

# ENOC

European Network of Ombudspersons for Children

SYNTHESIS REPORT

# Child and Adolescent Mental Health in Europe

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SEPTEMBER 2018

# ENOC

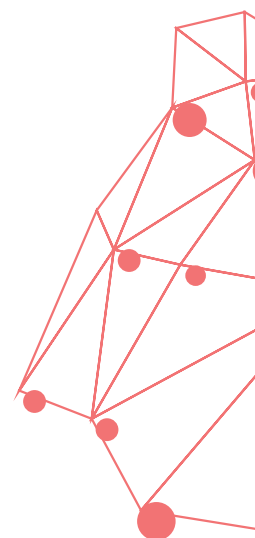
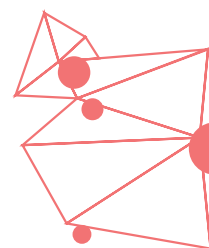
European Network of Ombudspersons for Children

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**Child  
and Adolescent  
Mental Health  
in Europe**

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# Table of contents

<b>1. Introduction</b>	05
<b>1.1</b> Presentation of the European Network of Ombudspersons for Children (ENOC)	05
<b>1.2</b> Methodology	06
<b>2. Comparative analysis of the current situation in Europe</b>	07
<b>2.1</b> A broad approach to mental health	07
<b>2.2</b> Lack of homogenous data	08
<b>2.3</b> Taking mental health into account in public policy	10
<b>2.4</b> Members facing similar difficulties	12
• Insufficient coordination of stakeholders involved despite some improved resources in schools	12
• Widening territorial and social inequalities	13
• Mental health care services organised in a way that is often complex and little conducive to early identification	14
• Services saturated with a changing demand	14
<b>3. Rights and participation of children and adolescents</b>	16
<b>3.1</b> The low consideration of the consent of minor patients	16
<b>3.2</b> A limited right to information	18
<b>3.3</b> The presence of minors in adult services	19
<b>4. Stigma and mental illness</b>	22
<b>4.1</b> Awareness raising campaigns to combat stigmatisation	22
<b>4.2</b> Children and adolescents particularly vulnerable to stigma	23
• Children and adolescents with disabilities	24
• Children and adolescents under child protection plans	25
• Unaccompanied minors	26
<b>4.3</b> Good practices of awareness raising and inclusion in society	27







# 1. Introduction

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## 1.1 Presentation of the European Network of Ombudspersons for Children (ENOC)

This report is part of the **annual programme of the European Network of Ombudspersons for Children (ENOC)** which is a not-for-profit organisation federating independent children's rights institutions (ICRIs). Its mandate is **to facilitate the promotion and protection of the rights of children, as formulated in the Convention on the Rights of the Child (CRC)**.

Founded in 1997, the mandate of ENOC is to:

- **develop strategies** for the implementation of the recommendations of the CRC;
- **facilitate information sharing and exchange** between its members;
- **at international level, promote** the establishment of ICRIs in countries where these do not yet exist and assist in their setup;
- **encourage** contact and mutual assistance between ICRIs and their members.

**A recognised partner of the European Union and the Council of Europe**, the Network comprises a General Assembly, an office and a secretariat. Members must meet a number of criteria relating to the status and functioning of the independent institution attached to a Council of Europe member State. Furthermore, the independent nature of the institution must be enshrined in law and its missions must be to promote and protect the rights of the child. Institutions may be separately constituted or attached to an independent human rights institution at regional or national level. Those which cannot give sufficient guarantees of independence or do not fulfil all the criteria for membership may under certain conditions be granted the status of associate member and thus participate in the work of ENOC.

The Network currently has **42 members in 34 States** throughout the Council of Europe area. Twenty-three of these States are members of the European Union.

### • The members of ENOC are

Albania, Armenia, Azerbaijan, Flemish Belgium, Belgium (French Community), Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Georgia, Greece, Hungary, Iceland, Italy, Ireland, Latvia, Lithuania, Luxembourg, Malta, Moldova, Montenegro, Norway, Poland, Bosnia and Herzegovina/Republika Srpska, Serbia, Slovakia x 2, Slovenia, Andalusia (Spain), Catalonia (Spain), Basque Country (Spain), Sweden, Netherlands, England (UK), Scotland (UK), Northern Ireland (UK), Wales (UK), and Ukraine.

