 41500 km².

The Netherlands is divided into twelve provinces. Amsterdam, The Hague, Rotterdam and Utrecht all belong to the large Randstad urban region, which has a population of ten million (almost two thirds of the entire Dutch population), making it one of the largest metropolitan areas in Europe. There are 430 municipalities.

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

6.2. Target population

In 2010, the Dutch population of less than 18 years[34] of age counted 3.514.478 persons. In the Netherlands, the term youth is applied to children and young people from 0 up to the age of 24. Approximately 30% of the Dutch population falls into this category, and one in five young people have a non-Dutch ethnic background[35].

6.2.1. Age limits

In the Netherlands, young people are considered legally as minors under the age of 18 years. Youth social care in the Netherlands is for young people up to the age of eighteen who are going through serious psycho-emotional problems, and who cannot find help in the general systems that provide education, healthcare and social support. Youth social care can also be provided up to the age of twenty-three, if a youth care agency (see further) indicates the necessity[36] .

6.2.2. Epidemiologic data

Van Yperen (2009)[37] indicates a considerable increase in the use of specialist services in youth mental health care, youth social care, and special education for children with psychiatric and psychosocial disorders (cluster 4), during the assessment period from 1997 to 2007.

6.2.2.1. Youth mental health care

It has been estimated that only 16% of the children and 8% of the young people suffering from clinically relevant emotional and behavioral problems accessed specialized camhs (Zwaanswijk, 2005[38]). The number of patients in treatment and the number of activities is outlined in Appendix table 6.1. Most children and young people receive ambulatory care. At the end of 2007 about 22,900 children and adolescents were on a waiting list to receive appropriate mental health care (table 2, Appendix)[39].

6.2.2.2. Youth social care

Approximately 15% of the Dutch adolescents has some type of socio-emotional problems and may need some additional support, mostly temporary. A small part of this group, approximately 5%, is structurally at risk in their development, and receive some type of youth social care (±

33 http://www.minbuza.nl/

34 http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=7461BEV&D1=0&D2=1-2&D3=0-100&D4=0,10,20,30,40,50,l&HDR=T,G3&STB=G1,G2&VW=T

35 http://www.nji.nl

36 Youth care in the Netherlands. The Youth Care Act. International Publication Series Health, Welfare and Sport no. 21. Ministry of Health, Welfare and Sport, The Hague, June 2005

37 Van Yperen, T. Closer links, working on an effective system for youth and parenting (Betere ketens. Bouwen aan een effectief stelsel voor jeugd en opvoeding in Graas, D., et al,(Eds.; 2009). De Wet Jeugdzorg in de dagelijkse praktijk (p. 89-108). Houten: Bohn Stafleu van Loghum.)

38 Zwaanswijk, M. 2005, Pathways to care: helpseeking for child and adolescent mental health problems, Universiteit Utrecht

39 http://www.nationaalkompas.nl/zorg

160.000). Some 5500 of them are supervised by the state and 25.000 receive residential care.

The last few years, there has been an increase in the demand on all types of care except residential care. For instance, the use of non-residential care increased by 18%, foster care by 6%, and daily care by 10%.[40] More figures are available in the Report of the Youth Care (2008)[41].

6.2.3. Defining target population and population needs

Since the end of 2009 every municipality in the Netherlands works with a Reference Index for youth at risk. (Verwijsindex Risicojongeren, VIR). This is a national electronic signposting system that brings together risk signals of youth (up to 23 years), as reported by social workers. Its aim is, among other, to stimulate collaboration within the network of services. It is compulsory for the Youth and family centres, the School care and advice teams and the Child protection services (see further).

6.3. Health and social care organization

The health care system in the Netherlands[42] can be divided into preventive care, primary care, secondary care (including several tiers), and long-term care (after one year of illness).

The Ministry of Health, Welfare and Sport has the overall responsibility for the health care system. It shares this responsibility with the municipalities for preventive care. The Ministry of Social Affairs and Employment has an additional role for sickness or disability benefits.

Preventive care is mainly provided by public health services, called GGD (gemeentelijke gezondheidsdienst), under the responsibility of municipalities. The GGD has a special accountability to organize youth health preventive services, which is called Youth health care (JGZ, jeugdgezondheidszorg). As from 2012, this JGZ will be part of the municipal Youth and family centres (CJG) as will be explained further. Private health care providers have the main responsibility for the provision of primary, secondary or long-term health care services. Access to secondary care is limited; for most services general practitioners (GPs) function as gatekeepers.

For primary and secondary health services, the Health insurance act (Zorgverzekeringswet, ZVW) makes health coverage statutory for everybody. The system is a private health insurance with social conditions, operated by private health insurance companies. Insurers are at the same time responsible for “buying” health care from health care providers; they must provide a standard benefits package (included e.g. general practitioners, drugs), but they are free to offer additional services.

Long-term care, i.e. care for illnesses or disabilities that last more than one year, belongs to the responsibility of another national system, defined under the Exceptional medical expenses act (Algemene wet bijzondere ziektekosten, AWBZ). Typical AWBZ care can be treatment, nursing, accommodation, provision of daytime supervision etc. Care offices (zorgkantoren) are responsible for organizing care by “buying” services from providers; they are funded directly by the Government. An independent agency, the Centre for needs assessment (Centrum indicatiestelling zorg, CiZ) decides whether one is entitled a certain reimbursement or not,

Besides health care, the Ministry of Health, Welfare and Sport is also responsible for social support and welfare, such as Youth social care (“Youth care”) or matters regulated by the Social support act (Wmo, wet maatschappelijke ondersteuning) such as support to run the household, to homeless persons, etc. Implementation of Wmo related services is confined to the municipalities.

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40 factsheet youth care nji download at http://www.youthpolicy.nl/eCache/DEF/1/06/363.html

41 Brancherapportage Jeugdzorg 2008 and Gebruikscijfers 2004-2008 download at: http://www.youthpolicy.nl/eCache/DEF/1/06/363.html

42 European observatory on health systems and policy, Netherland HiT, 2010, http://www.euro.who.int/

6.4. Health care: camh service organization & stakeholders

6.4.1. Camhs organization: services level

In the Netherlands, camhs is organized in 3 tiers; parents, children and youth up to 18 years and in some cases up to 23 years can find advice and care.

The first tier is directly accessible by families or young people for ambulatory advice and support. Most professionals at tier 1 are broadly qualified in health or youth care; if necessary they can refer to or be assisted by specialized camhs professionals. The second and third tier or "specialized camhs" are only accessible by referral (see further); they provide outpatient or inpatient services depending on the patient's needs. The largest part of specialized camh services is delivered within tier 2; some separate services exist for specific target groups. Tier 3 refers to a small group of patients that are in need of very specialized care for highly complex disorders.

First tier camhs

Primary (mental health) care professionals advice or support families in their natural role of care-giving, and refer if necessary to more specialized services.

The general practitioner (GP) or primary care psychologist can be consulted directly. Specialist youth mental health services can support the GP[43] or psychologist at primary care.

Another important provider of this type of care are the municipalities. From 2012 onwards, every municipality should have a Youth and family centre (Centrum voor jeugd en gezin, CJG), including consultation centres (0-4 years), and youth health centres (5-19 years) (see also paragraph 6.6.1 Youth care). The CJG aught to be a highly visible and easy accessible local centre providing advise and information about health, development and parenting and with the emerging policies, it will be a central contact point for primary care and should coordinate collaboration between care providers.

Other primary care services are the school care and advice teams (ZAT) (see also paragraph 6.6.4 Education). Since many problems first come visible at school, every school is supposed to participate in a ZAT as of 2011. The ZAT's, under the shared responsibility of the educational system and the municipalities, facilitate collaboration between schools and youth (social) care professionals, in order to intercept signals and make appropriate referrals at an early stage.

Second tier camhs: integrated care at the youth circuit

For complex and severe mental health problems, referral is made to specialist mental health care services at the secondary care level: the "youth circuit" of the general mental health services. Access is only possible through referral by the Youth care agency, a GP or medical specialist, or a psychologist at primary care level. If a GP, medical specialist or psychologist directly refers a child to camhs, they have to inform the Youth care agency (see further).

The "youth circuit" mostly provides integrated ambulatory and inpatient mental health care. It includes the formal RIAGG-youth departments (regional institutes for ambulatory mental health) as well as the child and adolescent psychiatric hospitals or institutes (and policlinics)[44]. Many of the RIAGGs and of the child and adolescent psychiatric institutes are part of large facilities that provide, in an integrated way, a comprehensive spectrum of inpatient and outpatient mental health care services for adults and/or for children. These large integrated facilities emerged since the 1990's; only little information is available on the precise components and care delivery processes. It is generally assumed that their unique financing system (exclusively under the long term care system (ABWZ)) contributed a lot to the ease and success of service integration. They continue to have an important influence on mental health care organisation, although this financing system was abolished with the 2006 health insurance reforms

43 POH-GGZ : praktijkondersteuning van huisartsen

44 http://www.ggznederland.nl/index.php?p=115302

and replaced by the conventional short term (ZVW)/long term (AWBZ) financing[45]; the effects of this measure remain to be evaluated.

Tier 2 camh services are offered by 9 institutions specifically for child and adolescent psychiatry, and by 32 youth departments of mental health centres offering care for all ages. These services are regionally embedded, often with some local divisions. Some child psychiatrists and psychotherapists offer services in private practices on a self-employed basis. In tier 2 camhs, outpatient care is offered predominantly (95% of total care). Nationwide about 1906 places are available for inpatient camh services of which 1744 (~50/100 000 inhabitants 0-18 yrs) are effectively in use[46]. For day treatment, 1350 places are available; outreach through assertive community treatment (ACT) exists as well. Emergency consultation is available at 24/7 base. After consultation hours it is organised jointly with the general mental health services crisis offer.

In the last years there is a growing trend to commercialise the provision of mental health care by private mental health service providers. This is probably due to the integration of mental health care in the main insurance package (ZVW).

Second tier camhs: Special target groups

In the Netherlands, specific target groups are defined within second tier camhs[47][48].

- Compulsory youth mental health care

Most of the youth mental health hospitals are recognized for compulsory care, meaning they have a certain capacity for compulsory mental health care. They are subject to the Act on compulsory mental health care (Wet bijzondere opnemingen in psychiatrische ziekenhuizen, BOPZ). This Act contains rules and regulations for compulsory admittance and compulsory treatment. These differ from the ones for compulsory care under the Youth Care Act. The BOPZ only applies when a person is a danger to him-herself or the environment, due to a psychiatric disorder; for admission an order of the Children's judge is necessary.

- Forensic youth mental health care

Forensic youth mental health care for youth offenders suffering from a combination of severe behavioural problems, psychiatric problems and/or mental retardation and/or addiction problems. Different subtypes exist, e.g. for diagnostic issues, for youngsters in severe crisis, for severe (sexual) behaviour problems, for youngsters unable to function in social groups or suffering from mild mental retardation (see also further). Some of the wards are organized by the government under the accountability of the Ministry of Security and Justice[49] while other are private. The Ministry of Security and Justice remains responsible for funding of this type of care and 'buys' the necessary camh services.

- Ortho-psychiatric care

Non-compulsory, ortho-psychiatric care for severe conduct problems in combination with psychiatric problems (9 wards, with an inpatient capacity for 180 youngsters, and outpatient care). The Ministry of Health, Welfare and Sport supports the development of this type of care under the Health insurance act (ZVW), additionally to the existing specialized camh services. Camhs in these institutes is embedded in the regular care supply[50], but if necessary, there is also collaboration with external specialized camh services.

- Addiction problems

Separate provisions are available for youth with addiction problems. Eight clinics with a total number of 300 beds specifically accept young people

45 Trimbos. Trendrapportage GGZ Deel 1-2-3. Utrecht: 2008. Available from: www.trimbos.nl

46 Hilderink et al, 2009- Hilderinck,I. Van 't Land, H, GGZ in tabellen,Trimbos-instituut, Utrecht,2009

47 "Jeugd-ggz, investeren in de toekomst, ambities voor 2011-2014" GGZ-Nederland, 02-2001

48 Early parent-child interventions for young children of mothers with psychiatric disorders are no special target group but are provided within existing care supply structures, see www.nji.nl

49 http://www.forensischepsychiatrie.nl/links/953/954/

50 http://www.inzichtnijmegen.nl/

with addiction problems; another 1500 adolescents (<18 yrs) are treated by general addiction services.

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

Besides specific educational arrangements (special schools…), support of young people with a mild mental retardation ("LVG-jongeren"; IQ 50-85) typically belongs to the domain of long term care (AWBZ, Algemene wet bijzondere ziektenkosten, Exceptional medical expenses act). However, many of these persons also suffer from important mental health problems and specific programs exist within the youth circuits for this target group.

- Specific diagnostic and indication needs

In order to access specific care, e.g. to be able to buy services with the PGB, personal budget (AWBZ, see further) or to motivate and assign educational specific care, specialist diagnostic examination is required which cannot always be performed by professionals of these sectors.

A substantial amount of these diagnostic evaluation requests enlarge treatment waiting lists.

Third tier camhs

1. This is highly specialised mental health care for extremely complex disorders ("topreferente en topklinische zorg"). It is a small segment of the child and adolescent mental health care, mainly attached to academic centres for child and adolescent psychiatry, in combination with research.

Access to specialized camhs: the Youth care agency

2. An important recent evolution concerns the joint access point to specialized services of traditional youth social care ("youth care"), of child and adolescent mental health care (camhs), and of care for young people with mild mental retardation: the Youth care agency (Bureau jeugdzorg BJZ). The Youth care agency, an assessment and referral service, plays an important role in interconnecting the different specialized services for youth, especially when there is need of several services (foster care, family support, youth mental health care…) (see also paragraph 6.5.2). Nevertheless, in 2009 an official evaluation report (see also further), learned that most referrals to specialized camhs are done by GPs[51].

6.4.2. Stakeholders: health services level

6.4.2.1. Professionals involved

In youth mental health care many professionals are involved. Training requirements for professions in mental health care are regulated by the BIG Act for psychiatrists, mental health psychologists en clinical psychologists, psychotherapists, psychiatric nurses; mental health specialist nurses, nurse practitioners, and specialised therapists. The BIG Act (wet beroepen in de individuele gezondheidszorg) is the legal underpinning for the health professions and their accountabilities.

About 1375 psychologists are working at the first tier (primary care, 1e lijns-psycholoog). About 350 Child and adolescent psychiatrists and about 1500 "behaviour scientists" are working at the second tier in the youth mental health centres (SCEM-Acare, 2011), and additionally about 85 child psychiatrists and 244 psychologists are working as independent care givers at the secondary mental health care level.

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

6.4.2.2. Participation of children and adolescents

The legal position of the minors in the field of the health care is determined by the Act on the medical treatment agreement (Wet op de geneeskundige behandelovereenkomst WGBO). This act states that minors as of the age of 12 years have to agree with a proposed treatment along with their parents. Under the age of 12, this is the responsibility of the parents, or the judge. Young people of 16 years of age and older can act themselves.

The recent Act on compulsory mental health care (BOPZ) regulates compulsory and forced care, stipulating among other things, that minors as of the age of 12 years are in the possibility to make commitments and

[51] Evaluatieonderzoek Wet op de Jeugdzorg (2009); http://www.nji.nl/nji/dossierDownloads/Jeugdzorg_Evaluatieonderzoek_Wet_091103.pdf

agreements on their need of compulsory or forced care in some pre-defined circumstances

6.5. Health care: camh policies and policy stakeholders

6.5.1. Health care: Policy stakeholders

6.5.1.1. National Government

Youth policy in the Netherlands was a responsibility of the Ministry of Youth and Families until 2010. This ministry was first created in 2007 to coordinate policies concerning youth, youth care in its most extended sense and families; it had to integrate the youth policies of four Ministries: Health, Welfare and Sport; Security and Justice; Education, Culture and Science; Social Affairs and Employment.

With the arrival of a new government as of October 14th, 2010, this ministry does not exist anymore. Youth policy[52] is now one of the main responsibilities of the State Secretary for Health, Welfare and Sport. This ministry has the main responsibility for health care, including youth (mental) health care. It shares the main responsibility for youth social care ("youth care") with the Ministry of Justice. For other aspects, it shares the responsibility for youth policy with the 2 other Ministries involved in youth affairs.

6.5.1.2. Health care organization

The Dutch health insurance act (ZVW) defines a nationwide mandatory system of private health insurance with social conditions. Mental health care and youth mental health care are covered by the basic health insurance package that is guaranteed under this system. In the Dutch health care system, private health care providers are primarily responsible for the provision of services.

Long term youth mental health care, defined as care lasting longer than one year, is regulated by the AWBZ (see paragraph "Long term or disability care")

6.5.1.3. Provinces

In the Netherlands, youth mental health care and youth social care ("youth care") are strongly interwoven, e.g. by their joint access point (see also further). The provinces are funded by the government to organize youth care. The central agency to assign specialized youth care is the Youth care agency, also organised by the provinces.

6.5.1.4. Municipalities

The municipalities are responsible to organise and fund prevention and health promotion. The municipal centres for youth and family (CJG) play a central role in the implementation of this accountability. Government plans to transfer gradually all youth care tasks to the municipalities (see further).

6.5.2. Health care: camh policies

Since 2005, the main issue of policies involving camhs is the collaboration of camhs and youth social care.

6.5.2.1. Youth care act 2005

The actual youth care organization in the Netherlands is regulated by the Youth care act of 2005 (see also before). This Act deals with youth social care, youth mental health care, and care for young people with mild mental retardation. The Youth care act states that the Youth care agency (Bureau jeugdzorg BJZ) is the joint access point to specialized services of (non-compulsory) youth social care, and of specialized child and adolescent mental health care (camhs). It is responsible for assessment and referral. Whereas for access to specialized (non-compulsory) youth social care, the Youth care agency is the only and mandatory gatekeeper, it shares the gate-keeping role for access to specialized camhs with the GPs, primary care psychologists and medical specialists; however, the latter have to inform the Youth care agency of the referral. The Youth care agency can refer to certain care services within the AWBZ regulation; the main gate-keeping role within the AWBZ is hold by the CiZ (see before). Although the educational system is not explicitly involved in the Youth care act, referral to specialized educational services by the Youth care agency is possible

52 http://www.youthpolicy.nl/eCache/DEF/1/23/750.html

but access cannot be claimed. The Youth care agency participates in the CJGs and the ZATs, which facilitates collaboration at the first tier of care.

