

NEW PERSPECTIVES IN CHILD AND ADOLESCENT PSYCHIATRY

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SUMMARY

Mental and behavioural problems during childhood and adolescence are a serious public concern and are increasing actually and in the next 10 years. In Belgium, policymakers have reorganize mental health care for children and adolescents in care circuits and care network that include and support intersectoral collaborations. They also support creation of mobile out-reach team for crisis and assertive care to help patient and their families in the least restrictive environment possible. Specific programs are developed for double diagnosis and disabled children but also juvenile offenders with psychiatric problems. The care network should also assure a rapid liaison function to the first line professionals.

Key words: organization of mental health – child - adolescent - psychiatry

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INTRODUCTION

Belgium spends 6% of the total health budget on mental health. The primary sources of mental health financing are social insurance, private insurances, out of pocket expenditure by the patient or family and tax based. The Flemish and French speaking communities are in charge of all non-hospital mental health care such as sheltered housing and mental health services. The Federal Government is in charge of hospitals, location of psychiatric care and quality of hospital care. Mental health is a part of primary health care system and treatment of severe mental disorders is available at the primary care level.

Belgium has a long history of community care. The city of Geel is known for the early adoption of deinstitutionalization. The earliest Geel infirmary and the model where patients go into town, interact with the community during the day, and return to the hospital at night to sleep, date from the 13th century. This practice is based on the positive effects that placement in a host family gives the patient, most importantly access to family life that would otherwise have been denied.

There is specific child and adolescent psychiatric beds in general, paediatric or psychiatric hospitals in Belgium. Since, 2002, there is also a specific training in child and adolescent psychiatry and since 2004 a new nomenclature for child and adolescent psychiatric consultations.

A new reform on mental health services had been signed by all federal and regional ministers en April 2010 with the presentation of the «guide for a better mental health through *care circuits and care network*» with a two steps application, one for adult and the second one for children and adolescents mental health.

In 2005, World Health Organisation estimated the prevalence of child and adolescent psychic problems around 20%, with 4 to 6% who need a clinical intervention for an observed significant mental disorder

(WHO 2005). Some international studies showed that only 16 to 27% of that population received specialized mental health services (Waddel et al. 2002). Care for children and adolescent with mental health problems is often intersectoral in nature so the policymakers should give incentives and guidance for intersectoral collaboration (Pumariega et al. 2003, Belfer 2007). In addition, more and more epidemiological studies indicate that adult chronic psychiatric disorders begin at the age of adolescence, explain by specific brain and neuronal reorganisation during puberty (Paus et al. 2008). Around 50% of psychiatric disorders begin before the age of 14.

Moreover, a 50% of increase asks for mental health care in child and adolescent is estimated in the next 10 years (Di Lorenzo et al. 2016)

NEW MENTAL HEALTH POLICY IN BELGIUM

The first phase of the reform concern adult population, from 16 years, and propose a global approach with 5 different functions in the care network (1. Prevention and promotion of the mental health care; 2. Acute and chronic mobile teams; 3. Inclusion and social rehabilitation; 4. Adapted acute hospitalisations; 5. Residential care). De-institutionalization, inclusion, de-categorization, intensification and consolidation are key words of the project.

The national plan for the new politic in child and adolescent mental health (CAMH) is founded on the strategic objectives of the Mental Health Action Plan 2013-2020 of the WHO (2013). The second phase of the reform was presented in May 2015 and considers specific mental health needs of child and adolescent population (0-18 years) that were not covered in the past. In addition, the CAMH care were not integrated and didn't take into account the health determinants and socio-economic context.

Different sources have supported the propositions of the new politic: the report of the “conseil national des établissements hospitaliers”; the Belgian child and adolescent mental health system and an international review of practices conducted by the “Kennis Centrum voor Evaluatie”.

MISSION AND VISION OF THE NEW POLITIC IN CHILD AND ADOLESCENT MENTAL HEALTH (GUIDE, 2015)

The new politic in CAMH is a global approach centred on C&A and their environment: parents, family but also friends, ... which integrated all the sectors and partners in the field of C&A in a collaborative way: educators and professors, social workers, juvenile justice, self-help groups, parent associations, general practitioners, paediatrician, ... Dialogue, transparency, openness, participation and implication of the C&A and their parents are essential at the different time of the decisional process. The global approach is based on bio-psycho-social references.