Every year, an annual conference is held to allow members **to discuss their practices in terms of improving the rights of children in Europe** with regard to the CRC and its fundamental principles.

Moreover, the Network adopts a **joint declaration which formulates recommendations** aimed at improving the fundamental rights of children and adolescents. Past declarations have addressed migrant minors, the development of public policies on children's rights, poverty, sexuality education, etc.

For 2018, the joint working theme is **child and adolescent mental health**. Many challenges exist in this regard: improving access to mental health care services, promoting better information regarding the rights of young people in care, helping to change attitudes towards psychiatric disorders and fighting the stigma surrounding them with a particular focus on vulnerable groups (young migrants, people with disabilities, the LGBTI community, etc.), and reducing territorial and social inequalities in order to affirm the possibility of equal well-being for all.

## 1.2 Methodology

This report aims to provide a first insight into the current state of affairs in Europe regarding child and adolescent mental health.

In order to give an overview of the current situation, a questionnaire was sent to all ENOC members in February 2018. The objectives of the questionnaire are to:

- understand the definition of mental health used in the different countries and regions;
- document the organisation of public policies and national strategies pursued;
- take stock of the current situation in each member State as regards access to mental health services and respect for the rights of children and adolescents in care;
- identify good practices in this area;
- and, lastly, to collect knowledge on access to mental health services for particularly vulnerable children and adolescents.

Insufficient work has been done to establish an overview of the issue at European level, and in most cases existing data are incomplete and make it difficult to detect potential new mental health trends, particularly amid our changing societies.

The responses studied are not claimed to be exhaustive in terms of the current situation of child and adolescent mental health in Europe.

**The 25 responses received were analysed** to provide an essential basis for comparison and to give an initial insight into the current state of affairs at European level with regard to child and adolescent mental health care.

The ENOC members who completed the questionnaire are referred to in this report as the “respondents”.

This report begins with a cross-cutting analysis of the current situation in Europe by presenting the definition of mental health used in the respondents’ countries, public policies adopted to improve mental health, and the main difficulties observed in these countries (Chapter 2). The measures put in place to promote the rights and participation of children and adolescents in hospital (Chapter 3) will then be outlined. Lastly, issues related to the exclusion and stigmatisation of young people with psychiatric disorders (Chapter 4) will be addressed.

## 2.

# Comparative analysis of the current situation in Europe

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### 2.1

#### A broad approach to mental health

En the absence of a precise definition of the term “mental health”, the vast majority of the respondents adopt a definition **similar to that of the World Health Organization (WHO)**, i.e. “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

The International Convention on the Rights of the Child (CRC) recognises a right to health. Article 24 of the CRC states that: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” The right of the child and adolescent to health is subject to the realisation of all other rights enshrined in the Convention.

For the respondents, **mental health is a major public health issue**, encompassing all the ways in which psychological suffering is treated. Although a connection is made with psychological suffering, the approach adopted does not limit mental health to the consideration of psychopathology alone. Unlike in psychiatry, psychopathology is just one of the many facets of mental health, in addition to family life, education, etc., in which health care and social services are very much linked.

In Norway, the term “mental health” is also used as a comprehensive term to describe services provided to persons with mental disorders and has replaced the term “psychiatry” previously used.

The approach to mental health as adopted by respondents includes serious and severe psychiatric disorders, psychological distress that corresponds to challenging situations and existential difficulties, and the more recent notion of “positive mental health” that pays particular attention to the assertion of personal fulfilment with the dimension of well-being, which must be equal for all.

In a majority of cases, respondents report that a definition is given in the legislative framework without, however, distinctions made between age groups, with mental health texts applying to both adults and minors.

Sometimes referred to as “mental disorder”, it is then a question of considering - like Scotland - mental health as including: personality disorders, mental health, and learning disabilities.