6.5.2.2. The Dutch Youth and Family programme

In June 2007, the Youth and Family Programme 'Every Opportunity for Every Child' (2007–2011) was issued by the Ministry of Youth and Families. One of the purposes was to break down the walls between different care sectors for children, and between different government levels.

The programme is based on a threefold strategy: to support the family's natural role in bringing up children; to focus on prevention and developing primary care; and to impose binding commitments to all stakeholders working with children and families.

The policy also states that by 2012 there has to be a Youth and family centre in every municipality, to support families in parenting. Secondly the policy states that School care and advice teams (ZATs) have to be accessible all over the country, for all ages of children and youth.

6.5.2.3. Youth care closer (2010)

As of 2009 the national government initiated an inquiry to evaluate the Youth care act (see also 6.6.1). The government discussed the results of this evaluation and a parliamentary working group elaborated in 2010 a final report "Youth care closer" (2010)[53] that was adopted by the new government (after the 2010 elections).

The report stresses the importance of prevention and primary care, not only to enhance early detection and intervention, but also to empower families and educators. This should be a counterpart for the tendency to consider normal difficulties as problems that need professional help, and should reduce the referral to the second level specialist care services. Also financial flows have to be reorganised. The report proposes to bring all non-compulsory youth care (including youth mental health care and care for young people with mild mental retardation) under the accountability of the municipal government, in order to bring care closer to the families. The scattered financial flows are seen as a barrier to integrate youth care[54]. Therefore the report proposes to join the financial flows in a municipal fund. Further reasons (personal communication, civil servant) to transfer all youth care tasks to the municipalities are that this brings all types of care under one governance, which might facilitate care integration. Also, the municipalities are close to the citizens, and hence are in the right position to judge on the local needs. They are at the same time responsible for prevention, and overview other services that are also important for the integration of youth in the society, such as services for housing or employment, etc. Collaboration with and coherence between the policies of all these sectors might be improved when the municipalities would be responsible for all youth care tasks.

6.5.2.4. Work In Progress

In their document "Work in Progress"[55], van Yperen et al (2011) discuss a blueprint for the reform of the entire youth care system, based on initial values and with 2 central ideas: the quality of the environment of the child (called civil society) and the coherence of care. This care is to be delivered in three compartments: (1) strengthen parenting and education, (2) support of this educational strengthening, intensifying care, and (3) taking over education. The bulk of the care should be delivered in compartment one. Wraparound processes (for definition, see chapter literature review) could serve as good practice. Specialist camhs, along with other specialist care, mainly is delivered in compartment 2 and 3. The compartments can be linked through a stepped care process[56]. The report makes no overt judgment on whether camhs should be part of youth social care or health care.

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53 http://www.nji.nl/eCache/DEF/1/16/390.html

54 report " Van klein naar groot" by the commission Zorg om Jeugd, for the Association of Netherlands Municipalities, download at http://www.vng.nl/smartsite.dws?id=1699&it=2 or http://www.nji.nl/eCache/DEF/63/258.html

55 van Yperen,T. Et al,: werk in uitvoering, bouwen aan het nieuwe jeugdstelsel, NJI, Utrecht, mei 2011

56 van Yperen, T., et al , Closer links, NJI, Utrecht, 2009

6.5.2.5. Limitations of the integrated youth care model

The proposal of the Dutch Government to bring all non-compulsory youth care, including specialist camhs, to the municipalities is actually vividly debated. This debate questions the difficult position of specialist camhs as a part of the comprehensive care for children and adolescents, generally covered by the social care and wellbeing sector, while, according to some stakeholders[57], specialist camhs is also an undivided part of healthcare and more specifically mental health care.

In his essay on behalf of the GGD (municipal preventive health care services) on the decentralisation of Youth care, de Waal (2011)[58] considers several breakpoints that challenge policy makers in the process of reforms in youth (mental) (health) care:

- Supporting civil society versus professional care
- Delivering care in the family, empowering (outreach) instead of institutionalisation (out of home placement, clinics)
- Generalist against specialist care
- Professionals' judgement (health care professionals) versus political-administrative judgement (indication Youth care agency etc.)
- Collective prevention versus curative care

These breakpoints question the actual ad preferable youth care organization in the Netherlands.

6.6. Other sectors involved in children's mental health and wellbeing

In the following paragraphs, additional explanation is given for sectors interfering with camhs: Youth social care, Juvenile justice, Long term and disability care, and Special educational services (see fig 6.1).

Sentences specifically referring to camhs or to collaboration with camhs, are put in italics.

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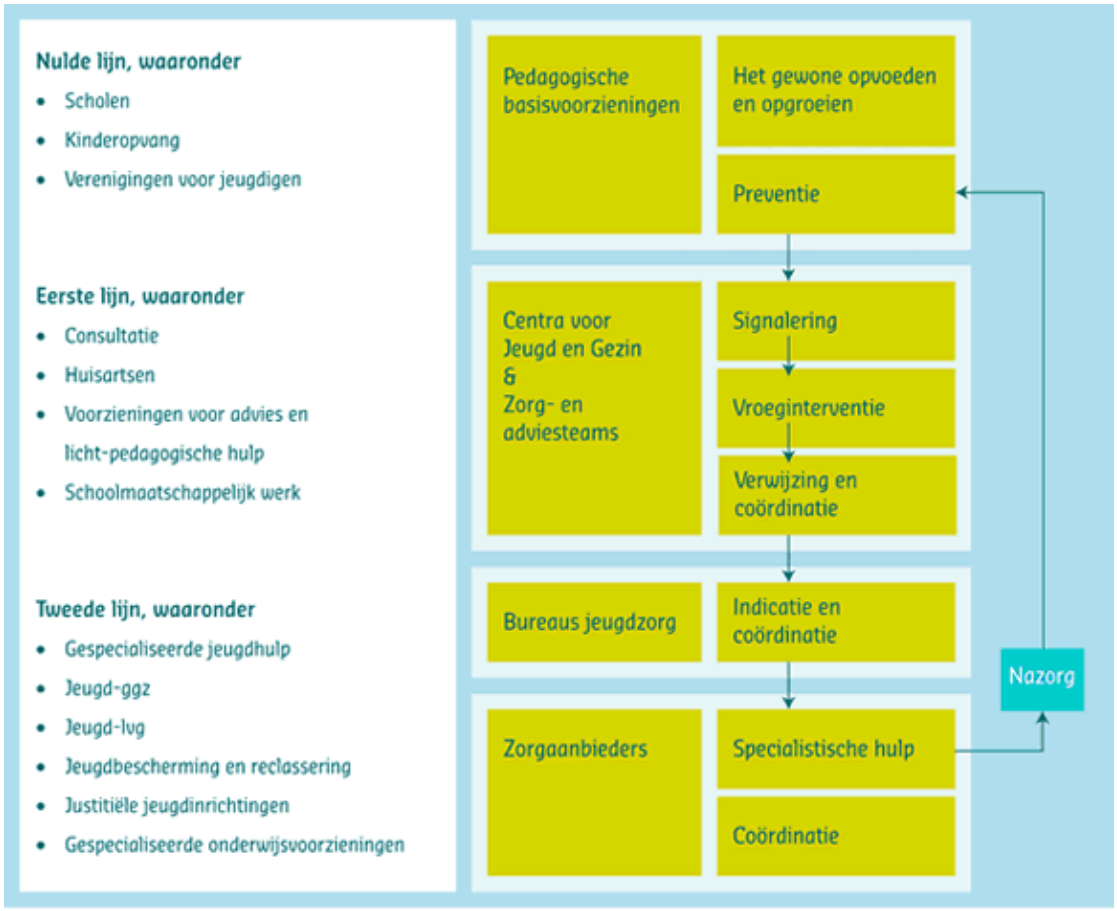
57 jeugdggz Nederland:investeren in de toekomst, 2011 http:www.ggznederland.nl; Nederlandse Vereniging voor Psychiatrie: http://www.nvvp.net/nieuws/verenigingsnieuws/?newsId=a600e748-f84d-4006-b4e5-2fc85cba6b68; http://www.ggznederland.nl/beleid-in-de-ggz/beleidsthemas/jeugdzorg/jeugdzorg/visiedocument-jeugd-ggz_investeren-in-de-toekomst_.html?year=2011

58 de Waal S,: Een betere Zorg voor Jeugd. Decentralisatie van de Jeugdzorg als kans. Een reiziger blijft zich verwonderen, GGD Nederland 2011 viewed on 9/6/2011 at www.ggd.nl

Fig. 6.1: Services for Youth: organization in the Netherlands (NJI)



6.6.1. Social care: Youth care

Youth social care ("Youth care") belongs to the responsibility of the Ministry of Health, Welfare and Sport for the non-compulsory services, and to the Ministry of Security and Justice for the compulsory services. Traditionally, youth care had been active in the field of socio-educational support for socially vulnerable families, protection for children or youth in danger and resettlement of youth after criminal acts. However, given the frequent co-existence within these traditional youth care domains, of mental health problems or sometimes mild mental retardation, the Youth care act (2005) and the "Indication protocol for youngsters with psychiatric problems" of 2006[59] created a common entrance door (the Youth care agency, Bureau Jeugdzorg BJZ) for all young people and their families in need of help within one of those domains. From there, referral should be made to the appropriate type(s) of support, within the sector of youth care, mental health care, long term or disability care, or within specialized educational services. The Youth care agency should also play an important role in interconnecting the different services, especially when there is need of several services (foster care, family support, youth mental health care…). The Youth care agency participates in the CJGs and the ZATs, which facilitates collaboration at the first tier of care. *Since 2005, the term "youth care" is often used broadly to indicate the traditional youth care, camhs, and services for mild mental retardation together. The first tier services for these 3 subgroups overlap strongly; however, the specialized care organisation and financing system is different for these 3 subgroups (youth social care (mostly provinces); health care (ZVW); and long term care (AWBZ or specialized educational services respectively).*

Youth care (in its traditional meaning) is organized in a two-tier system[60]. The system is typically open to young people up to the age of 23 years. The first tier is directly accessible; the second tier is only accessible by referral of the Youth care agency (Bureau Jeugdzorg) and, for compulsory care, an indication by the Children's judge.

6.6.1.1. First tier Youth care

The first tier aims at recognizing mild problems and tackling them by pedagogical advice etc. *The main service providers are the same as for the first tier camhs*, in fact advice and care at this level is often generic in nature (see paragraph 6.5.2). It are the Youth and family centres (Centrum voor Jeugd en Gezin, CJG), the School care and advice teams (ZAT), and GPs, other medical specialists or first line psychologists. Every municipality has to organize a Youth and family centre from 2012 onwards, including consultation centres (0-4 years), and youth health centres (5-19 years). The CJGs should become the corner stone of first tier generic advice and care for youth and families, including first tier youth care. The ZAT's, under the shared responsibility of the educational system and the municipalities, aim to facilitate collaboration between schools and youth (social) care professionals.

6.6.1.2. Second tier Youth care

Secondary youth care services are specialized services for youth care. It can be non-compulsory care in case the family or youngster seeks and/or accepts help; examples are intensive family advice and support, foster care (pleegzorg), or institutional care (jeugzorginstellingen). In the case of compulsory care imposed by the Children's judge, and if no criminal act has been committed, possible youth protection measures (jeugdbescherming) can be guardianship (voogdij), a supervision order, or a closed youth institution[61]. For a closed institution, there has to be an indication given by the Youth care agency as well. *In closed youth institutions, educational support is embedded in the regular care supply*[62]*. Also mental health care can be embedded to a certain degree in the regular care supply, but usually there is an intensive collaboration with external specialized camh services if necessary*.

In case of criminal acts (12-18 years), the Children's judge can impose resettlement measures (jeugdreclassering), which are executed by the

59 http://www.nji.nl/eCache/DEF/1/16/390.html

60 http://www.rijksoverheid.nl/onderwerpen/jeugdzorg; http://www.youthpolicy.nl/eCache/DEF/1/06/363.html

61 http://www.rijksoverheid.nl/onderwerpen/jeugdzorg/documenten-en-publicaties/rapporten/2010/05/18/jeugdzorg-dichterbij.html

62 http://www.jeugdzorgplus.nl/

Youth care agency. The Judge can also punish the youngster and impose a community service or send him to a custodial youth institution (JJI, justitiële jeugdinrichting); but these measures are not considered to be part of youth care; they are executed under the responsibility of the Ministry of Security and Justice (see paragraph 6.6.2).

Provinces receive money from the national government to organize accessible specialized youth care of high quality. They buy services from agencies and organizations providing youth care services.

6.6.1.3. The Youth care agency

There are 15 youth care agencies in the Netherlands (one per province, and one in Amsterdam, Rotterdam and The Hague). They are funded by the provinces and their policy is outlined in the provincial policy framework. This policy framework takes into account data from the Youth care agency and the youth care providers, the municipalities, the health insurers, the Ministry of Security and Justice.

Their main responsibilities are:

- assessment and referral to appropriate care, coordination of this care;
- execution of the assignments of the Advice and reporting centre for child abuse and neglect (Advies- en Meldpunt Kindermishandeling, AMK) which itself is a part of the Youth care agency;
- implementation of youth protection orders and resettlement arrangements.

The Youth care agency participates in many municipal or local initiatives, e.g. the ZAT's.

6.6.1.4. Professional training in Youth social care

As of 2007 an "Action plan professionalising youth care" was developed[63]. This implicates that a training- and education structure has been set up in an agreement between profession organizations, employer organizations, government, and user organizations. Along with professional training and in-service training, professional accreditation, a profession's ethical code, and a disciplinary tribunal has been established. Much attention is spent on dealing with legal issues about information exchange.

6.6.1.5. Evaluation of the Youth care act (2009)

In 2009, the Government ordered an independent evaluation of the implementation of the Youth care act[64] (ref). Within the traditional domains of non-compulsory and compulsory youth care, the new rules were mostly positively evaluated and had contributed to a more efficient collaboration between the different players in the field. *However, referral to specialized camhs was still almost exclusively delivered by the GP and not by the Youth care agency; and Youth care agencies did not yet deal with young people with a mild mental retardation (licht verstandelijk gehandicapt of LVG-jeugd, typically IQ 50-85) which remains a responsibility of the CIZ ("Centrum indicatiestelling zorg", agency for needs assessment within the AWBZ).* Several reasons were given for these facts. Another problem was that the Youth care agencies had difficulties to make indications within the domains of long term or disability care (AWBZ), for which often additional evaluation by the CIZ was necessary; which doubles the invested effort and time. Also, the Youth care agency only holds a mandate for some CIZ indications, not for other CIZ domains. Mutatis mutandum, the same problems were noticed for indications within the domain of support within the (special) educational system. Although almost all Youth care agencies participate in the ZATs, the educational system is not obliged to participate in the larger care network the Youth care act aims at, and there are still large cultural differences between Youth care and Education.

6.6.2. Juvenile justice

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

There are 2 main action domains: compulsory youth protection and judging on youth (12-18 years) that committed a criminal act.

63 http://www.nji.nl/eCache/DEF/1/07/544.html

64 Evaluatieonderzoek Wet op de Jeugdzorg (2009); http://www.nji.nl/nji/dossierDownloads/Jeugdzorg_Evaluatieonderzoek_Wet_091103.pdf;

6.6.2.1. Compulsory youth protection

When secure child development and education cannot be guaranteed by the child's family or natural living environment, and when non-compulsory care is not sufficient or not accepted by the family, the Child protection council can ask the Children's judge for compulsory care. The judge can place the child under guardianship (voogdij), or for adolescents (12-17 years) he can impose provisional guardianship or a supervision order. When due to behavioural difficulties there is a risk that a child or adolescent would endanger himself or his environment, the judge can also impose measures such as compulsory treatment in one of the 16 closed youth institutions (JJI, gesloten jeugdzorginstellingen, Ministry of Health, Welfare and Sport), in consultation with the Youth care agency.

6.6.2.2. Youth criminal acts

Children under the age of 12 years that committed a criminal act, can be referred by the police to the Youth care agency (see before). Once adolescents (from 12 years onwards), they come under the responsibility of the Children's judge. Instead of a punishment, the Children's judge can impose ambulatory "resettlement measures". Alternatively, they can be sentenced with a community service or they can be sent to one of the 12 custodial youth institutions (JJI, justitiële jeugdinrichting).

Some of the custodial youth institutions have specialist services for:

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

The Ministry of Security and Justice is responsible for organizing and financing of the custodial youth institutions. If specialized camhs services are to be offered in these institutions, they "buy" these specialized services from health care suppliers. Youth (social) care, under the Ministry of Health, Welfare and Sport, is responsible for organizing and financing of the services for youth resettlement and the closed youth institutions (ref: Jeugdzorg dichterbij (2010)[65]). In closed youth institutions, educational support is embedded in the regular care supply[66]. Also mental health care can be embedded to a certain degree in the regular care supply, but usually there is an intensive collaboration with external specialized camh services if necessary.

6.6.3. Long term or disability care

Care for people with long-lasting illnesses (more than one year) or with disabilities is defined under the Exceptional medical expenses act (Algemene wet bijzondere ziektekosten, AWBZ). It comes under the government of the Ministry of Health, Welfare and Sport. To benefit, an indication by the Centre for needs assessment (Centrum indicatiestelling zorg, CiZ) is necessary. For children and adolescents with a problem in the field of youth care, youth mental health care and/or mild mental retardation, this indication can also be given by the Youth care agency. Typical AWBZ care can be treatment, nursing, accommodation, provision of daytime supervision etc. Mental health care can be delivered within the indication "treatment".