The CAMH care concern psychopathological disorders adapted to the developmental state. A particular attention is solicited for very young children in coordination with the professional of the maternity, the neonatology department and the paediatric services to identify and detect early signs of suffering or signs of dysfunction in the development. A specific concern is also proposed for the “transition period” (16-23 years). The new politic sustain collaborative programs with adult mental health (AMH) professionals to prevent the gap between CAMH and AMH.

The essential missions of the new politic are early detection, screening and orientation, diagnostic, treatment and inclusion in all C&A domains of life. The prevention and mental health promotion are also included in the program to prevent, as possible, a potential adult mental health disorder. It also supports the exchange and valorisation of expertise.

The out-reach interventions are promoted: each time as possible, the patient has to be treated in his own environment, so that the environmental factors are taking into account. The first line health workers had to be supported and included.

The in-patient treatment had to be reserved to acute situations, when no home treatment is possible or unwished. The social re-integration is the objective of the treatment. Specific concerns had to be done to high risk group of patients such like: double diagnosis (mental health problems in disabled children), adolescent with mental health and judiciary problems, addiction problems, child of mentally parents....

All these actions need to be coordinated and organised in a regional care network which include professional mental health (C&A mental health structure: hospital, day treatment, ambulatory care) but also intersectoral sectors (education, child welfare, youth

social care, services for disabled children and juvenile justice, parent associations, self help organisations...)

The implementation of the mental health care for C&A need to be as nearest as possible to the community by integrating mutual experience and expertise (intersectoral intervention or supervision, courses, stages, exchange of workers...). The link between each sector must be rapid and efficient.

THE DIFFERENT PROGRAMS OF CARE

To develop the new politic, each of the 8 provinces in Belgium plus Brussels had received additional financing balanced by the peculiarities of their population (index of poverty, number of youths, socio economic problems...). The development of the care network has been supported by the “Platforms” that exists since 20 years. These “Platforms” of dialogue grouped together psychiatric care structures for each region. Their objective was to highlight the study of health service research needs and to open dialogue between the stakeholders in mental health to improve the availability of care.

The first step of the project has been to realize cooperation and harmonisation within the mental health sector and the intersectoral by the creation of the coordination function of the care network. They begin their action by listed all the available resources of care in CAMH. All the mental health sectors were invited to participate (hospital, day treatment and ambulatory sectors) and sign a convention to participate to the network.

The convention include the list of the different partners, the target population group and the geographic area, the missions and objectives of the network, the engagement of the partners, the organisational construct of the network and the different procedures to adhere, to retract and to mediate conflict.

Most of the new politic is supported by new dispositive of intensive and mobile treatment teams (crisis and assertive) which intervene in the life setting of the C&A and their families.

Then, five specific programs need to be implemented in each province: the crisis program, the assertive care program, the ADHD evaluation program (one year), the consultation avec intersectoral program and the double diagnosis program.

The crisis program is supported by an out-reach team and a provision of K BED in the hospital. To promote the accessibility of in-patient care in crisis situations, 10% of the C&A psychiatric bed have to be devoted to the project with a specific crisis program of 5 to 10 days of hospitalization. Then, before and after, the continuation care had to be supported by the out-reach crisis team. E&A in an acute suffering but without life danger will be help intensively and rapidly, in a few days.

The assertive care program concern very complex situations, chronic and severe psychopathologies, which usually need recurrent hospitalization and generally with a scarce demand of help and relatively few compliance to care: youth with psychopathology and judiciary problems, addiction, double diagnosis, ... An assertive team will follow the patient and his family at home, regularly, continually, for a long period of time, in coordination with all the partners.

EVALUATION OF THE PROJECT

As the new politic in CAMH had been supported by an additional budget of nearly 12 million of euros, the politics have added an evaluation chapter to the implementation of this new practice. The method of the "patient traceur" has been choosing in the Brussels project. It's a qualitative method of evaluation that consist in a re-evaluation of all steps of the care trajectory in a partnership approach with the patient, his parents and each of the stakeholders.

In addition, the government reinforce the programs of data management to evaluate the optimization of care and the evaluation of cost/benefit of this new politic. Different researches could be added to the programs to promote knowledge in the field of CAMH.

CONCLUSIONS

The first strategic objective of the new politic in CAMH is to reinforce the leadership in the field and to promote specific and appropriate mental health care to C&A and their parents. The second one is to create a global, integrated working model with the intersectoral partners, which put the children, the adolescent and their

families in the centre of the care network. Mobile team increase accessibility to care for crisis situation but also for complex and chronic problematic.

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