En Ireland, the Mental Health Act, the main legislative framework in this area<sup>1</sup>, defines “mental disorder” as mental illness, serious dementia or significant intellectual disability where:

- because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons;
- because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission;

<sup>1</sup> Article 328 of the 2003 Mental Health Act.



- the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

According to the respondents, the **WHO definition makes it possible to consider positive aspects such as the notion of well-being** and to take into account the influence of environmental and social factors.

As part of the Scottish Government's 2017-2027 strategy, it therefore applies to a continuum, from emotional well-being such as happiness and sadness, to mental disorder such as acute reaction which can lead to stress, and to mental illness such as schizophrenia.

In Estonia, which defines the concept in the Child Protection Act<sup>2</sup>, the well-being of the child is seen as “the condition supporting the development of the child in which the physical, medical, psychological, emotional, social, cognitive, educational and economic needs of the child are satisfied.”

In Georgia, the 2013 Mental Health Act defines mental health as the ability of individuals, groups and their environment to interact with each other in such a way as to promote subjective well-being, optimal development and use of cognitive, emotional and relational mental skills, and the achievement of personal and collective goals that are appropriate and which enable the achievement and preservation of conditions of fundamental equality.

Bringing together the notion of well-being as well as the most serious psychiatric disorders, the approach adopted is very broad, **which makes the scope covered problematic**: what exactly is meant by “mental health”? What is mental health? Often, on initial examination, respondents note this difficulty and yet, at the same time, because the meaning of mental health appears evident at first glance, a more precise definition of it is hardly ever put forward.

The term “mental health” may therefore, in some respects, seem somewhat “catch-all” according to the respondents, which can be explained by the distinctive nature of the subject. Moreover, the notion of well-being that has emerged more recently **reaffirms the right to good mental health for all**. While this notion considerably broadens its scope, it also allows for special attention to be paid to issues related to disparities in access to care.

## 2.2 Lack of homogenous data

**For purposes of clarity:** *owing to a lack of data, respondents were sometimes unable to provide information in this area. Similarly, some responses were not supported by concrete sources.*

Given that mental health is a broad concept that encompasses a large number of aspects ranging from the notion of well-being and suffering to the diagnosis of serious psychiatric disorders, **the data available are poorly covered**. For the respondents, the very broad nature of the notion poses difficulties in terms of the availability of indicators on the subject.

**Paradoxically, despite the importance attached to this issue, mental health appears to be given little consideration in national surveys and programmes** of the countries of the responding institutions, **particularly with regard to children and adolescents**. Some also report that the indicators used by health care systems, particularly indicators on alcohol consumption, self-harm, etc., are ill-adapted to children under 16.

In most cases respondents provide data on suicides, self-harm, medication use, addiction, treatment in health care establishments and the notion of well-being. The data are incomplete and therefore do not provide a comprehensive picture of the child and adolescent mental health in Europe.

As an example, **regarding addiction**, according to a Serbian survey conducted in 2013 among 1,000 students in 3<sup>rd</sup> year of secondary education (16-17 years old on average): **alcohol consumption is significant in this population**, one in ten young people uses tobacco, 14% of young people have tried psychotropic substances, and 49% of young people reported having been intoxicated at least once.

<sup>2</sup> Article 4 of the Estonian Child Protection Act.



In terms of **suicide**, in Northern Ireland, **youth suicide rates are higher than anywhere else in the UK**. In 2012, the suicide rate among 15-19 year olds was four times higher in Northern Ireland than in England and Wales. According to the third report of the French National Suicide Observatory (ONS), suicide is the second leading cause of death among 15-24 year olds in France, after traffic accidents, and accounts for 16% of the deaths in this age group in 2014.

With respect to the **number of children receiving mental health care treatment**, data from health care system information systems provide accurate information on the number of children and adolescents who are inpatients or monitored on an outpatient basis, the number of diagnoses for mental disorders, etc.