When confronted with (functional) disability or chronic illness, e.g. a young child with autism, or a child with acquired brain injury and behavioral problems, parents can get support through the MEE agency[67]. For all age categories, MEE provides independently information to and assists parents for all types of problems. *Specifically for children up to 4 years of age, the MEE agency provides case management and coordinates services collaborating in providing integrated early intervention and care.* Partners in this integrated care might be services for disabled care, institutions for

65 http://www.rijksoverheid.nl/onderwerpen/jeugdzorg/documenten-en-publicaties/rapporten/2010/05/18/jeugdzorg-dichterbij.html

66 http://www.jeugdzorgplus.nl/

67 http://www.demeentgroep.nl/

child rehabilitation (revalidatie), as well as the Youth care agency, home care, GGD en even hospitals.

6.6.4. The Dutch Education system

The overall responsibility of the Dutch Education system[68] belongs to the Minister and the State Secretaries of Education, Culture and Science. The municipal authorities have certain responsibilities for all schools in their area e.g. funding (changes in) accommodation for primary and secondary schools; allocating resources from the budget for eliminating educational disadvantages; preventing early school leaving and registration of early school leavers etc.

The competent authority of every school, the school board, manages the school or schools for which it is responsible, and receives a block grant from the central government. School boards are free to spend this money at their own discretion. This includes paying (or not) for some forms of support of pupils with special educational needs for which no special governmental funds are foreseen, e.g. specialist teachers.

As of 2011, every school is supposed to participate in a ZAT. The ZAT's, under the shared responsibility of the educational system and the municipalities, facilitate collaboration between schools and youth care professionals, in order to intercept signals and make appropriate referrals at an early stage. Necessary participants are psychologists or masters in educational sciences, social workers, representatives from services for inclusive education and special education institutes, a school physician and the Youth care agency; police or specialized camhs workers are optional.

Current policy, as supported by legislation, places emphasis on educating children with special educational needs alongside their peers in mainstream schools, whenever possible. If the pupil's special needs are difficult to meet, the teacher can be supported by the school's special needs coordinator, by support teachers from the regional school support service, or by teachers from special schools ("peripatetic supervision"). *To strengthen inclusion, the "Going to School Together" policy implies that schools are responsible for providing all pupils with appropriate education and guidance; if necessary they can apply to the ministry for extra support. The policy targets all pupils with special needs, but four specific categories are recognized: autistic children; children suffering from ADHD;* dyslexic children; gifted children.

For those children who need special education outside the mainstream system, "special schools for primary education" provide teaching for children with learning difficulties or for children with learning and behavioural difficulties. Classes for pre-school children with developmental difficulties are also part of the "special schools for primary education". The "Going to School Together" policy applies also to these schools.

Besides the "special schools for primary education", Regional expertise centres (RECs) have been set up, i.e., consortiums of special schools and secondary special schools within a district. There are four categories: visually handicapped pupils (category 1); deaf or hearing-impaired pupils and pupils with severe speech disorders (category 2); physically, mentally (IQ<55) and multi-handicapped pupils, and chronically sick pupils (category 3); *pupils with behavioural disorders; severely maladjusted children, chronically sick (psycho-somatic) children and pupils in "paedological" (pedagogic) institutes (category 4).* Pupils are eligible for one of these categories if they meet certain criteria, largely based on medical criteria. *For behaviourally disturbed pupils the criteria require a diagnosis in terms of categories of the DSM-IV, problems at school, at home and in the community and a limited participation in education as a result of the behaviour problems.*

Pupils for whom a special educational need is suspected, be it in be a mainstream or a special school, need an indication for it by a regional independent agency (commissie voor indicatiestelling, CvI). *Parents of children with a sensory, physical, or mental disability and/or learning difficulties or behavioural problems can receive a funding, assigned to the pupil, to choose between care within regular education settings or care within special educational settings. (This is called 'leerlinggebonden*

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

financiering, ('pupil-bound budget' or "financial backpackage"). Accreditation is delivered by the CvI.

At this moment, new legislation is being prepared, which would dramatically change the current situation; one proposal is to abolish the 'pupil-bound budget'.

6.7. Financing and funding

In general, health systems can be divided into two broad categories: national health services systems ("Beveridge") and social security (based) health care systems ("Bismarck"). The inclusion of a country's system into one of the two categories is mainly based on the way the systems are funded.

In the Netherlands, the health care system consists of a Bismarck model (Social security health care system), in which health care is funded by means of insurance premiums, mainly from salaried employees. In this system, there is less state influence and physicians and hospitals tend to be private.

6.7.1. Financing of health care

In general, the Dutch healthcare system comprises two types of acts: the Health Insurance Act (Zorgverzekeringswet, ZVW) and the Exceptional Medical Expenses Act (Algemene wet bijzondere ziektekosten, AWBZ)

6.7.1.1. Health Insurance Act - ZVW.

The aim of the ZVW (2006) is to create strong price competition between health insurers and to improve the efficiency of healthcare provision. In this act it is stated that all residents are mandated to buy a basic benefits package from a choice of private health insurers. Insured pay a flat-rate premium ("nominal premium", not linked to the actual risk of an individual) directly to the health insurer of their choice. The nominal premium is community rated, which means that for each product an insurer must ask the same amount from each individual, independent of the individual's risk characteristics[69]. Employers contribute by making a compulsory payment towards the income-related insurance contribution of their employees. These contributions are transferred to the Health insurance fund and then allocated among the health insurers according to a risk-adjustment system.

Health insurers have to offer the basic benefit package and must accept every resident in their area of activity. This is facilitated by the Health insurance fund, which is a risk equalization fund and prevents direct or indirect risk selection.

6.7.1.2. Exceptional Medical Expenses Act - AWBZ

The AWBZ is a mandatory national insurance scheme for long-term care. It is intended to provide the insured with chronic and continuous care which involves considerable financial consequences (e.g. care for people with mental disorders). The AWBZ is mainly financed through income-dependent contributions to the central government.

To be qualified for care under the AWBZ, a patient has to apply for a needs assessment at the Centre for needs assessment (CIZ). This centre establishes whether care is really required and, if so, what type of care and how much care are needed.

The patient can receive his benefits in-kind, or in the form of a personal care budget (persoonsgebonden budget – PGB). A patient who opts for a personal budget may individually purchase care from professional organizations, from family or from other non-professionals. If the client opts for benefits in-kind, the care is organized by a Care office (zorgkantoor). Care offices are organized regionally and are operated by the regionally dominant health insurer, although the financing is directly through the central government and not influenced by the ZVW system of private health insurance.

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69 van de Ven WP; Schut FP. Universal mandatory health insurance in the Netherlands: a model for the United States? Health Affairs. 2008 ;27(3) :771-81.

6.7.1.3. Payment mechanisms

GPs are paid via a combination of capitation fees (per registered patient) and fee-for-service.

Hospitals are paid through Diagnosis treatment combinations (DBCs) since 2005. The DBC system is inspired by the concept of DRGs (diagnosis-related groups), but provides a DBC for each diagnosis/treatment combination and thus, more than one DBC per patient is possible. A reform of the system is planned by 2011.

Medical specialists are paid through the DBC system. For each DBC a normative time spent by the specialist and an hourly tariff were established.

Long-term care providers are paid according to care intensity packages (zorgzwaartepakketten).The care intensity and complexity of each patient is independently assessed.

6.7.2. Financing of mental health care

About 10% of the total health care budget is spent on mental health care.

Until 2008, mental health care was financed exclusively by the Exceptional medical expenses act (AWBZ). It is generally assumed that this unique financing system contributed a lot to the ease and success of service integration.

Since 2008, the first 365 days of mental health treatment are a part of the basic health insurance (ZVW). After the first year, mental health care is considered long-term care and is funded through the AWBZ. The funding of preventive mental health care was transferred to the Social Support Act (Wmo), and the organization of this care was shifted to municipalities.

6.7.2.1. Health Insurance Act - ZVW

For mental health care, the benefit package of the basic health insurance consists of ambulatory mental care and inpatient mental care for the first year.

Eight sessions with a psychologist are included in the basic package for primary care. For secondary care (mental problems that are considered too complex for short-term interventions), there is no limit of the number of sessions.

Mental inpatient care is funded through the DBCs system. There are two main determinants for establishing DBCs in mental care: (1) the type of health care demand and diagnosis; and (2) the care profile (diagnostics, counselling, treatment, stay). Combined, this leads to product groups which are split into “treatment” and “stay” groups. In 2009, 145 treatment groups and 70 stay groups were established. The treatment groups consist of a diagnosis and duration of the treatment component. The stay groups concern inpatient stays of 24 hours or more. Treatment groups and stay groups may be combined, theoretically leading to 145 x 70 different DBCs[70].

6.7.2.2. Exceptional Medical Expenses Act - AWBZ

For long-term inpatient mental health care, 13 care intensity packages have been defined.

6.8. Processes of Change

No additional information.

6.9. Efficacy

6.9.1. Knowledge centres

The Netherlands Youth Institute[71] (Nederlands jeugd instituut NJI) is the national knowledge centre for the development and dissemination of knowledge on youth care, parenting support and child education; it also helps to implement these interventions by working closely together with other Dutch governmental and non-governmental organizations in the youth field. The NJI hosts the Database of effective youth interventions[72], a searchable database of evidence based interventions in youth care, youth health care, youth welfare and criminal law. These effective interventions have to be evaluated and certified by an independent commission.

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70 HiT report Netherland, 2010.

71 http://www.nji.nl/

72 http://www.nji.nl/eCache/DEF/1/03/055.html

Other important knowledge centres that are specifically active in the domain of mental health care, are the Trimbos institute[73] and the National knowledge centre for child and adolescent mental health care (Landelijk Kenniscentrum Kinder- en Jeugdpsychiatrie)[74]. Both institutes also develop and disseminate evidence based knowledge and guidelines.

6.9.2. Needs assessment and outcome measurement

One of the systems that can be used to enhance the global view on what are the real care needs at the population level is the VIR (see also 6.2.3). Since the end of 2009 every municipality in the Netherlands works with a Reference Index for youth at risk (Verwijsindex Risicojongeren, VIR), a national electronic system that brings together risk signals of youth (up to 23 years).

Other data are used as well to inform the Government on (health) care needs. E.g. the Youth care agency, the youth care providers, the municipalities, the health insurers, and the Ministry of Security and Justice have to provide data to the Provinces, who can use the data to improve the effectiveness of youth (social) care planning. However, there is no uniform and comprehensive system of data collection in place that specifically aims to drive youth (mental) health services planning; rather, market-driven principles influence health care supply.

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

Policy evaluations to inform on the results of previous political decisions are regularly performed (e.g. Request of the Government to evaluate the Youth care act, see 6.5.2).

[73] http://www.trimbos.nl/

[74] http://www.kenniscentrum-kjp.nl/

6.10. The Netherlands: Additional documents

6.10.1. Target population

Tabel 6.1: Aantal cliënten (naar type behandeling) circuit jeugd (GGZNederland)

	2007	2008	2009	groei 08-09 (%)
residentieel	5.917	6.073	6.428	6
gemengd residentieel	2.474	2.878	2.936	2
deeltijd	1.571	1.678	1.734	3
ambulant	217.371	237.601	256.618	8
totaal	227.333	248.230	267.716	8
aantal verrichtingen				
ambulant	1.931.748	2.135.961	2.373.496	11
klinisch	546.486	562.423	593.653	6
deeltijd	259.070	277.331	270.711	-2
totaal	2.737.304	2.975.716	3.237.860	9
productiewaarde verrichtingen (x 1 miljoen)				
ambulant	236,6	255,3	282,3	11
klinisch	181,5	191,0	201,6	6
deeltijd	54,4	58,7	57,7	-2
totaal	472,6	505,0	541,6	7

GGZ Nederland sectorrapport (2011)

Tabel 6.2: Aantal wachtenden op 31 december 2007 (Bron: GGZ Nederland, 2009bGGZ Nederland. Zorg op waarde geschat. Sectorrapport GGZ 2009. Amersfoort, 2009b).

Wachtfase	Aantal kinderen en jongeren	% geholpen binnen Treeknorm a
Aanmelding	8.300	47
Beoordeling	9.400	60
Be-handeling	5.200	71
Totaal	22.900	

[a]*Treeknormen zijn de uitkomsten van het zogenaamde Treekoverleg waarin zorgaanbieders en verzekeraars afspraken maken over aanvaardbare wachttijden in de zorg.*

Tabel 6.3: Aantal jeugdigen per sector in 2009 (Bron: GGZ Nederland, 2009bGGZ Nederland. Zorg op waarde geschat. Sectorrapport GGZ 2009. Amersfoort, 2009b) (in het Engels?)

Tabel 2.2: Aantal jeugdigen per sector in 2009. Sector	Cliënten 0-18 of trajecten	Percentage van de jeugd
Jeugd en opvoedhulp2	75.323 (unieke cliënten in geïndiceerde jeugdzorg)	2,1
Bureau Jeugdzorg en LWI's2	51.014 maatregelen jeugdbescherming 23.139 maatregelen jeugdreclassering (gestart of in uitvoering; geen unieke cliënten)	2,1
Jeugd-GGZ3	142.323 (0-17 jarigen circuit jeugd GGZ instellingen en kinderen en jeugdigen bij zelfstandig gevestigden)	4,0
Jeugd-LVG4	10.493 (cliënten van 0-17 in orthopedagogische behandelcentra: berekening auteurs)	0,3
Speciaal onderwijs5	27.698 (leerlingen van 0-17 in cluster IV leerjaar 2008/'09)	0,8
JJI's & jeugdzorg plus2, 6	3.819 (jeugdigen bereikt)	0,1

Tabel 6.4: Verwijzingen naar de tweedelijns ggz voor kinderen en jongeren. Bron: GGZ Nederland, 2009b

	% kinderen en jongeren in 2007
Huisarts	43
Bureau Jeugdzorg	20
Andere ggz-instelling	12
Eigen initiatief/directe omgeving	9
Ziekenhuis/verpleeghuis	9
Maatschappelijke opvang/politie	5
Vrijgevestigde psychiater/psycholoog	1
totaal	100

Tabel 6.5: Structuur Nederlandse jeugdzorg anno 2010 (personal communication J. Rietveld)

	Consultatie-bureaus 0-4	**JGZ 4-19**	**Lokaal jeugdwerk**	**BJZ zorg**	**BJZ bescherming**	**Jeugdzorg**	**Gesloten jeugdzorg**	**Jeugd-GGZ**	**LVG-centra**	**RvdK**	**JJI**
Wetgeving	Wet Publieke Gezondheid	Wet Publieke Gezondheid	Wet Maatsch. Ondersteuning	Wet op de Jeugdzorg	Wet op de Jeugdzorg	Wet op de Jeugdzorg	Wet op de Jeugdzorg	Zorgverzek. wet/ AWBZ/ WGBO	AWBZ/WGBO	Burgerlijk Wetboek	Beginselen-Wet JJI's/Wet Gedragsbeinvl. maatregel
Beleidsbepaler landelijk	VWS dir. DG	VWS dir. DG	n.v.t.	J&G	J&G/ Justitie	J&G	J&G	VWS dir. Cur. Zorg	VWS dir. Care	Justitie	Justitie
Uitvoerders	Thuiszorg/ GGD	GGD	MW-instellingen	BJZ	BJZ	Jeugdzorg-instellingen	Partic. instellingen	GGZ- instellingen	LVG-centra	Raden	Rijks- en part. inst.
Subsidiënt	Gemeenten	Gemeenten	Gemeenten	Provincies	Provincies	Provincies	J&G	Verzekeraars/ Zorgkantoren	Zorg-kantoren	Justitie	Justitie
Bekostigingsbron	Doeluitkering Rijk	Doeluitkering Rijk	Gemeentelijke subsidies	Doeluitkering Jeugd/Prov. subsidies	Doeluitkering Jeugd/Prov. subsidies	Doeluitkering Jeugd/Prov. subsidies	Doeluitkering Rijk	Zorgverzek. premies/AWBZ	AWBZ	Begroting Justitie	Begroting Justitie

7. APPENDIX 7 CANADA

7.1. General overview

7.1.1. Country profile

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

A recent policy analysis (2009) in Canada[yyy] revealed that only four provinces have a Child and Adolescent Mental Health Policy and (or) plan. Alberta, Ontario and Saskatchewan released their plan in 2006. British Columbia was, in 2003, the first province to release a child and adolescent mental health plan and continues to be a leader in child and youth mental health programming and services. Therefore, we will limit the study to the Federal level and British Columbia.

British Columbia has a surface area of about 944700 km². It has an estimated population of 4.5 million inhabitants, which is 13% of the total population in Canada (34.3 million). Aboriginals, that is, North American Indian (also called First Nations people), Métis or Inuit people, are distinct groups having unique heritages, languages and cultures. In Canada and British Columbia 3.8% and 4.8%, respectively, identified themselves as an Aboriginal person[zzz].

Frequently, the figure of 20% is cited when referring to percentage of children and adolescent that may have significant mental disorders[aaaa]. These figures are based on a wide range of populations and problems. Therefore, Waddell et al. (2002) reviewed child psychiatric epidemiological research with a specific focus on relevance for Canadian public policy making.[bbbb] Epidemiologic data indicate that about 14% of children suffer from a clinically important mental disorder (i.e. impairment included into threshold for defining the problem 'clinically important') at any given moment in time. This translates into approximately 1.1 million Canadian children (and 140.000 children in British Columbia) who might be affected. Anxiety, attention, conduct, and depressive disorders were the most common. Only 16 to 27% of children received specialized mental health services.