Based on 2016 data, Montenegro reports that the number of new patients registered under the category of diagnoses of mental and behavioural disorders was **778 for children aged 0 to 14, and 1,160, for 0-19 year olds**. 786 children saw their GP for reasons falling within the category of diagnoses of mental and behavioural disorders, i.e. 0.24% of all child appointments.

In Poland, the data regarding the percentage of children with mental disorders in need of professional treatment is around 9%, which gives around 630 000 persons below the age of 18 needing psychiatric and psychological treatment, according to a 2016 report.

In the Basque Country in 2015, 9.964 children and adolescents aged between 0 and 17 (2,9% of the population in this age group) were attended in the diverse services that make up the Basque mental health network.

In Denmark, studies suggest that 10 to 15 per cent of young people are affected by difficulties related to their mental health during their childhood; and this figure is rising. More than 7000 children in 2016 have been diagnosed with anxiety or depression; they were 2354 in 2006.

The data **are sometimes difficult to compare because of the way in which significantly different health care systems function**. Equivalent care may be provided on an outpatient basis in some of the respondents' countries, while for others this care is given in full inpatient units. **This raises the question of harmonising data collection methods** to make Europe-wide comparisons.

**With regard to well-being**, a French survey shows that 10 to 15% of young people go through very difficult times that may be exacerbated by personal living conditions or problems at school.

<sup>3</sup> "Bien-être et santé des jeunes" ("Youth Well-Being and Health") mission report, Marie Rose Moro and Jean Louis Brison, November 2016 .

Between 15 and 17% of young people experience a confirmed depressive episode between the ages of 16 and 25 (and, according to studies, girls are more likely to be affected)<sup>3</sup>. Less than 10% of adolescents report having gone to see a psychologist or psychiatrist in France.

Swedish studies show that around 25% of children and adolescents often feel nervous and tense, and over 35% of 15-year-old girls have felt depressed more than once a week in the previous six months.

In Iceland, surveys conducted by the Directorate of Health indicate that the **well-being of young people as a whole is decreasing**. In 2007, 16.8% of Icelanders aged 18 to 24 said their mental health was average to poor. The percentage was 22.3% in 2012 compared to 15.8% in 2009.

**National health surveys and/or research cited by some respondents identify new trends** in terms of child and adolescent mental health.

**Concerning self-harm, several respondents report an increase in this disorder.** For example, in the last five years, Scotland has seen an increase in the number of admissions for cases of self-harm in certain parts of the country. In Northern Ireland, between 2012 and 2014, there was a 14% increase in the number of under-16s presenting to emergency departments for self-harm.

**There was also an increase in medication use**, an issue that is now a source of concern for some respondents.

In Iceland, surveys conducted by the Directorate of Health show that children and adolescents use around 20 times more tranquillizers than in the neighbouring Nordic countries. Prescriptions and medication use for Attention Deficit Hyperactivity Disorder (ADHD) are also much higher than in the neighbouring countries, with about 13% of boys aged 10-14 taking this type of treatment.

Respondents provide **data related to young people in precarious situations which reveal the prevalence of psychological disorders in this population.**

For example, in Northern Ireland, a longitudinal study currently being conducted across the UK has found that children and young people who have lived in persistent poverty are three times more likely to suffer from mental health problems by the age of 11 than those who have never experienced poverty.

The data **do not cover the different age groups**, despite the fact that respondents stress the difference in disorders according to the child's level of development. What indicators can be used on the trajectories of children and adolescents as well as on the progression of disorders? Moreover, **the data do not cover all the areas covered by mental health**: psychiatric care, positive mental health, etc.

However, providing epidemiological data in different areas of mental health can be costly, and therefore should member States be obliged to make arrangements to collect standardised data using a similar method or should efforts be made to encourage research whose results would contribute to improving knowledge in this field?

## 2.3

### Taking mental health into account in public policy

The vast majority of respondents mention the existence of public mental health policies. Usually embedded in health-related strategies, these policies can take the form of national programmes, guidelines, etc., and constitute the framework of public mental health policy. Reaffirming the WHO principle that health must be an objective of all public policies, **these policies are usually aimed at mental health promotion, prevention, care and integration, without, however, making a distinction between different age groups.**

In December 2013, the Georgian Parliament adopted the “**National Concept on Mental Health**” with a view to breaking down barriers to mental health services so that people with mental disorders receive treatment in the least restrictive environment possible, if possible in their own home or close by, based on their basic needs, and to ensure maximum protection of the rights of patients and their full and meaningful participation in society on an equal basis with other citizens.

The **new Mental Capacity (NI) Act**, which came into force in 2016, aims to merge mental health and mental capacity legislation in Northern Ireland. However, this legislation does not concern minors under 16 years of age, who are thus excluded from the new protective measures that will be put in place for 16-18 year olds and adults.

Some countries have, however, implemented mental health strategies specifically aimed at minors, such as Luxembourg, which in 2010 introduced “[a national strategy on the mental health of children and young people](#)”, one of the main objectives of which is to establish policies based on multidisciplinary strategies to improve coordination between stakeholders. Recognising the need to consider the child from a holistic perspective, the strategy pays particular attention to the participation of children and young people: “An active role must be offered to them so as to consider them as full partners, without forgetting to take their age and skills into account”.

In Ireland, recommendations from **a national working group on youth mental health known as the “National Youth Mental Health Taskforce”** involved consultation and advocacy, awareness raising and training, online support and consent issues. The Government is committed to improving early access to youth mental health services and the coordination of support services, with a focus on improving mental health knowledge and reducing incidents of self-harm and suicide<sup>4</sup>. Work on this topic continues with recommendations for a new government strategy that specifically targets the mental health needs of children and adolescents, which has been the subject of public consultation<sup>5</sup>.

The objectives pursued sometimes tend to promote access to care with particular attention to territorial and social inequalities in terms of mental health.

In 2016, the [interministerial action plan entitled “Bien-être et santé des jeunes” \(“Youth Well-Being and Health”\)](#) in France pursued several objectives including enabling professionals to better identify the signs of suffering in adolescents and refer them immediately to professionals. The plan, which was based on the conclusions of a report, led to the implementation of a trial called “The Youth Health Pass”, to facilitate young people’s access to psychologists in the private sector. Ten sessions are covered by the Assurance Maladie (French public health insurance agency), including 2 sessions with the parents. The [2011-2015 “psychiatry and mental health” plan](#) highlights **the priority given to combating inequalities in access to treatment** to improve care for people. Measures to encourage equal access to high-quality care, regardless of where a person lives and their social situation, are proposed in this framework. Lastly, in 2017, the Défenseur des enfants (Children’s Ombudsman) encouraged the public authorities to take steps to obtain the views of children and adolescents as part of work on developing the national health strategy 2017-2022.

**Sometimes defined in the context of youth policies**, mental health appears to be one of the main priorities. Its inclusion in a policy focussing on young people offers the advantage of fostering the adoption of specific measures likely to be better adapted to the well-being of children, young people and their families.

The National Youth Policy (2015) and the National Child Policy (2017) of Malta make reference to the mental health of young people and children respectively. In the context of health policy, Malta has therefore created an **interministerial strategy to promote the participation of all government ministries and bodies**. This strategy includes actions to promote the mental health and emotional well-being of young people, the fight against alcoholism and drug addiction, etc.

While mental health is a major concern in the various national strategies, **the measures adopted are sometimes poorly implemented**, with discrepancies between the stated intentions and the resources allocated thereto.

In Ireland, there has been no increase in budgets in this area. According to a 2017 report on mental health services for Irish children, “The percentage of the total health budget for mental health has decreased from 13% in 1984 to 7.3% in 2004, to the current 6.1%. This allocation of funding is in stark contrast to many other western European health care systems, such as those in France, Germany and the United Kingdom, where spending on mental health services is approximately 10% to 12% of their overall health budget on mental health services.” *[sic]*<sup>6</sup>.

<sup>4</sup> Set out in the national policy for children and young people 2014-2020.

<sup>5</sup> Entitled “Children and Young People’s Vision for Change”.