When speaking about children and adolescents, it is important to keep the age of majority in mind. In Canada, this is determined by each province

www Newfoundland and Labrador; Prince Edward Island; Nova Scotia; New Brunswick; Quebec; Ontario; Manitoba;

Saskatchewan; Alberta; British Columbia;

xxx Yukon; Northwest Territories; Nunavult. The major difference between a Canadian province and a territory is that provinces are jurisdictions that receive their power and authority directly from the Constitution Act, 1867, whereas territories derive their mandates and powers from the federal government. In modern Canadian constitutional theory, the provinces are considered to be co-sovereign divisions, and each province has its own "Crown" represented by the lieutenenant-governor, whereas the territories are not sovereign, but simply parts of the federal realm, and have a commissioner.

yyy Kutcher S, Hampton MJ, Wilson J. Child and adolescent mental health policy and plans in Canada: An analytical

review. Can. J. Psychiatry.55(2):100-7.

zzz www.statcan.gc.ca

aaaa WHO. Child and adolescent mental health policies and plans. Geneva: World Health Organization; 2005.

bbbb Waddell C, Offord DR, Shepherd CA, Hua JM, McEwan K. Child psychiatric epidemiology and Canadian public

policy-making: The state of the science and the art of the possible. The Canadian Journal of Psychiatry / La

Revue canadienne de psychiatrie Vol. 2002;47(9):825-32.

and territory. The threshold of adulthood in British Columbia is the age of 19. In 2010, the number of minors in British Columbia is estimated to be 970428.[cccc]

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

7.1.2. Health care system

7.1.2.1. Health Policy

In Canada, health policy is both a responsibility of the federal government and the authorities at the provincial and territorial level. The Federal approach to health care in Canada is under the jurisdiction of the Canada Health Act (1983) which identifies the conditions under which transfer payments will be provided. The Federal government is responsible for providing health data, research and regulatory infrastructure. The federal government also directly finances and administers a number of health services including those for First Nations people living on reserves, Inuit, members of the armed forces and the Royal Canadian Mounted Police, veterans, and inmates of federal penitentiaries.[dddd] The Federal Government also funds and operates two national health entities; the Public Health Agency of Canada and Health Canada. These agencies provide a variety of national health activities. Other national bodies such as the Health Council of Canada and the Canadian Institute for Health Information participate in various national health related activities.

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

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

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

7.1.2.2. Financing and General Healthcare organization

Canada has a predominantly publicly financed health system. The Canadian health care system includes ten provincial and three territorial health insurance plans. The system, known as “medicare”, provides access to universal, comprehensive coverage for medically necessary hospital and physician services. [gggg]

The majority of health care services are administered and financed by the provincial and territorial governments. The regional health authorities are responsible for the organization of the services. Health care services include insured primary health care (such as the services of physicians and other health professionals) and care in hospitals, which account for the majority of provincial and territorial health expenditures. In general, primary health care (e.g. family physicians, nurse practitioner) provides direct

cccc http://www.bcstats.gov.bc.ca/data/pop/pop/estspop.asp#agesex

dddd Marchildon GP. Health Systems in Transition: Canada. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.

eeee Marchildon GP. Health Systems in Transition: Canada. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.

ffff www.hc-sc.gc.ca

gggg http://www.hc-sc.gc.ca/hcs-sss/index-eng.php

provision of first-contact health care services and coordinates patients health care services to ensure continuity of care and ease of movement across the health care system when more specialized care (e.g. specialists, hospitals) are needed. However, no formal gate-keeping system exists and there are variations in how primary health care is structured both across and within provincial jurisdictions.

7.2. Health care: CAMH Service Organization & Stakeholders

Responsibilities for the organisation of Child and adolescent mental health services (camhs) are mainly situated at the provincial level and there is variation amongst provinces in how these services are structured and funded. In British Columbia three ministries are involved (The Ministries of Children and Family Development; Health and Education) in the organisation of camhs.

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

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

[hhhh] http://www.mcf.gov.bc.ca/mental_health/pdf/cymh_plan.pdf

7.2.1. Camhs organization: services level

In British Columbia three levels (“tiers”) of camhs are recognized.

7.2.1.1. Primary mental health care

Frequently, physicians (family physicians or paediatricians) are the first point of contact for families with a child experiencing any kind of physical, emotional, mental or behavioural disturbance. These physicians (who are paid on a fee-for service or on a contract basis) can refer patients to more specialized services or remain the primary support for these patients. Other entry points into (mental) healthcare are tele-help lines, special education services, school counsellors or teachers .

7.2.1.2. Secondary tier mental health care: specialist camhs

Child and Youth Mental Health Offices are pivotal at the secondary (i.e. specialized mental health care) tier. These community-based services for children and youth (0-18 years) affected by serious mental health problems and mental disorders, are publically funded by the Ministry of Children and Family Development and are available free of charge to British Columbian citizens.

British Columbia has a network of around 120 local mental health offices, staffed by multidisciplinary teams (typically psychologists, social workers, counsellors with graduate degrees, nurses and child psychiatrists). These offices are operated by the Ministry of Child and Family Development or contracted agencies. In addition, an extensive program of more than 130 contracted service agencies extends these programs by providing specialized and complementary mental health-related community-based services.[iiii] They offer a flexible way of responding to varying regional needs. While these services are funded directly by Ministry of Child and Family Development, they can be funded jointly with other ministries, and non-government sources.

[iiii] Auditor General of British Columbia. The Child and Youth Mental Health Plan: a promising start to meeting an urgent need. Ministry of Child and Family Development. June 2007.

Referrals to Child and Youth Mental Health Offices can be made by primary care workers, the child, youth or their family or anyone else directly involved with children or youth. If the referral is considered to be inappropriate the person will be linked to a more suitable agency or health provider. The Child and Youth Mental Health Offices provide four types of services[jjjj]:

- Early intervention. An example is "FRIENDS for Life". This is a school-based early intervention and prevention program aiming to build resilience and reduce risk of anxiety disorders among elementary school children.[kkkk]
- Assessment and treatment. The Child and Youth Mental Health Offices also work with case management for care coordination. A case manager is a professional who has an ongoing relationship with the family such as a mental health clinician or a social worker.
- Crisis response (short term therapy, resources and referral coordination).
- Targeted Community Development. Mental health education for other service providers (e.g. school counsellors, family physicians). Currently, most Child and Youth Mental Health Offices are unable to provide these services due to the over-riding demands of direct clinical services.

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

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

7.2.1.3. Secondary tier mental health care: special target groups

Youth Day Treatment Programs target youth (aged 13 to 18) requiring intensive psychiatric treatment and educational programming. Child and Youth Mental Health offices make referrals for youth with mental health issues that interfere with school, family and friendships. The daily schedule includes a school session, group or individual therapy, and recreational activities. Youth Day Treatment Programs are a partnership between the Regional Board of Education, the Ministry of Child and Family Development and the Regional Health Authority.[llll]

Autism. A program of the Provincial Health Services Authority (under responsibility of Ministry of Health) is responsible for assessing and diagnosing children who may have autism. The program, called "British Columbia Autism Assessment Network" accepts referrals from all physicians. Once diagnosed with autism, the Ministry of Children and Family Development provides two Autism Funding Programs (<6 years: up to $22,000 per year; Ages 6-18 years: up to $6,000 per year. The Autism funding assists in purchasing eligible autism intervention services and therapies (e.g. behaviour consultants).[mmmm]

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

[jjjj] http://www.gov.bc.ca/mcf/

[kkkk] www.mcf.gov.bc.ca/mental_health/friends.htm

[llll] http://www.gov.bc.ca/mcf/

[mmmm] http://www.gov.bc.ca/mcf/

and the Ministry of Health since the former is responsible for youth mental health and the latter is responsible for addiction services.[nnnn]

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

7.2.1.4. Third tier camhs

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

The Maples Adolescent Treatment Centre targets psychiatrically and behaviourally troubled young people aged 12 -17, as well as those found not criminally responsible due to a mental illness. It is mandated to provide residential, non-residential and outreach services to support youth, families and communities. Youth can only be admitted if they are referred by a regional Child and Youth Mental Health office (including youth admitted in a hospital). To be eligible youth should have a Case Manager. This may be a professional who has an ongoing relationship with the family such as a mental health clinician, a probation officer, or a social worker. Their role is to educate the youth and family about the Maples programs and to coordinate care before and after admission to Maples. The maples programs provide a period of stabilization and intensive intervention followed by support for families/caregivers to implement a long-term community-based care plan. The programs and services are staffed with a multidisciplinary team of social workers, psychiatrists, psychologists, nurses, and child and youth counsellors. The 2003 Child and Youth mental health plan for British Columbia provided funding to allow the re-focusing of some existing resources from institutionally-based programs at the Maples to specialized community-based programs (e.g. multi-systemic therapy). [oooo]

Youth Forensic Psychiatric Services provide court-ordered and court-related assessment and treatment services to adolescents aged 12 - 17 years old in need of services for mental health and/or behaviour problems. Only direct referrals from Youth Justice Courts, Youth Probation Officers and Youth Custody Centres are accepted. Outpatient services are provided throughout the province by 7 community clinics and a network of private contractors. Each clinic provides a full range of assessment and treatment (e.g. specialized programs for sexual and violent offences) services. In 2008-2009 this resulted in 949 and 1342 admissions for assessment and treatment, respectively. Inpatient Services are provided by the Burnaby Inpatient Assessment Unit which is a designated place of temporary custody. It is staffed by nurses, health care workers, psychiatrists and a general practitioner. In 2008-2009, 137 patients were admitted.[pppp]

The **Child and Youth Mental Health Program at British Columbia Children's Hospital** is a provincial resource providing mental health assessment and treatment for British Columbian and Yukon children, youth, and their families. The program includes both inpatient and outpatient clinical services to complement community-based mental health centres and regional hospitals by providing specialized consultation, outreach, and education services. All programs and clinics require written referrals from physicians. The inpatient programs only accept referrals from Child and Youth Mental Health Teams (Ministry of Children and Family Development). Each referral is reviewed by a clinical team. If a child cannot be place alternate community resources will be recommended. [qqqq]

[nnnn] http://www.gov.bc.ca/health/index.html

[oooo] http://www.gov.bc.ca/mcf/

[pppp] Youth Forensic Psychiatric Services (Annual Report 2008-2009): www.mcf.gov.bc.ca\yfps\index.htm

[qqqq] http://www.bcchildrens.ca/default.htm

7.2.2. Stakeholders: health services level

7.2.2.1. Professionals involved and training requirements

Post-graduate continuing education is often provided by professional organizations; and the government does not set professional standards for post-graduate education. A recent initiative in this area is the development of an evidence based primary care physician training program for identification, diagnosis and treatment of the most common child and youth mental disorders (ADHD; Depression; Anxiety Disorders) lead by the British Columbia Medical Association[rrrr] in partnership with numerous governmental, professional and NGO stakeholders.

However, not all mental health care professions have strong professional organisations that provide continuing education. A recent initiative to enhance accessibility of knowledge especially in the field of teenage mental health care, has been taken by a Canadian non-governmental organization (NGO)[ssss]. The project aims at interpreting, translating and disseminating scientifically-validated information about adolescent mental health. A variety of formats is used, to reach teenagers themselves (e.g. animations), their families, as well as professionals (e.g. face-to-face or web-based training programs).

7.2.2.2. Participation of children and adolescents

A national mental health consumer organization, the Canadian Mental Health Association, with various Provincial and regional sections, provides a national NGO mental health forum; it welcomes all persons with mental disorders among which (parents of) children and adolescents[tttt]. A new national parent lead and family focused NGO, the Institute of Families for Child & Youth Mental Health has just been formed[uuuu]. It aims to bring the family perspective to national child and youth mental health domains.

Both for the development of the federal framework "Evergreen" (2010) and for the evaluation of BC's Child and Youth Mental Health Plan (2008), large-scale public consultations were organized.

7.3. Health care: camhs POLICY and policy Stakeholders

7.3.1. Health care: Policy stakeholders

7.3.1.1. Ministries involved in camhs in British Columbia

As noted above, three Ministries are involved in camhs: the Ministry of Children and Family Development, of Health, and of Education.

Through the 2003 Child and Youth Mental Health Plan, it was attempted to coordinate efforts across these Ministries.

7.3.1.2. Child and Youth Advisory Committee for the Mental Health Commission of Canada

In 2006, the Senate published "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada" which stressed the importance of a profound re-form of Mental Health Care in Canada.[vvvv] In this report, children's mental health services were declared the most neglected piece of the Canadian health care system, "the orphan's orphans". In reaction to this report, the strong need of a specific mental health care plan for children and youth was published[wwww]. The Senate report prompted the Government of Canada to establish the "Mental Health Commission of Canada" in 2008; this commission entailed a Child and Youth Advisory Committee which developed with 'Evergreen' a national child and youth mental health framework.

Various other national bodies associated with child and youth mental health exist.

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rrrr https://www.bcma.org/

ssss www.teenmentalhealth.org

tttt http://www.cmha.ca/bins/index.asp

uuuu http://www.instituteoffamilies.ca/index.php

vvvv http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06part1-e.pdf

wwww McEwan K, Waddell C, Barker J. Bringing children's mental health "out of the shadows". CMAJ. 176 (4). 471-472

7.3.2. Health care: Child and Adolescent Mental Health Policies & Plans

While provinces are, almost exclusively, responsible for health care implementation and governance some issues are addressed nationally. Since 2010 with the publication of "Evergeen" a national framework is available to support provinces in the creation or modification of their child and youth mental health policies and plans. The Evergreen framework aims to offer an overarching vision, common values and principles to guide provincial and territorial policy. Local interpretation of the national framework, on the other hand, allows for tailoring mental health policies to meet local realities.[xxxx]

An analysis of existing policies (2009) revealed that only four provinces had a specific policy and or plan for child and adolescent mental health care, indicating that a national framework was more than necessary.[yyyy]

British Columbia was, in 2003, the first province to release a child and adolescent mental health plan and continues to be a leader in child and youth mental health programming and services. The framework of its plan is even broader than the national framework, and it encompasses a public health perspective[zzzz]. The child and youth mental health budget has, at the end of phase 1 of its implementation, more than doubled (from approximately $40 million in 2003 to $80 million in 2008).[aaaaa] In 2010, BC introduced a new cross-governmental 10-year mental health plan that encompasses both children and adults, as well as encompassing both prevention and treatment. This new plan is actually considerably more comprehensive than the 2003 plan[bbbbb].

In British Columbia, 15% of camhs resources are targeted for disorder prevention and other risk-reduction initiatives. This is notable, given that British Columbia, like other Canadian jurisdictions, typically devotes only 5% of the overall health spending to public health, including prevention activities[ccccc]. British Columbia's prevention investments exemplify a new and deliberate shift from exclusively focussing "downstream" on treatment services toward a broader public-health strategy to reach greater numbers of people early in life. The Plan has shifted policy investments "upstream".[ddddd]

Given the relative inaccessibility (i.e. waiting lists) of specialist mental health services, the importance of primary care practice and school-based care in improving access to child and youth mental health services is evident.[eeeee] Therefore, the emphasis of British Columbia's 2003 Child and youth mental health plan on an improved collaboration between primary care physicians and specialized camhs was sensible.[fffff] In adult mental health care, Canada has been a pioneer in developing models for collaboration between primary care physicians and specialized mental health care, called "collaborative care" (personal communication, S Kutcher)

With engagement from over 600 stakeholders, the resounding message communicated to reviewers of the Plan five years after implementation was one of support for the plan, its coherence and follow-through. The mental health plan of British Columbia has been successful in reaching more

xxxx http://www.mentalhealthcommission.ca/English/Pages/evergreen.aspx

yyyy Kutcher S, McLuckie A. Evergreen: Towards a child and youth mental health framework for Canada. J. Can. Acad. Child Adolesc. Psychiatry.18(2):89-91.

zzzz Waddell et al. A public health strategy to improve the mental health of Canadian children, Canadian Journal of Psychiatry, 2005; 50:226-233

aaaaa Mcewan K, Wadell C, Barker J. Bringing children's mental health "out of the shadows". CMAJ. 176 (4). 471-472.

bbbbb http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

ccccc Canadian Institute for Health Information

ddddd http://www.mcf.gov.bc.ca/mental_health/pdf/cymh_plan.pdf

eeeee http://www.cihr-irsc.gc.ca/e/43055.html#s2

fffff http://www.mcf.gov.bc.ca/mental_health/pdf/cymh_review_full_report_final.pdf

children and families in need of assistance with mental health challenges. In 2006/2007 the Ministry of Child and Family Development served 19,952 children and youth through community based services. In 2004/2005 only 11,000 children and youth received mental health support from the Ministry. Recommendations included more and better data collection, increased collaboration between professionals and sectors, and efforts to address wait times. [ggggg]

Three other provinces (i.e. Ontario, Saskatchewan, Alberta) released their plans in 2006. The most other provinces organize policies and plans around issues (e.g. substance abuse, suicide) and not by age cohort or have general mental health plans in which child and adolescent mental health is referenced. [hhhhh]

7.4. Other Sectors Involved in Children's (mental) health and wellbeing

Most services for children and families in British Columbia have been consolidated under one ministry that is governed by several provincial acts. The Ministry for Children and Family Development, was formed in 1996 by transferring existing programs serving children, youth and families from the Ministries of Education, Health, Social Services, Attorney General and Women's Equality to the new Ministry.

7.4.1. Juvenile Justice

7.4.1.1. Health Policy

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

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

7.4.1.2. Services

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

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ggggg http://www.cihr-irsc.gc.ca/e/43055.html#s2

hhhhh Kutcher S, Hampton MJ, Wilson J. Child and adolescent mental health policy and plans in Canada: An analytical review. Can. J. Psychiatry.55(2):100-7.

iiiii http://www.rcybc.ca/Images/PDFs/Reports/Youth%20Justice%20Joint%20Rpt%20FINAL%20.pdf

jjjjj http://www.rcybc.ca/Images/PDFs/Reports/Youth%20Justice%20Joint%20Rpt%20FINAL%20.pdf

kkkkk http://www.mcf.gov.bc.ca/youth_justice/index.htm

Youth Forensic Psychiatric Services (responsibility of the Ministry of Children and Family Development) provides court-ordered and court-related assessment and treatment services for troubled youth.