<sup>6</sup> <http://www.oireachtas.ie/parliament/media/committees/seanadpublicconsultationcommittee/reports/2017-10-18-Children-Mental-Health-Services-Report.pdf>.



In Serbia, despite a number of strategies on mental health (Strategy for the Development of Mental Health Protection; Strategy for Mental Health in Young People; National Strategy for Youth), these have not been sufficiently followed up.

In Georgia, the implementation of legislative measures is problematic and practices have not developed.

In Montenegro, an Action Plan for the Promotion of Mental Health 2011-2018 provided for the launch of activities related to mental health prevention and promotion - however, resources were not allocated to the organisers for the development of annual programmes.

## 2.4 Members facing similar difficulties

The idea of a situation that is getting worse over time is recurrent, with many similarities in the problems reported by respondents, who highlight: a lack of coordination of stakeholders with a marked separation between the social and health care sectors, widening territorial and social inequalities, difficulties in accessing specialists owing to there being too few or the uneven distribution thereof, and overly long waiting times to access specialised treatment services..

### • Insufficient coordination of stakeholders involved despite some improved resources in schools

The respondents observe that, in addition to a legal framework that can lead to compartmentalisation, care, which involves a large number of stakeholders, is provided by means of various different mechanisms with very varied professional practices as well as institutional rationales.

The Irish Ombudsperson notes, for example, **the lack of collaboration between the stakeholders involved in day centres and community mental health services (CAMHS) with other health care services**. In its 2015 report submitted to the UN Committee on the Rights of the Child, it thus highlighted a lack of coordination between child protection, mental health and disability services, sometimes resulting in inadequate care.

In Luxembourg, the various sectors have developed according to relatively compartmentalised individual operating models. **Services are created independently of each other, without national consultation, epidemiological basis, or clear criteria and procedures for creating structures.**

For some respondents, the lack of coordination between the health care sector and the education sector is particularly problematic, despite the educational community often being cited as a key stakeholder in the early detection of mental disorders in children and adolescents and the promotion of mental health.

Some countries of the responding institutions are trying to mobilise the resources available in schools to ensure coordination between the different stakeholders, including those in the educational community and the health care sector.

In Northern Ireland, for example, the “**iMatter Programme**” currently underway aims to promote pupil resilience and well-being. Teachers are provided with leaflets and posters on topics of concern to young people such as self-esteem, drug use and coping with stress and anxiety. **Lessons on “personal, social and health education” and “everyday and emotional life” are also provided.** A [Children and Young People’s Strategic Partnership](#) has also been established to promote the coordination of services for children and their families<sup>7</sup>. The main objective is to improve interdisciplinary work to better monitor the outcomes of the treatment of children and young people, and the impact of services.

In Malta, awareness raising campaigns are carried out by the Directorate for Health Promotion and Disease Prevention, school health care services and the Education Division. Awareness raising activities based on sessions on social and professional development are organised in all secondary-level classes. In each school, a counsellor is appointed to assist teachers and refer children and/or adolescents to appropriate services.

In Italy, in order to ensure school integration, the Law n. 104/1992, provides for coordinated programming of educational institutions with health, social care, cultural, recreational, sports services and with other territorial activities. The Italian Mental Health Action Plan pays particular attention to neuropsychiatric disorders in children and adolescents and it recommends an approach such as to guarantee personalized care, and continuity of care.

Among the proposed actions in the Mental Health Policy for Iceland, approved by the Parliament in 2016, is the setting up of local cross sectoral teams with local health care, municipal social services and schools, responsible for providing education, training, advice and support for parents. The Croatian Institute has launched a **health promotion programme entitled “Healthy Living”**, which was officially adopted by the government in July 2015. This programme aims to improve teachers’ knowledge and awareness in order to help them detect any disorders in pupils and ensure that these pupils are referred to care services.