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

For many years, British Columbia has had a rate of youth incarceration substantially below the average rate in most other provinces. The introduction of the federal Youth Criminal Justice Act reinforced this trend. Average counts per day of youth custody in British Columbia have dropped from a high of 400 youth in 1995 to 129 youth in 2007. It was highlighted that special attention should be given to Aboriginals since their proportion increased from 29 to 40% in that same timeframe. [lllll]

7.4.2. Child Welfare

The Minister of Children and Family Development is also responsible for the development of policies, standards and programs, and for the overall quality of services provided to children and families. This is regulated by the Child, Family and Community Service Act. The Minister designates the Director of Child Protection, with the responsibilities over adoption, child protection and guardianship services.

The authority of the designated Child Protection Director is further delegated to a range of ministry staff (e.g. social workers) who manage the service delivery system, oversee the operations of the system and ultimately carry out the provision of services in the community (e.g. Child Abuse Team, Child Protection Manager, Rapid Response Team). These services are organized per region with a total of approximately 430 ministry offices and a number of delegated Aboriginal agencies.

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

7.4.3. Disabled persons

British Columbia closed all its institutions for people with intellectual disabilities during the late eighties. The Ministry of Children and Family Development undertook the responsibility for the resettlement of these services within the community. With the closure of institutions, specific health and social care protocols were developed between the Ministries of Health and of Children and Family Development[nnnnn]

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

lllll http://www.rcybc.ca/Images/PDFs/Reports/Youth%20Justice%20Joint%20Rpt%20FINAL%20.pdf

mmmmm http://www.gov.bc.ca/mcf/

nnnnn Tang B, Byrne C, Friedlander R, McKibbin D, Riley M, Thibeault A. The other dual diagnosis: developmental disability and mental health disorders. BC Medical Journal. 50 (6). 2008. 319-324.

care for people with intellectual disabilities and mental health needs these teams are still active.[ooooo]

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

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

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

ooooo Friedlander R. Mental Health for Persons with Intellectual Disability in the Post-Deinstitutionalization Era:

Experiences from British Columbia. Isr J Psychiatry Relat sci. 43 (4). 2006. 275-280.

ppppp Friedlander R. Mental Health for Persons with Intellectual Disability in the Post-Deinstitutionalization Era:

Experiences from British Columbia. Isr J Psychiatry Relat sci. 43 (4). 2006. 275-280.

qqqqq Friedlander R. Mental Health for Persons with Intellectual Disability in the Post-Deinstitutionalization Era: Experiences from British Columbia. Isr J Psychiatry Relat sci. 43 (4). 2006. 275-280.

7.4.4. Education

The main source for this paragraph[rrrrr] is the website of the Ministry of Education of British Columbia, including the British Columbia manual of policies, procedures and guidelines for special education services (Feb. 2011). Education is compulsory from the age of 5 to 16.[sssss]

7.4.4.1. Policy level

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

School boards have a duty to govern districts and their schools in accordance with specified powers in a fiscally responsible and cost effective manner. School boards also have a policy role, which is to set education policies that reflect the aspirations of the community and that are consistent with overall provincial guidelines.

At the school level, school principals have the right to exercise professional judgment in managing the school in accordance with specified duties and powers.

7.4.4.2. Service level

Most schools in British Columbia are public schools funded by the Ministry of Education. However, a network of private schools (including schools targeting children with learning disabilities) also exists[ttttt]. These private schools are under certain conditions partially funded by the Ministry of Education. All private schools must register with the government education ministry, but this doesn't necessarily mean schools are formally inspected.

rrrrr http://www.gov.bc.ca/bced/; http://www.bced.gov.bc.ca/specialed/ppandg.htm

sssss http://www.bced.gov.bc.ca/policy/primer/roles.htm

ttttt http://www.bced.gov.bc.ca/independentschools/bc_guide/grants.htm

British Columbia promotes, for its public schools, an inclusive education system in which students with special needs are fully participating members of a community of learners. The emphasis on educating students with special needs in neighbourhood school classrooms with their age and grade peers, however, does not preclude the appropriate use of resource rooms, self-contained classes, community-based programs, or specialized settings. Students with special needs may be placed in settings other than a neighbourhood school classroom with age and grade peers. This should only be done when the school board has made all reasonable efforts to integrate the student, and it is clear that a combination of education in such classes and supplementary support cannot meet their educational or social needs, or when there is clear evidence that partial or full placement in another setting is the only option after considering their educational needs or the educational needs of others. A formal system of special education schools does not exist in British Columbia.

Students with special needs may require additional support (e.g. by a school counsellor or learning assistance teachers) and accommodations to enable them to access and participate in educational programs. The Basic Allocation, a standard amount of money provided per school age student enrolled in a school district, includes funds to support the learning needs of students who are identified as having learning disabilities, mild intellectual disabilities, students requiring moderate behaviour supports and students who are gifted.

Additional supplementary funding recognizes the additional cost of providing programs for students with special needs in the following categories: dependent handicapped, deaf-blind, moderate to profound intellectual disabled, physically disabled/chronic health impaired, visually impaired, deaf/hard of hearing, Autism Spectrum Disorder, and intensive behaviour interventions or serious mental illness.

7.5. Financing and funding of camhs

7.5.1. Financing models

Canada has a Beveridge health care system. Health care is financed by the government through tax payments. The Canadian national health insurance program 'Medicare' is composed of 13 provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. The aim of the insurance program is to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Roles and responsibilities for the health care system are shared between the federal and provincial-territorial governments. Under the Canada Health Act, the federal health insurance legislation, criteria and conditions are specified that must be satisfied by the provincial and territorial governments health care insurance plans in order to qualify for their full share of the federal cash contribution, available under the Canada Health Transfer.

This means that the federal government provides funding through cash and tax transfers to the provinces and territories to help pay for health care services, but the actual delivery of services is a provincial/territorial responsibility. Criteria specified in the Canada Health Act require universal coverage (for all insured persons) for all "medically necessary" hospital and physician services, without co-payments.

Most health care services are not administered directly by the provinces and territories, but by geographically based regional health authorities. Regional Health Authorities receive global budgets from the provinces which they can allocate to health resources in a manner that optimally serves the needs of their respective populations[uuuuu].

7.5.2. British Columbia: financing of child and adolescent mental health care services.

In British Columbia, the community-based Child and youth mental health offices are funded by the Ministry of Children and Family Development through a global budget, but they can be funded jointly with other ministries

[uuuuu] HiT report Canada, 2005

and non-government sources. Child psychiatry services of regional hospitals, as well as addiction treatment services are funded by the Ministry of Health Services. Third level province-wide services, are partly financed by the Ministry of Children and Family Development e.g. the Maples centre, and partly by the Ministry of Health Services, e.g. services at the British Columbia Children's hospital.

Private psychologists services are not reimbursed by the Ministry, but are often included in extended health benefits programs paid by employers.

Private (child) psychiatrists services are reimbursed by the Ministry of Health Services, on a fee-for-service basis or on contract basis (global funding).

7.6. Efficacy

Research funding for child and adolescent mental health domains is primarily provided through the Canadian Institutes for Health Research and through various Provincial and private Health/Mental Health/Neuroscience Research Foundations.

Knowledge institutes e.g. CADTH (Canadian Agency for Drugs and Technologies in Health) provide evidence-based guidelines in many health care domains. The Ministry of Children and Family Development works together with the research unit at Children's Health policy centre, Simon Frazer University, headed up by Dr. C. Waddell, to help identify evidence based programs and guidelines, and to conduct health systems research related to child and adolescent mental health[vvvvv].

In British Columbia, there is no specific assessment instrument in use to support evaluation of child and adolescent treatment needs. In the BC camhs plan, a regular performance measurement is recommended, and an onset of performance measurement is being made. Policy evaluations to inform on the results of previous political decisions are regularly performed, e.g. review of the 2003 BC camhs plan, five years after its implementation[wwwww].

[vvvvv] http://www.childhealthpolicy.sfu.ca/

[wwwww] http://www.cihr-irsc.gc.ca/e/43055.html#s2

8. APPENDIX 8 ENGLAND

8.1. General overview

8.1.1. Country profile

England is with Wales, Scotland, and Northern Ireland one of the four constituent countries of the United Kingdom, which is it self a constitutional monarchy, governed by two houses of representatives (the House of Commons and the House of Lords). Health and social care matters are organized on the level of each constituent country. This study is limited to England, the largest and most populated constituent country. England has a population number of 51,8 million inhabitants (83% of UK population), of which nearly 9,800 million are <15 years of age and 11,012 million <18 years of age (2009)[xxxxx]. The territory of England is about 130400 km². There are 354 local authorities (counties); these are re-organized in 150 Local authorities which have a main responsibility in the organization of social care, education and disability care; there are 38 local justice areas.

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

8.1.2. Preliminary remark

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

[xxxxx] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

8.1.3. Health care organization

Health care in the UK is the responsibility of the Department of Health. The National Health Service (NHS), the UK's publicly funded health service, was launched in 1948. The NHS is centrally funded from national taxation, but the NHS services in the constituent countries are managed separately. The NHS in England is the biggest part of the systems, employing more than 1.3 million people and receiving more than £100 billion[yyyyy]. With some exceptions NHS services are free of charge at the point of delivery for any resident of the UK.

The Department of Health controls England's ten Strategic health authorities (SHA), each of them controlling the NHS trusts in its area as well as holding responsibility for public health[zzzzz].

The NHS is divided in two main sections: primary and secondary care (cf.fig 8.1)[aaaaaa]. Primary care is the first point of contact and is delivered by a wide range of independent contractors (including General Practitioners or GP, dentists, pharmacists). Secondary care (also called "acute care") can be elective care such as planned specialist medical care or surgery, or emergency care.

Primary care trusts (PCTs[bbbbbb]) are local organizations, in charge of organizing primary care providers, and commissioning secondary care, in a way that the local needs are met. The PCTs control +-80% of the NHS budget. They also hold the responsibility of realizing goals set by the Department of Health in the field of public health and prevention.

Acute trusts are managing hospitals but also provide services in the community through health centres, clinics or at home. Ambulance trusts are responsible for providing emergency access to healthcare. NHS Foundation Trusts or "NHS Trusts" are a new type of more locally organized trusts that run a hospital.

Care trusts are responsible to set up collaboration between the NHS and local authorities in the field of health and social care, mental health care and primary care.

Mental Health Trusts are a separate part of the NHS, and are overseen by the local PCT. Mental health services in England can be delivered by the GP, primary health care services or through more specialist care services. This specialist care is provided by mental health trusts.

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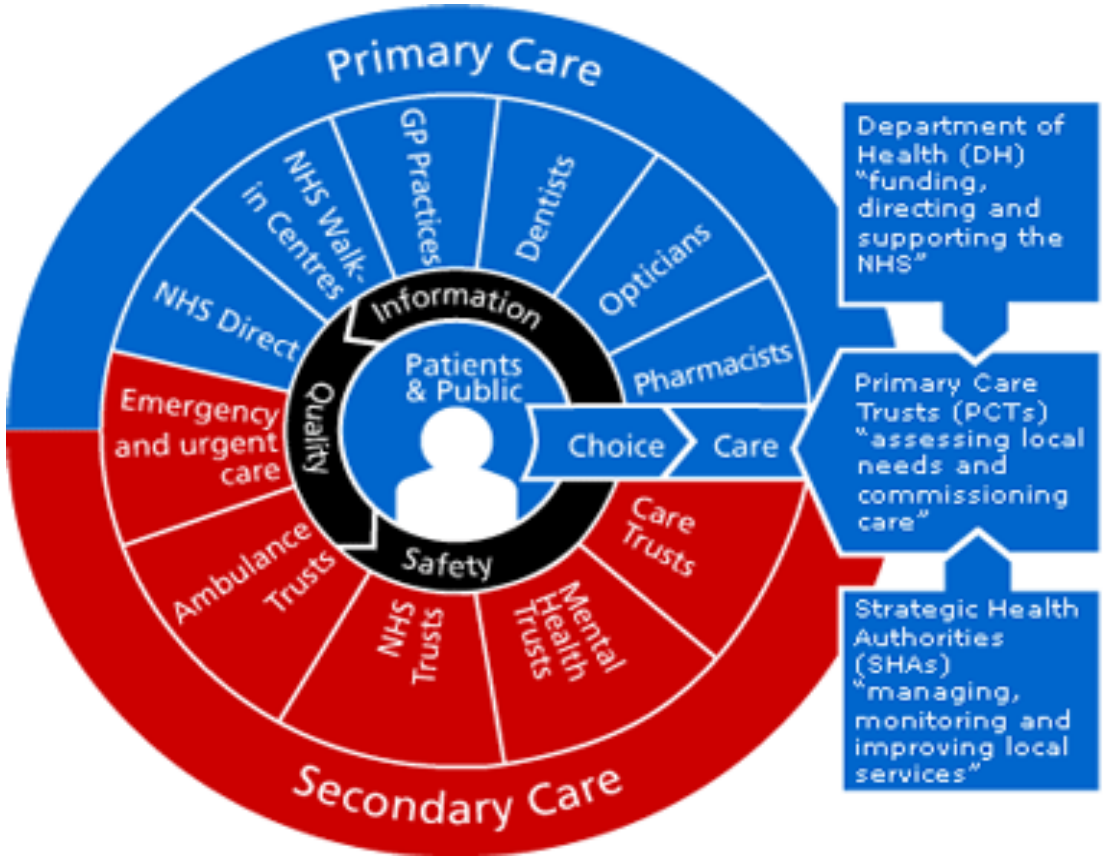
yyyyy http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

zzzzz HiT Report England, 2011

aaaaaa http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx

bbbbbb In 2010, there were 145 PCTs and 6 Care trusts in England, or together 151 NHS primary care organizations (source: HiT England, 2011).

Figure 8.1: NHS structure



*(source : NHS at: **http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx**)*

The UK Government (May 2010) has set out major reforms to the NHS in its legislation (see 'Equity and excellence: Liberating the NHS' (July 2010)[ccccccc]) and in the Health and Social Care Bill 2011. Reforms will be implemented gradually.

8.2. Target population

8.2.1. Age limits

The NHS National service framework for children, young people and maternity services (NSFCYMS, standard 9, see further) published by the NHS in 2004, sets the age limits between 0 to 18 years.

8.2.2. Epidemiologic data

The NSFCYMS (2004) states "ten per cent of five to fifteen year olds" to have a diagnosable mental health disorder. This suggests that around 1.1 million children and young people under eighteen years in the UK would benefit from specialist services. There are up to 45,000 young people with a severe mental health disorder. Around forty per cent of children with a mental health disorder are not currently receiving any specialist service".[dddddd]

In the Camhee report (2009), more detailed figures are available concerning estimated rates of prevalence for various disorders, children in care, youth offenders, and school avoiders[eeeeee].

8.3. Health care: camh service organization & stakeholders

8.3.1. Camhs organization: services level

Health care policy in England is implemented in a top-down way, but elements of administration of this policy are decentralized. The local organizations (e.g. PCTs) have a large responsibility in implementing health care policy and in practical organization of service delivery.

8.3.1.1. Four tiers framework

Child and adolescent mental health services in England are delivered in a variety of ways and a schematic approach to a "tiered" delivery system has proved helpful. Standard 9 of the NSFCYMS[ffffff] sets out a four tiers delivery framework (see also fig 8.2 in Additional documents). The system is intended to be a stepped care model.

Tier 1:

Tier 1 services are services at a primary level of care, including promotion and prevention of health, providing early identification, and offering general advice and treatment for less severe problems. Professionals working at this level often are not camh professionals. These services refer to more specialist services if required. Professionals involved include: GPs, Health visitors, School nurses, Social workers, Teachers, Juvenile justice workers, Voluntary agencies, Social services. Children's centres, which deliver generic support in health and family matters for young children (0-6 years), also belong to tier 1 camhs (see section youth social care).

Tier 2:

Camhs at tier 2 are services provided by specialists working individually in community and primary care settings (such as primary mental health workers, pediatricians, psychologists and child and adolescent psychiatrists). They offer consultation to families, outreach to identify severe/complex needs, assessments, and training to practitioners at Tier 1

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ccccccc http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

dddddd http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114.

eeeeee Camhee Report downloaded at www.camhee.eu: Braddick, F., Carral, V., Jenkins, R., & Jane-Llopis, E. (2009). Child and Adolescent Mental Health in Europe: Infrastructures, Policy and Programmes. Luxembourg: European Communities

ffffff http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114

to support service delivery. They make referrals to tiers 3 or tiers 4 if necessary. Professionals involved include: Child and Adolescent Mental Health workers, Clinical child psychologists, Educational psychologists, Child & adolescent psychiatrists, Child and adolescent psychotherapists, Community nurses/nurse specialists, Family therapists, Paediatricians (especially community).

Tier 3:

Specialized services, for more severe, complex or persistent disorders, usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient or community settings. These services offer assessment and treatment; assessment for referrals tot T4; contributions to the services, consultation and training at T1 and T2; research and audit. Professionals include: Child & adolescent psychiatrists, Clinical child psychologists, Nurses (community or in-patient), Child psychotherapists, Occupational therapists, Speech and language therapist, Art, music and drama therapists, Family therapists

Tier 4:

Services at tier 4 are services for children and young people with the most serious problems. These services include day units, highly specialized outpatient teams including outreach services, inpatient units, or other highly specialised assessment consultation and intervention services which usually serve more than one area. Amongst the highly specialist services, inpatient psychiatric units for both children and adolescents, but separately provided to ensure that the developmental needs of different age ranges are met, are essential resources, representing 'the intensive care of child mental health'. Examples of tier 4 services are child and adolescent inpatient units; secure forensic units, eating disorders units, specialist teams (e.g. sexual abuse), and specialist teams for neuropsychiatric problems. Professionals may include Child & adolescent psychiatrists, Clinical child psychologists, Nurses (community or in-patient), Child psychotherapists, Occupational therapists, Speech and language therapists, Art, music and drama therapists, Family therapists. In the Additional documents, an estimate of capacity for tiers 4 is given; there are overall 725 inpatient beds in England, or 0,66/10000 inhabitants (0-18 years) (2009/2010). Besides this, there are 1175 day care and other *intensive* tier 4 ambulatory care places (1,07/10000 inhabitants (0-18 years), 2009/2010). The NSFCYMS (2004) admits that the number of inpatient adolescent beds is insufficient, and that some adolescents inappropriately are being cared for in adult psychiatric beds.

8.3.1.2. Four team types

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

- Generic team:

Generic camhs teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area. Generic (multi) teams are made up of camhs professionals from a number of disciplines that work together to ensure integrated provision. Generic (single) teams are single disciplinary groups of staff that provide a range of therapeutic interventions.

- Targeted team:

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

- Dedicated worker team:

[ggggggg] Wistow, R. and Barnes, D. (2009) *A profile of child and adolescent mental health services in England 2007/8: findings from children's services mapping*, download at http://www.childrensmapping.org.uk/publications/camhs/

[hhhhhh] In England, ADHD and ASD clinics seem to be frequent in community pediatric services; in 2008/2009, of these services (N=231), 74% respectively 79% had ADHD respectively ASD clinics in place (www.childrensmapping.org.uk; profile 2008/2009, Barnes et al; accessed Feb 2011).

[iiiiii] www.childrensmapping.org.uk

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

- Tier 4 team:

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

8.3.1.3. Evidence base for developing multi-faceted tier 4 camhs

Traditionally, camhs tier 4 was essentially an inpatient service and synonymous with psychiatric inpatient provision. However, more recently it has developed as "multi-faceted with multi-agency services that can include whole- or half-day activities, in-patient care, or outreach support (such as emergency or after care), intensive and crisis community initiatives, therapeutic fostering or other services that may be described as wrap around and are considered an alternative to in-patient care; some agencies may provide more than one of these types of care" [jjjjjj].

Kurtz (2009)[kkkkkk] reviewed the evidence on these recent evolutions in camhs tier 4 organization in the UK. He argues that evidence for camhs interventions through gold standards by quantitative methods (as randomized controlled trials) is very limited, but rather comes from qualitative research, as was revealed already by the Fort Bragg studies by Bickman et al (1996)[llllll](see also literature review). He further argues that evidence supports the use of alternatives (such as multi-systemic family therapy, assertive outreach and treatment foster care) to inpatient care for certain groups of young people with mental health problems. The approaches however are not new, but could better be understood as ways of working that are integrated within tier 3 and tier 4 and needing some residential components.

8.3.1.4. Specific target groups

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

8.3.1.5. Outreach and liaison services

Most teams tend to be based in health settings such as hospitals or community health services, but about 1/5 are based in other sectors e.g. the social, educational or juvenile justice sector. Teams are also increasing accessibility through outreach work. In 2007/8, of all teams (N=1040), 49% outreached into other health settings such as community health centres and GP practices; 37% of teams provided outreach in education settings (mainstream as well as special schools); 28% of teams provided home visits on a regular basis, 11% worked in children's centres (see further), 7% in secure residential settings and 9% with youth offending teams[oooooo]. Consultation and liaison services (i.e. not including intervention) are provided to children's centres and other social care services including services for looked-after children, educational services, juvenile justice

[jjjjjj] Kurtz, Z., The evidence base to guide development of tier 4 CAMHS, download at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103444

[kkkkkk] Kurtz, Z., The evidence base to guide development of tier 4 CAMHS, download at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103444

[llllll] Bickman, L. et al 1996, Evaluating managed mental health services: the Fort Bragg experiments N.Y. Plenum press

[mmmmmm] http://www.childrensmapping.org.uk/

[nnnnnn] http://www.chimat.org.uk/camhs/commissioning

[oooooo] Atlas 2007/2008 by Wistow et al (http://www.childrensmapping.org.uk/).

services, disabled children's services; 20% of all teams provide at least weekly liaison services to each of these other sectors[ppppp].

8.3.2. Stakeholders: health services level

- Involved professions and training

The provision of mental health services is a matter of many actors and services. The aim of the national 2003 policy (ECM, see further) was to create a broad frontline delivery of primary care on the community level. The national camhs review (2008, see further) stated that child and adolescent mental health is "everybody's matter", and that everybody dealing with children should be aware of their mental health development and needs. The NSFCYMS (2004) stresses the importance of broad Tier 1 and Tier 2 services and well endorsed Tier 3 and Tier 4 specialist services. This implies a lot of involved professions with sufficient core training for every involved professional and the necessary specialist skills (see table 8.1).

[ppppp] Atlas 2007/2008 by Wistow et al (http://www.childrensmapping.org.uk/)

Table 8.1: professions involved:

Frontline care delivery:	Specialist CAMHS:
Midwives	Child & adolescent psychiatrists
Health visitors	Clinical child psychologists
Teachers	Paediatricians
General Practitioners	Child psychotherapists
Police	Nurses (community or in-patient)
Educational Psychologists	Educational psychologists
School nurses	Occupational therapists
Community nurses	Speech and language therapists
	Systemic and Family therapists

In 2008 government has set up the 2020 Children and Young People's Workforce Strategy to support everyone who works with children and young people and to ensure that, whatever their role is, everyone has the skills and knowledge to help children and young people develop and achieve the outcomes underlying ECM.

- Participation of Children and Young people:

The national policy of 2003 (ECM, see further) engages in the "Participation Works" partnership of six national children and young people's agencies that enables organizations to effectively involve children and young people[qqqqqq].

The NHS launched "Young Minds: Putting Participation into Practice", a guide for practitioners working in services to promote the mental health and well-being of children and young people (2005) including tools for developing participation in camhs.

8.4. Health care: camh policies and policy stakeholders

8.4.1. Health care: policy stakeholders

- National Government
  - Three different Departments are involved: the Department for Education (DfE) (formerly Department for Children, Schools and Families (DCSF)); the Department of Health (DH); and the Department of Justice.
- Department for Education (DfE):

Education, social care for children, as well as a part of disability care for children, are the responsibility of the Department for Education (DfE)[rrrrrr]. This department is overseen by the Secretary of State for Education, and his ministerial team, of which the Minister of State for Schools and the Minister of State for Children and Families are a team member. The Minister of State for Children and Families has the responsibility for the children's centres, child care, some public health issues, special education needs and disabled children, and children's social services commissioning.

qqqqqq http://www.participationworks.org.uk/home

rrrrrr http://www.education.gov.uk/

Care for disabled children is a joint responsibility of the Minister of State for Children and Families, and of the Secretary of State for Health.

-Department of Health (DH): overall responsibility for health care; controls the National Health Service (NHS). Joint responsibility with the DfE for disabled children.

-Department of Justice: Juvenile justice is a matter of the Ministry of Justice and the Secretary of State for Justice.

- Local level: Children's trusts (2004-2010)

In 2003, the Government launched the "Every Child Matters" program (ECM, see further), as a response to the report into the death of Victoria Climbié, an 8 years old girl, abused and murdered by her guardians. The program was supported in legislation by the Children Act (2004), and initiated a shift towards a child centred approach of care, meaning that all agencies serving children and adolescents should collaborate to support children's safety, health achievement, social contribution and economic wellbeing. To develop collaboration and promote service integration between different sectors, Children's trusts were launched. However, as a part of new policies after the 2010 elections, the obligation for local communities to establish a Children's trust is withdrawn.

A Children's Trust was defined as a local area partnership led by the local authority bringing together the key local agencies - some of which were under a statutory "duty to co-operate" - to improve children's well-being through integrated services focused on delivering the five Every Child Matters outcomes.

Children's trusts held the overall responsibility for overlooking, joint planning and commissioning of all services for children and adolescents in their area, be it health care, mental health care (including specialized camhs), social care, educational or disability support, or juvenile justice services (see fig 8.2).

Children's Trusts were made up of:

- the local authority, including all services with impact on children and families, e.g. social care, housing
- statutory 'relevant partners':
  - Primary care trusts and SHA (health care, mental health care) (GPs, paediatricians, community nurses), the most important partner;
  - Youth offending teams (YOT, Justice)
  - Police
  - Probation services (Justice)
  - Educational support services (Connexions)
  - Jobcentre Plus.
- other partners considered appropriate by the local authority.

Children's trusts were made possible through joint policies of the Department for Health (DH) and the Department for Education (DfE); the Department of Justice was involved as well. As Primary care trusts (PCTs, health care commissioning) and Local authorities (LAs, social care and disability care commissioning; organization of education) have distinct systems of financial management, new mechanisms to align local PCT and LA budgets were developed (see also paragraph 8.6.3).

Besides commissioning, central activities of the Children's trust were the joint strategic needs assessment, evaluating the local needs, and the development of the Children's and young people's plan (CYPP), defining the local priorities and goals for the next three years. In 2008, 94% of Children's trusts had carried out a joint strategic needs assessment to identify the needs of children, young people and their families in the Trust area. The most commonly included elements were analysis of population and its age profile (86%), healthy weight (85%), teenage pregnancy (83%) and children living in poverty (81%)[ssssss].

As a part of new policies after the new elections in 2010, the Children's trusts are not statutory required anymore and commissioning will gradually be taken over by GP consortia and new local health and wellbeing boards[ttttt]. While the statutory guidance for Children's trusts has been

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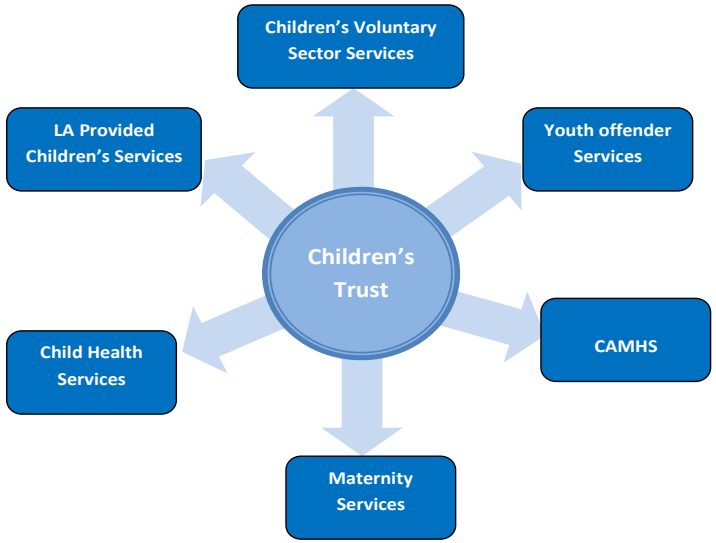
ssssss www.childrensmapping.org.uk, profile 2008/2009, Barnes et al., accessed Feb 2011.

ttttt http://www.chimat.org.uk/camhs/commissioning

withdrawn, the expectation however remains that local services will be planned through partnership working, with GP consortia and local health and wellbeing boards as a vehicle for commissioning children's services

Fig. 8.2: Collaboration model in Children's trusts (Source: www.childrensmapping.org.uk.)



Camh partnerships

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

- Sectorial stakeholders and charity organizations

The Mental Health Foundation[uuuuuu]: charity improving the lives of those with mental health problems or learning disabilities.

Young Minds: Young Minds is a national charity committed to improving the mental health and emotional well being of all children and young people[vvvvvv].

Children and Young People's Mental Health Coalition (CYPMHC)[wwwwww]: The CYPMHC brings together leading charities to campaign jointly on the mental health and wellbeing of children and young people.

This list does not aim to be exhaustive.

8.4.1.1. Health care: camh policies

In the last decade the UK Government developed several national policies to improve health and wellbeing for children. The country profile for England in the report of the European program "Child and adolescent mental health in an enlarged Europe" (Camhee)[xxxxxx] provides an extensive overview of the different policies and programmes for mental health promotion, mental disorder prevention and care in childhood and adolescence. Two key documents however are worth to discuss, since they are fundamental in setting out the overall national policy: Every Child Matters (ECM)[yyyyyy], underpinned by the Children Act 2004[zzzzzz], and the National Service Framework or children, young people and maternity services (NSFCYMS, 2004)[aaaaaaa]

uuuuuu http://www.mentalhealth.org.uk/

vvvvvv http://www.youngminds.org.uk/

wwwwww http://www.cypmhc.org.uk/

xxxxxx Camhee Report "child and adolescent mental health in Europe: infrastructures, policy and programmes, downloaded at www.camhee.eu

yyyyyy http://www.dcsf.gov.uk/everychildmatters/about/aims/aims/

zzzzzz http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

aaaaaaa http://www.dh.gov.uk/en/Healthcare/Children/index.htm

In 2010 a new cabinet, emerging from a new coalition after elections, took office, and as of April 2011 new guidelines in organizing (mental) health are released gradually, e.g. "No health without mental health"[bbbbbbb].

Every Child Matters (ECM)

Every child matters (ECM) was the overall national policy for children and adolescents, launched by the government in 2003. It provides an integrated framework to support children's safety, health achievement, social contribution and economic wellbeing. Involved in this policy are the health care sector (including mental health care), the social care sector, the education and disability sector and the juvenile justice sector. The ECM-program does not reflect the national policy of the new Government (2010) anymore, but many elements still influence the actual policy.

The starting point of the ECM program is improved outcomes for all children and adolescents, which depend on the action taken in the 150 Local Change programs of which the local authorities are responsible. The Children's trust (see above) has a central organizing and commissioning role. Action is driven by an analysis of local priorities, and secured through more integrated frontline care delivery, processes, strategy and governance. The Children and young people's plan (CYPP) is a 3-years plan of the Children's trust, setting out the local strategy.

Integrated frontline care delivery means:

- More integrated, accessible and personalised services built around the needs of children and young people, not around professional or service boundaries.
- Shift to prevention, early intervention and improved safeguarding; but specialized services should be available if needed.
- Services co-located in places such as children's centres or schools.
- Workforce reform to ensure sufficient, suitably trained staff. All staff working with children, in whatever sector, has a "common core" of knowledge and understanding about children's needs. Core competencies for specialized camhs staff have been specified as well
- Development of multi-disciplinary teams and lead professionals.

Examples of integrated processes implemented by the ECM program are:

- The Common assessment framework (CAF), a national common process for initial assessment to identify the needs of the child and its family;
- Information-sharing system between professionals, with national standards for information sharing across local children's services with clear guidance for practitioners covering health, education, social care and youth offending.

Integrated strategy means:

- Joint assessment of local needs involving children, young people and parents.
- Single plan shared between all children's services reflecting national and local priorities for improved outcomes.
- Pooling of budgets to support joint commissioning of services.
- New Joint Area Reviews (JARs) to inspect local children's services.
- The delivery of integrated frontline services to improve outcomes for children and young people will need support at a strategic level.

National service framework for children, young people and maternity services

National Service Frameworks (NSF) are policies set out by the National Health Service (NHS) to define standards of health care. The NSFCYMS (2004) establishes clear standards for promoting health and well being of children and young people and for providing high quality services that meet their needs. The Framework is divided into three parts and eleven standards. In the first part (standards 1 to 5) the Framework is dealing with general health and wellbeing for all children up to 18 years. In the second part (standards 6 to 10) the Framework is dealing with special problems

[bbbbbbb] No health without mental health: a cross-government mental health outcomes strategy for people of all ages, at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

like illness and hospitalisation, disabled children and complex health needs, and mental health problems. Part 3 (standard 11) is about maternity services. The Framework clearly states that the NHS is a key actor in achieving the outcomes set out by the "Every Child Matters" program (2003). It makes also clear that there is a cross-linking between the NHS services for children and other services serving children and young people through the Children's trusts, the Common assessment framework (CAF), information–sharing and common core of training for work-force. It makes mental health care a joint responsibility of the DH (Department of Health) and the DfE (Department for Education).

Standard 9 of the NSFCYMS addresses the mental health needs of children and young people and states the need to provide mental health services at all levels. This implies a range of services varying from universal services promoting health and providing early interventions to highly specialized and inpatient services, in a four tiers framework (see before). Organization and priorities are set out in an extensive way in the policy program.

Recent developments: No Health without Mental Health

As of 2010, general elections gave birth to a new coalition and a new Government in the UK. At the end of 2010 new guidelines and policies emerged, announcing (mental) health care organization reforms. One of those is a thorough reform of the NHS (Liberating the NHS)[ccccccc].

New strategies are announced for mental health in the paper: "No health without Mental Health, a cross-government mental health outcomes strategy for people of all ages".[ddddddd]

This strategy is directed to the general population and stresses interconnections between mental health, housing, employment and the criminal justice system. This policy also seems to apply to children and adolescents, considering them as a target group by age, of the general strategy.

One of the aims of the new policy is to extend the NHS program "Improved access to psychological therapies" (IAPT) to the target group of children and young people[eeeeeee]. Staff will be trained to an agreed national curriculum for best evidence based (NICE approved) treatments; and the capacity of existing targeted and specialist CAMHS (Tiers 2 and 3) will be upgraded.

8.5. Other sectors involved in children's mental health and wellbeing

8.5.1. Social care: Youth care

8.5.1.1. Policy level

Introduction

Children under age 18 who are provided with social care, fostering, adoption or residential care by children's services are called "looked after children" (LAC)[fffffff]. Children come into care on a voluntary basis through an agreement with their parents; parental responsibility stays with the parent in this case. If a child is in danger of being harmed, the court can make an order and the children's service acquires parental responsibility. Some services for young offenders sentenced by the Youth court are also provided under the responsibility of the social care sector (see further).

Actually, a reform of the social work is on its way. Aim of the Government is to empower social workers to do their job effectively, and to reduce bureaucracy. A Social Work Reform Board (SWRB) is set up to develop a

ccccccc http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

ddddddd http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

eeeeeee http://www.iapt.nhs.uk/

fffffff notation first introduced by the Children Act of 1989; http://www.legislation.gov.uk/ukpga/1989/41/part/III/crossheading/duties-of-local-authorities-in-relation-to-children-looked-after-by-them

national social work reform programme, covering all aspects of social work for adults and children[ggggggg]

The Every child matters (ECM) program

The "Every child matters" program (2003) and the Children act 2004 underpinning ECM initiated a shift towards a child centred approach of care. The focus of the ECM policy is on interagency working with a central role for the Children's trust; it stresses local collaboration between the health care sector (including mental health care), the social care sector, the education and disability sector and the juvenile justice sector (see before). Since 2010, the ECM-programme does not reflect the national policy anymore but many elements still influence the actual social care policy. Interagency and integrated working processes remain central policy issues[hhhhhhh].

The Common assessment framework (CAF); the Team around the child (TAC)

The Common assessment framework (CAF) and the Team around the child (TAC) are key elements in interagency integrated working. The CAF is a standardized approach for joint assessment of children's needs, used by practitioners from a range of backgrounds in the frontline services (see before). The TAC is a multi-disciplinary team of practitioners, established on a case- by case basis to support a child or young person. This team can be considered to be a "virtual" or flexible multi-agency team that will change as needs change. A Lead Professional is to coordinate the delivery of agreed actions which are expressed in one common TAC support plan. There are regular team meetings involving the child/young person. The lead professional acts as a single point of contact for the family and involved practitioners. The teams can be enlarged as Teams around the Family (TAF), or teams around the School (TAS)[iiiiiii]. So far, TACs seem to be used preferably to offer early intervention when universal, generic first tier services are not sufficient[jjjjjjj], and when at the same time most of the child's needs are at the lower level of complexity and there is no indication of statutory care because of more severe, complex needs[kkkkkkk]. Although intended to involve all types of children's services (social care, health care and mental health care, educational services etc.), the DfE took a lead role in developing the TAC teams[lllllll]. Other models to organize inter-agency collaboration at the patient level are in use as well, e.g. regular inter sector meetings at the level of a local area to discuss specific cases, to appoint a Lead professional, etc [mmmmmmm].

8.5.1.2. Services Level

Local authorities (LAs) have the main responsibility to organize or commission social care services and receive money from the central Government to realize this; they must ensure that needs in their area are met. In practice, the 354 counties are re-organized in 150 Local authorities which are in charge of social care organization and commissioning. For children and young people, several service types exist:

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ggggggg http://www.education.gov.uk/childrenandyoungpeople/safeguarding/socialworkreform/a0071063/social-work-reform-board-swrb

hhhhhhh http://www.cwdcouncil.org.uk

iiiiiii http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0068944/team-around-the-child-tac

jjjjjjj http://www.cwdcouncil.org.uk/research/projects/tac; Report: Use of the Team Around the Child model for the 11–14 year age group, Nov 2009, Social Information Systems Ltd.

kkkkkkk https://www.education.gov.uk/publications/eOrderingDownload/LeadPro_Managers-Guide.pdf

lllllll https://www.education.gov.uk/publications/standard/publicationdetail/page1/IW92/0709

mmmmmmm https://www.education.gov.uk/publications/eOrderingDownload/LeadPro_Managers-Guide.pdf

-Children's centres: generic centres for young children and their families (0-6 years), delivering, in an integrated way, a variety of professional advice and support on health and family matters from maternity up to the start of the primary school. Most centres also provide childcare and early learning programs. Access is free as are many of the services. In Children's centres, primary care trusts, LAs, Jobcentre Plus, education and child care providers, social services, and community and voluntary agencies work together to deliver seamless holistic services. The centres are managed through partnerships that represent all agencies involved in delivery as well as the users of services themselves[nnnnnnn]. Under the new Government, it is advised to direct the Children's centres services especially to vulnerable families.

-Family Information Services (FIS): centres that provide generic information, advice and assistance to parents, carers and professionals on child care and other services that they may need for children up to 20 years of age.

-Services for Looked after children: about 0.5% of the 0-18 years of age in England are in some type of specialized social care of whom 18% are in residential places. 73 % is in foster care. Some 10 per cent are placed in children's homes. The rest are cared for in a number of different settings including residential schools and placement with parents.

-Child protection services: The Local safeguarding children board (LSCB) is responsible for the local safeguarding and protection strategy and implementation; local authorities are responsible for organizing the LSCB.

8.5.2. Juvenile justice

8.5.2.1. Policy Level

In England the legal age of criminal responsibility is 10 years of age.

The justice system for minors is a matter of the Ministry of Justice[ooooooo].

Children and young persons up to 18 years old committing offensive or anti-social behaviour can be referred to the Youth Justice System. The youth justice system is built on three tiers:

Prevention for youth at risk of offending and anti-social behaviour (targeted prevention).

Pre-court: when a young person commits a first or second offence, admitting guilt, or when he is behaving ant-socially.

Youth Court: when a young person is charged by the police, after having committed further offences, or being charged with a more serious offence he/she can be referred to the Youth court by the Crown Prosecution Service (CPS). Youth Court can refer to the Crown Court if the young person is charged with a serious offence.

Targeted prevention is a key factor in justice policy. The Audit Commissions report Youth Justice 2004: "A Review of the Reformed Youth Justice System" calculated up to £80 million a year through early intervention of youth offending. A "Risk and Protective Factors" Report[ppppppp] was released indicating important problems that may lead to a young person's troublesome behaviour such as lack of education, poor family relationships, having family members or peers who have offended, and misuse of substances.

8.5.2.2. Services level

Youth offending teams (YOT) are key actors in the youth justice system. There is a YOT in every local authority in England. They are made up of representatives from police, Probation Service, social services, health, education, drugs and alcohol misuse and housing officers. Because the YOT incorporates representatives from a wide range of services, it can respond to the needs of young offenders in a comprehensive way. They

nnnnnnn http://webarchive.nationalarchives.gov.uk/20110104141502/dcsf.gov.uk/everychildmatters/about/surestart/surestart/

ooooooo http://www.yjb.gov.uk/en-gb/yjb/

ppppppp Download from: http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=58&eP=

are involved through the entire youth justice system[qqqqqqq]. They are also central in the prevention services[rrrrrrr]

Young offenders who plead guilty or are found guilty could have a Detention and Training Order (DTO) placed on them as a sentence. These can be given to anyone aged between 12 and 17. The sentence can range from 4 months to 2 years[sssssss]. The first half of the sentence is spent in custody, while the second half is spent in the community under supervision of the YOT. For more serious offences a sentence under section 90/91 can be given by the Crown Court.

Children and young people in the youth justice system can be taken in custody in:

- secure children's homes (run by the local authority's social department and overseen by the Department for Education),
- secure training centres (STC's, four private institutions under contract in England),
- young offender institutions (YOI's, run by the Prison Service and private providers, separate wings for 15-17 year-olds and 18-21 year-olds, separate units for males and females)[tttttt].

Since YOI's have lower ratios of staff than STC and Secure children's homes they are considered inappropriate for vulnerable young people with high risk factors such as mental health problems or substance abuse. Secure children's homes are generally used to accommodate young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed as vulnerable. STCs house vulnerable young people who are sentenced to custody or remanded to secure accommodation. All services related to the operation of an STC are provided on-site, including all education and training, primary healthcare, dentistry, and services to address the young person's offending behaviour (including input from mental health and social care professionals).

In all three types of custody institutes, education is compulsory. Likewise, substance abuse teams are at work in all three types of custody; PCTs (Department of Health) are responsible for commissioning these and other (mental) health services. For young people with severe mental health needs, a limited number of secure mental health beds are available, offered by 5 providers throughout England, under the responsibility of the Department of Health.

For December 2010, the population of the secure estate for children and young people for under 18 year olds was 1,918, the overall population of the secure estate for children and young people, including those aged 18 years old, was 2,091, or 80% of the available beds[uuuuuuu].

Children under 10 years of age can be placed under a Child Safety Order. If this is the case they will be supervised by a social worker or an officer from the Youth offending team (YOT). If the order is not complied with, the parent can be made the subject of a parenting order if that would be in the interest of preventing repetition of the behaviour that led to the child safety order being made.

8.5.3. Disability care

8.5.3.1. Policy Level

The competencies and services organisation for care for Children with disabilities and special learning needs belong to the DfE, along with the Department of Health. Aiming High for Disabled Children (AHDC)[vvvvvvv] is the program, jointly delivered by both departments[wwwwwww]. This program is

qqqqqqq (http://www.yjb.gov.uk/en-gb/yjs/Home.htm

rrrrrrr http://www.yjb.gov.uk/en-gb/yjs/Prevention/

sssssss http://www.courtroomadvice.co.uk/information-about-the-youth-court.html

tttttt http://www.yjb.gov.uk/en-gb/yjs/Custody/

uuuuuuu http://www.yjb.gov.uk/en-gb/yjs/Custody/Custodyfigures/

vvvvvvv http://www.education.gov.uk/childrenandyoungpeople/sen/ahdc/b0070490/aiming-high-for-disabled-children-ahdc

wwwwwww As of March 2011, the new Government launched a Green paper "Support and aspiration: a new approach to special educational needs and disability" in which a preliminary version of their new policy views is expressed; the final governmental directions will be published as of December 2011.

underpinned by the statements in the NHS framework "Healthy lives, Brighter futures", the National Service Framework of the NHS, Standard 8 (Children and young people who are disabled or who have complex health needs receive coordinated, high quality child and family-centreed services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives)[xxxxxxx], and in the DfE's Children's plan (based on the ECM policy). Until 2010, the ECM policy, including the central role of the Children's trusts, also applied to the child and adolescent services within the disability sector (see before). On the local level, the Local authorities and the Primary care trusts have to provide or organize the necessary services[yyyyyyy]. Some services are provided by the local authority free of charge, although LAs can also decide which services will have to be paid for. By 2014 the government will provide the option of a personal budget for all families with Children with a statement of special educational needs or disability, and pilot trials have been evaluated.[zzzzzzz].

8.5.3.2. Services level

Service need and access is done through a needs assessment (CAF) by the local social services, GP or health visitor, as a part of integrated frontline offer.

Special services and special education (see also section education) is provided for different types of disabilities. The main areas of difficulty or need are set out in the SEN Code of Practice, Chapter 7. They are Cognition and Learning; Behaviour, Emotional and Social Development (BESD); Communication and Interaction (including Autism Spectrum Disorder); Sensory and/or Physical Needs.

An extensive range of services is offered for the different types of disabilities[aaaaaaaa].

The Disabled Children's Access to Childcare (DCATCH) ensures access to free places or 15 hours a week for childcare for all three- and four-year olds. This is a local authority duty. From April 2011, local authorities also have the duty to provide a short break service to carers of disabled children.

8.5.4. Education system

In England, education is compulsory from the age of five to 16; the minimum age at which young people can leave learning will be increased to 18 from 2015.

8.5.4.1. Policy level

General organizing structures

At national level, the Department of Education (DfE) has overall responsibility for the central administration of all aspects of education up to the age of 18, excluding further and higher education, which come within the remit of the Department for Business, Innovation and Skills (BIS). DfE responsibilities include planning and monitoring the education service in pre-school institutions and schools. Besides this, it also ensures the provision of integrated services for children, and it brings together policy relating to children and young people[bbbbbbbb].

At local level, the responsibility for organizing publicly funded school education lies with 150 local authorities (LAs). Following the 'Every child matters' agenda and the Children act 2004 (see paragraph 8.4.1), LAs have established integrated departments responsible for education for

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089100

yyyyyyy http://www.education.gov.uk/childrenandyoungpeople/sen

zzzzzzz

https://www.education.gov.uk/publications/standard/publicationdetail/page1/DFE-RR024

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https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR147

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http://eacea.ec.europa.eu/education/eurydice/eurybase_en.php#description;

http://eacea.ec.europa.eu/education/eurydice/about_eurydice_en.php;

http://www.european-agency.org

children and young people, children's social services, and children's health and multi-agency functions.

The TaMHS project

In 2008, the former Government launched a project aiming at improving mental health outcomes of children aged 5-13 years who were at risk of, or were experiencing, mental health problems, through a school-based program[ccccccc].

The project was called TaMHS, Targetted mental health in schools[ddddddd]. The program at school had to be part of the wider first tier and specialized care and support system organized by LAs and PCTs. Typically, a primary mental health care worker, a dedicated camhs worker or an outreaching camh specialist could offer assessment and/or early intervention by brief interventions, working one-to-one or in small groups, in close collaboration with the school educational psychologist, and often operating for a cluster of schools. As of 2011, the project has been put to an end by the new Government.

8.5.4.2. Service level

Publicly funded schools are known as maintained schools. Private or independent schools also exist in England. These are non grant-aided institutions providing full-time education.

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

Support in mainstream schools can be provided by the services of Educational psychology; the SENCO (Special educational needs coordinator, a person in the school who has a particular responsibility for coordinating help for children with special educational needs); extra support from within the school (School Action Plan) e.g. help in a small group; or support from outside the school (School Action Plus Plan) e.g. a specialist teacher, a speech and language therapist etc. Sometimes special classes are provided in mainstream schools for SEN pupils. Another option is Pupil referral units (PRUs), which provide education on a *temporary* basis for school age children who may otherwise not receive suitable education. Such children may include SEN pupils, particularly those with emotional and behavioural difficulties (BESD) (although PRUs are distinct from special schools for pupils with EBD), but may also include other groups e.g. pupils excluded from school, school phobics and teenage mothers.

A small minority of children need more help than a mainstream school can provide. Special schools exist for BESD, visual or hearing impairment, severe learning difficulties. Some special schools for ASD exist, but most pupils with ASD not in mainstream schools are in special schools for learning difficulties. Specialist schools are expected to undertake outreach activity and share their expertise.

In January 2010, 92 per cent of pupils attended maintained schools (not including special schools) and 6.9 per cent attended independent schools, while 1.1 per cent attended special schools.

As of March 2011, the new Government launched a Green paper "Support and aspiration: a new approach to special educational needs and disability"[eeeeeeee] in which a preliminary version of their new policy views is

[ccccccc] http://www.chimat.org.uk/camhs/schools

[ddddddd] Learning from Targeted mental health in schools Phase 1 Pathfinders (Sept 2009); www.education.gov.uk/publications)

[eeeeeee] https://www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208027

expressed; the final governmental directions will be published as of December 2011.

8.5.4.3. Funding

LAs receive allocations in the form of grants from central government, which they are free to 'top up' with money from other sources, and which they then allocate to the publicly funded schools in their area. Local authorities decide how much money will be retained centrally for core services (like the educational psychology service) and how much will be delegated to schools (for example, funding that schools can use to provide additional support to children with special educational needs). It is for the school's Board and head teachers to decide how much of their school's delegated funding will be spent on SEN services. Special schools are funded according to local authority formulae, usually according the agreed number of places at the school, and also have delegated budgets.

8.6. Financing and funding

8.6.1. Financing models

In England, the health care system consists of a Beveridge model. Health care is provided and financed by the government through tax payments. Hospitals are owned by the government and many physicians are employees of the government.

8.6.2. Financing of health care

The National Health Service (NHS) is funded through general taxation and is run by the Department of Health. Beside the general taxation, the NHS can also raise income from patient co-payments. Next to the NHS, there are also private health providers. Patients pay for private healthcare either through insurance or when they use their services.

Health services are divided into 'primary' and 'secondary' and are provided by local NHS organizations called 'trusts'. Primary care trusts (PCT), which are responsible for commissioning health services to meet local need, are a crucial part of the NHS and they receive about 80% of the NHS budget.

8.6.3. Financing of child and adolescent mental health care

Historically, the structure of national and local government hinders the coordination between health services and other local services for children. The organizations commissioning and providing health services are part of the NHS, while school education, social services and other relevant agencies are parts of local government, to which they are directly accountable. They are only indirectly accountable to national departments.

In order to improve and integrate children's services, in 2003, Chidren's Trusts were created, which bring together functions of the local authority such as education, social services and leisure, with health services delegated by PCTs.

As local authorities and the NHS have distinct systems of financial management and accountability, new mechanisms for coordinating organizations' budgeting and accounting were developed.

With aligned budgets, "partners align resources to meet agreed aims for a particular service. Spending and performance are jointly monitored but the management of, and accountability for, health and social services funding streams are separate"[fffffffff] Funding by pooling budgets can be defined as "each partner making contributions to a common fund to be spent on pooled functions or agreed health or health-related services under the management of a host partner organization".

8.6.4. Recent developments

As of the new Government installed in May 2010, Children's Trusts have been abolished. Since Children's trusts have been established only after 2003, documents on their overall evaluation are scarce, as are documents informing on the underlying political motivations to put an end to their working. The process of developing and implementing new policy directions is still going on.

The NHS initiated financial reforms that aim at introducing payment by results (PbR); the first experiments recently started for PbR of camhs.

[fffffffff] Helen Weatherly et al. Financial integration across health and social care: evidence review, download at www.scotland.gov.uk/Resource/Doc/303234/0095107.pdf

8.7. Processes of Change

8.7.1. Motivation underlying change

Motivation for change in 2004 was on joint efforts by DfE and DH, after some traumatic events victimising children. The change was induced by policy after trials and a green paper on the case of Victoria Climbié (ECM).

8.7.2. Evaluation of process of change: an independent review

The National camhs review was ordered by the government in January 2008 to investigate recent progress in delivering services to meet the educational, health and social care needs of children and young people at risk of and experiencing mental health problems. A second task was to investigate practical solutions to address current challenges and third, methods to monitor these solutions[gggggggg].

The review was based on a literature review, focus groups with children, young people, parents and carers; visits to nine areas to review practice, and a national call for evidence. Expert groups contributed also to the review.

In the final report of the National camhs review "Children and Young People in Mind" (2008), the reviewers conclude that there was a significant progress since 2004, but that some improvements still were not as comprehensive as they could have been; 20 recommendations are made to enable further change

To follow up the review's recommendations, an independent body, the National advisory council for children's mental health and emotional wellbeing (NAC), was created[hhhhhhhh], it came to an end in March 2011. The NAC's remit was to:

- Champion the importance of mental health and psychological wellbeing and keep it as a national priority
- Ensure that the recommendations in the camhs review are effective
- Hold Government to account for its progress on implementing the 20 recommendations from the camhs review

One of the 2008 Review recommendations was to set up a national service improvement and development program. In answer to this, the DH and the DfE in 2008 commissioned the NCSS, the national camhs support service[iiiiiiii]. The work of the NCSS ceased on 31 March 2011. It worked close together with the Child and Maternal Health Observatory (ChiMat, see further). The NCSS was a highly respected team that considerably influenced change between 2003 and 2011; e.g. the NCSS legacy document on camhs commissioning is an important resource in this field[jjjjjjjj].

8.8. Efficacy

The NSFCYMS stresses the importance of monitoring and self-auditing. Several agencies deal with monitoring of outcome, improving efficacy of planning, and gathering knowledge on evidence based working, service development and service improvement. Policy evaluations to inform on the results of previous political decisions are also regularly performed.

8.8.1. Evaluation and monitoring

8.8.1.1. Outcome measurement

The Camhs outcome research consortium (CORC)[kkkkkkkk] is a not for profit collaboration between camh services across the UK (and internationally) with the aim of instituting a common model of routine outcome evaluation; over half of all services in England are members (2011). Collected data are analyzed and made available. Several scientifically validated outcome measurement instruments are used, registrating the parent and child perspective as well as the practitioner's perspective. The current core

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gggggggg http://webarchive.nationalarchives.gov.uk/20081024081225/http://publications.everychildmatters.gov.uk/ (Nov 2008)

hhhhhhhh http://nationaladvisorycouncilcmh.independent.gov.uk/index.htm

iiiiiiii http://www.chimat.org.uk/default.aspx?QN=NCSS_ABOUT

jjjjjjjj Better mental health outcomes for children and young people: a resource directory for commissioners, download at http://www.chimat.org.uk/camhs/commissioning

kkkkkkkk http://www.corc.uk.net/index.php; http://www.corc.uk.net/ (accessed June 2011)

measures are the Strengths and difficulties questionnaire (SDQ), Commission for health improvement (CHI) Experience of service questionnaire (ESQ), the Children's Global assessment scale (CGAS) and the Health of the nation outcome scales for children and adolescents (HoNOSCA), the Goals based outcomes measure (GBO), and the Teacher SDQ.

8.8.1.2. Data collection at the NHS Information centre

The NHS Information centre is developing a data warehouse compiling data from existing clinical records, among other in the field of camhs[lllllll]. Monthly submitted local data will be mapped for national submission and analysis purposes. As a "secondary uses" data set, it will re-use clinical and operational data for purposes other than direct patient care. The Camhs secondary uses data set will extract data in relation to the following key areas: demographics, background, family history, targeted needs, referrals to camh services, encounters, care planning, interventions, outcome measures, inpatient stays, presenting problems and diagnoses.

8.8.1.3. Integrated processes and interagency collaboration

Common assessment framework (CAF): the CAF is a national, common process for initial assessment to identify more accurately and efficiently the additional needs of children and young people at risk of poor outcomes, which aims to reduce duplication of assessment, produce a shared language across agencies and improve referral between agencies. This method is supposed to enhance efficacy of child-centred multi-agency (cross-sectorial) working[mmmmmmmm].

Information-sharing between professionals is also an important issue in conquering barriers of integrated working. The development of national standards for information sharing across local children's services, clear guidance for practitioners covering health, education, social care and youth offending, and creation of database or index systems to facilitate information sharing, on a legally base are important contributing factors[nnnnnnnn].

8.8.1.4. The Children's mapping service

Until 2009, the Children's services mapping (CSM), developed in 2002 and sponsored by the Government, collected and reported inter-sector data on all children's services that came under the responsibility of the Children's trusts, irrespective of which agency provided the services or how the services were commissioned or funded. All types of children's services were mapped, except schools. Collected data included what was provided, for whom, policy objectives, financial data, staffing[oooooooo]. Additionally, the CSM made outcome data collected by the CORC available through their website[ppppppp]. In 2010, the funding of the CSM came to an end, but the collected data are still available for consultation.

8.8.1.5. The College centre for quality improvement

The College centre for quality improvement (CCQI) is a national initiative of the Royal College of Psychiatrists[qqqqqqq]. The CCQI offers quality control by professional peer review, and measures services' performance against nationally agreed standards for the organisation and delivery of mental health services. The network encourages quality improvement and information sharing between peers. More than 90% of mental health services in the UK participate in the work of the CCQI. A quality network exists for inpatient camhs, for community camhs, and for perinatal mental health services.

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lllllll http://www.ic.nhs.uk/services/maternity-and-childrens-data-set/child-and-adolescent-mental-health-services-camhs-secondary-uses-data-set

mmmmmmmm http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068957/the-caf-process

nnnnnnnn http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0072915/information-sharing

oooooooo www.childrensmapping.org.uk; (accessed Feb 2011)

ppppppp http://www.childrensmapping.org.uk/topics/camhs/profile-45/

qqqqqqq http://www.rcpsych.ac.uk/quality/quality,accreditationaudit.aspx; http://www.rcpsych.ac.uk/quality.aspx

8.8.2. Efficacy of planning and camhs development from a child centred and family driven point of view: CAPA

To improve services accessibility and to engage people in change, York and Kingsbury[rrrrrrrr] developed a clinical system called CAPA, the Choice and partnership approach (CAPA)[sssssssss]. The key aim of CAPA is to privilege the young persons and family's viewpoint and choices, and to help local services manage demand and capacity. CAPA is focused on the young person and his family. The stance is collaborative and provides choices.

According to Barnes[ttttttt], the principal objectives are:

- Improve the service user experience by seeing them quickly and involving them in choices
- Improve the staff experience by managing capacity, increasing partnership with families and extending clinical skills into core capacity
- Improve the flow through the clinical system
- Reduce waiting lists (by offering Choice Appointments and Partnership Appointments to determine treatment; by offering specialist work to be done in core work time)
- Enhance partnership between multi-disciplinary teams and service users

Four basic ideas of CAPA are:

Choice (giving our young people and families as much choice as we can to engage them in our service and their change, working together on issues that matter to them)

Core and specific work (separating the clinical work we do into two segmented work streams: Core and Specific work.)

Selecting clinician for Partnership (matching the young person and family's choice of goals to a clinician with the right extended core skills to help them with these)

Job planning (individual plan with their individual Choice and Core and Specific Partnership activities described)

For the clinician there is a shift in position from an 'expert with power' to a 'facilitator with expertise'. There are 11 key components, including team job planning, goal setting, care planning and peer supervision[uuuuuuuu]

The DH commissioned the Mental health foundation in 2009 (Report 2009[vvvvvvvv]) to audit CAPA. Important findings reported by teams using CAPA were[wwwwwwww]:

- Reduced waiting times: 92% of families were seen within 13 weeks compared with the national average of 78% (camhs mapping). Families were pleasantly surprised at how quick they could get into the service
- Reduced demands on the service
- More formalised team working and better planning infrastructure
- Greater transparency for staff and families

8.8.3. Knowledge centres

8.8.3.1. The Child and Maternal Health Observatory

The Child and maternal health observatory (ChiMat) [xxxxxxxxyyyyyyyy] is a national public health observatory established to provide wide-ranging,

[rrrrrrrr] York et al, 2009, the C[rrrrrrrr] http://www.camhsnetwork.co.uk/index.htm hoice and Partnership approach, a guide to CAPA, www.camhsnetwork.co.uk

[sssssssss] http://www.camhsnetwork.co.uk/index.htm

[ttttttt] Barnes, V., 2010, Greenshire Audit report http://www.camhsnetwork.co.uk/Evaluation/local-camhs-audit.htm

[uuuuuuuu] http://www.camhsnetwork.co.uk/Basics/basics_whatiscapa.htm

[vvvvvvvv] http://www.mentalhealth.org.uk/our-work/research/completed-projects/capa/?view=Standard

[wwwwwwww] Robotham, D., James, K. & Cyhlarova, E. (2010). Managing demand and capacity within child and adolescent mental health services: an evaluation of the Choice and Partnership Approach. Mental Health Review Journal, 15(3), 22-30.

authoritative data, evidence and practice related to children's, young people's and maternal health.

This specialist observatory is part of the Yorkshire and Humber Public health observatory (YHPHO) that is a member of the Association of public health observatories (APHO). On its website the objectives are described as:

To support a co-ordinated national approach to the development and delivery of child and maternal health intelligence.

To enable easy access to high quality, up to date information and knowledge to support timely health service decision making.

To provide a single gateway and signposting service to a wide range of evidence, reliable health intelligence, expertise and support.

ChiMat acts as a support service on child and maternal health and provides tools developed by NCSS and others for improvement, decision making and commissioning of services, camhs integrated workforce planning, and it hosted the Children's service mapping.

ChiMat is, along with its other objectives also a knowledge hub on all aspects of children's, young people's and maternal health.

8.8.3.2. National Institute for Health and Clinical Excellence (NICE)

NICE describes itself as "an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health."[zzzzzzzz]

The aim is to provide guidance, to set clear standards and to manage a national database to improve health. NICE gathers evidence and information on best practice and makes recommendations to the NHS.

8.9. England: Additional documents

Table 8.2 to 8.6: Source: www.childrensmapping.org.uk; data from 2009-2010

[xxxxxxxx] http://www.chimat.org.uk/default.aspx

[yyyyyyyy] http://www.chimat.org.uk/resource/view.aspx?QN=CAMHS.

zzzzzzzz http://www.nice.org.uk/

Table 8.2: Tier 4 capacity

1 Tier 4 Capacity

Strategic Health Authority	No. Tier 4 Special Care Teams	Teams with acute inpatient beds available	Number of acute inpatient beds available[1]	Inpatient units with commssioned beds	All commissioned beds[2]	Teams with forensic beds available	Number of forensic beds available[1]	Teams with forensic beds commissioned	Number of forensic beds commissioned[2]	Teams with other inpatient beds available	Number of other inpatient beds available[1]	Teams with other beds commissioned	Number of other beds commissioned[2]	Teams with day places	Day Places	Teams with Intensive home support	Intensive home support places	Teams with Intensive foster care	Intensive foster care places	Teams with other intensive outreach	Other intensive outreach places	No. Tier 4 teams members of QNIC[3]
East Midlands	6	3	32	3	32	0	0	0	0	0	0	0	0	2	14	1	15	0	0	0	0	1
East of England	8	5	42	6	60	0	0	0	0	1	10	1	10	4	8	1	40	0	0	1	25	6
London	35	14	164	12	131	2	16	2	20	5	97	1	3	12	104	4	35	4	34	2	8	17
North East	10	6	64	6	61	2	9	2	32	1	10	2	32	2	22	0	0	0	0	0	0	11
North West	19	8	85	7	76	1	10	1	10	0	0	0	0	5	62	7	154	2	15	0	0	10
South Central	8	4	51	3	43	1	20	1	13	1	12	1	12	5	51	1	40	1	40	0	0	5
South East Coast	2	2	22	2	19	0	0	0	0	0	0	0	0	1	8	1	90	0	0	0	0	2
South West	11	5	48	5	48	0	0	0	0	0	0	0	0	5	55	1	80	0	0	3	142	5
West Midlands	9	1	8	1	8	1	20	1	20	2	29	4	49	0	0	3	32	2	9	0	0	6
Yorkshire and the Humber	9	6	38	6	40	0	0	0	0	1	6	1	6	6	60	2	32	0	0	0	0	8
No English region defined	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	118	54	554	51	518	7	75	7	95	11	164	10	112	42	384	21	518	9	98	6	175	71

1. The number of beds available on 1st November of the mapping year, taking into account the needs of patients, for example if you have a young person requiring constant observation and therefore additional nursing staff your actual capacity.
2. This is the fully funded permanent bed capacity. This number should stay the same year on year unless there are expansions or reductions in the contract.
3. A Quality Network for Inpatient CAMHS

Table 8.3: Alternatives to inpatient care (non-tier 4 teams)

Strategic Health Authority	Total number non-tier 4 teams	Intensive home support	Intensive day support	Early intervention service	Intensive treatment in foster care	Other intensive outreach
East Midlands	56	12	0	25	6	10
East of England	94	19	0	19	9	18
London	209	34	8	56	10	34
North East	65	18	1	27	10	10
North West	145	26	16	13	8	22
South Central	71	16	4	17	10	11
South East Coast	54	6	2	4	1	11
South West	74	10	2	14	8	4
West Midlands	81	14	6	19	13	10
Yorkshire and the Humber	77	13	1	12	8	8
No English region defined	13	0	0	0	0	0
Total	939	168	40	206	83	138

Table 8.4: Tier 4 forensic care

Strategic Health Authority	Teams with forensic beds available	Number of forensic beds available1	Teams with forensic beds commissioned	Number of forensic beds commissioned2	Total Tier 4 Forensic Staff (wte)
London	2	16	2	20	102.712
North East	2	9	2	32	55.250
North West	1	10	1	10	62.750
South Central	1	20	1	13	119.910
West Midlands	1	20	1	20	83.210
Total	7	75	7	95	423.832

The number of beds available on 1st November of the mapping year, taking into account the needs of patients, for example if you have a young person requiring constant observation and therefore additional nursing staff your actual capacity.

This is the fully funded permanent bed capacity. This number should stay the same year on year unless there are expansions or reductions in the contract.

Table 8.5: number of teams by team type

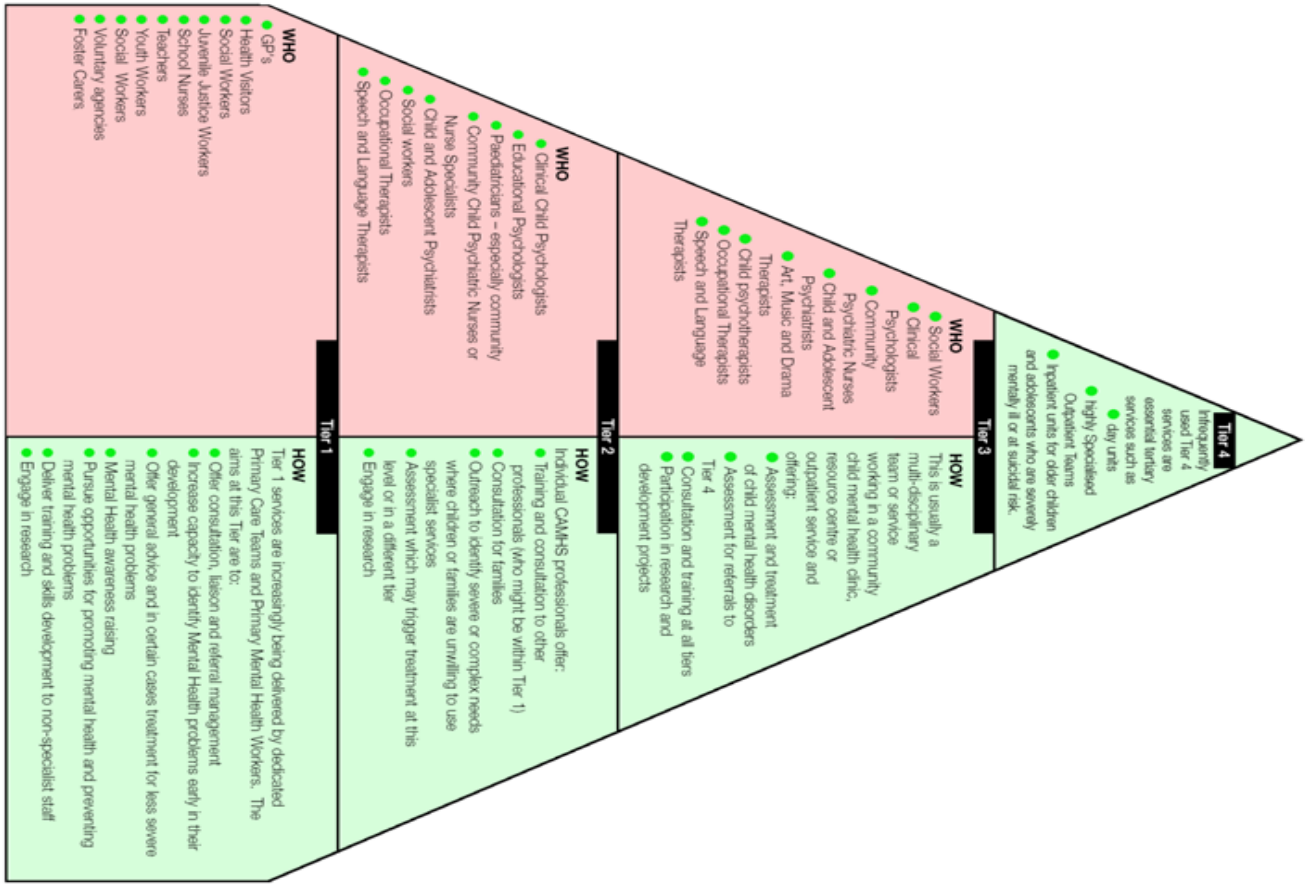
Strategic Health Authority	Generic teams	No. Targeted Teams	No. Dedicated Teams	No. Tier 4 Special Care Teams
East Midlands	31	23	2	6
East of England	48	35	11	8
London	87	87	35	35
North East	42	20	3	10
North West	71	65	9	19
South Central	44	20	7	8
South East Coast	31	11	12	2
South West	39	22	13	11
West Midlands	35	28	18	9
Yorkshire and the Humber	39	22	16	9
No English region defined	5	3	5	1
Total	472	336	131	118

Table 8.6: Types of targeted CAMHS team

Service Type	ASD and Aspergers 1	No. Targeted Teams	Abuse	ADHD	Eating disorder	Teams targeting mental health service for young offenders	Paediatric liaison	Self harm	Targeted social services/LAC teams	Mental health with mod/sev learning disability including Down's syndrome	Substance misuse	Other
Targeted CAMHS team	9	336	6	11	7	23	17	5	66	61	15	88

1.Autistic Spectrum Disorder (ASD)

Figure 8.2: Pyramid of CAHMS provision (Source: Gray, Pete and Cherry, Chris, A framework for CAMHS in school settings, Staffordshire Children's Trust, 2007, download at http://www.staffordshirechildrenstrust.org.uk/StrategiesFrameworks/)



Source: The 4 Tier model for CAMHS was originally advocated by the Health Advisory Service (1994). This adaptation is based on the comprehensiveness of provision aspired to in current local CAMHS Strategies within the West Midlands.

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