## ●

### **Widening territorial and social inequalities**

The main territorial inequalities observed are: **the unequal distribution of specialists, the insufficient number of health care professionals, particularly in the child psychiatry sector, and services with long waiting times. Furthermore, inequalities related to the financial situation of families compound these issues.** In areas where care is available, some families do not have sufficient financial resources to be able to access the services of psychologists, specialist doctors or therapists. Where costs are not covered by the Assurance Maladie, families have to pay for consultations, with a gap between those who have no choice but to “wait their turn” and those who have the means and knowledge to access specialist care.

Difficulties in accessing psychiatric specialists, and more specifically child psychiatrists, are a major concern for respondents. The supply of university hospital care in terms of child and adolescent psychiatry is inadequate and suffers from a lack of means, and specialised services are no longer able to meet demand.

<sup>7</sup> Entitled “Children and Young People’s Strategic Partnership” (CYPSP).

<sup>8</sup> Introduced in 2012.

In Croatia there is a concentration of child psychiatry services in the largest cities. In order to improve the supply of care services and to offset the particularly acute shortage of specialists in this country, the Croatian Government has created a training course in child and adolescent psychiatry<sup>8</sup>.

In Estonia, there is also a shortage of practitioners in the field of mental health, particularly child psychiatrists. It is difficult to access services in certain regions (Eastern Estonia, islands and rural areas).

In Montenegro, there are no establishments for the treatment of psychiatric disorders in children and no specialised practitioners are available in this field. Treatment for psychiatric disorders in children and adolescents is administered in the countries of the region.

### ●

## **Mental health care services organised in a way that is often complex and little conducive to early identification**

**The organisation of mental health care is sometimes reported to be complex and difficult to navigate for young people and their families**, which is likely to further impede access to rights and care services.

According to the respondents, the way in which mental health care services are organised does not always seem conducive to the treatment of children and adolescents - there are many practitioners and various structures whose roles are sometimes difficult to understand, and procedures for accessing care services are often complex, particularly for families in precarious situations who usually depend on the public sector, which is largely saturated.

The way in which care is organised is not always conducive to early identification and detection, despite the fact that this priority is unanimously shared by all respondents. The respondents feel that care should be provided as early as possible to ensure better child development, reduce the aggravation of mental disorders and provide support to families. In addition to insufficient referrals to specialised structures, the responses studied sometimes point to a lack of training on identifying signs of suffering for certain professionals, such as GPs, despite their status as key stakeholders in the field of health, as well as teachers, school doctors and social workers.

In France, a trial conducted by an centre for early medical-social action (CAMSP - centre for children presenting or likely to present psychomotor retardation, sensory, neuromotor or intellectual disorders, etc.) facilitated the launch of a training course bringing together paediatricians, educators, etc., for three-day modules, to encourage the sharing of professional practices and improve early identification. At the end of this training course, positive effects were seen, in that Mother and Child Protection Centres (PMIs)<sup>9</sup> referred younger children to CAMSPs.

In the Basque Country, the Early Action services guarantee comprehensive and effective care of development disorders (motor, cognitive, sensory and language development, emotional conduct and somatic expression disorders, and developmental delay) of children between the ages of 0 and 6. These services strive for a coordinated intervention of the sanitary, educational and social services through multidisciplinary teams which allow early identification of difficulties and intervention in stages of highest brain plasticity.

In Luxembourg, the organisation of the early identification system is based on the idea that parents are the main “alerters” and frontline practitioners their main point of contact, representing the cornerstone of an early identification system.

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## **Services saturated with a changing demand**

The vast majority of respondents report a bottleneck of services resulting in particularly long waiting times for an initial consultation and an inability to provide long-term care.

While problems in accessing general psychiatric treatment are noted, they are all the more glaring with respect to the field of child psychiatry. Full inpatient units are overcrowded with insufficient specialised inpatient beds.

<sup>9</sup> The PMI is a *Département*-level service placed under the authority of the Chairman of the *Département*-level Council and charged with the mandate of protecting the health of mothers and children.



For example, in France, inpatient capacity in child/youth psychiatric units represents only 5% of full inpatient capacity, while children and adolescents monitored in these units account for 26% of all patients monitored in these facilities<sup>10</sup>.

According to the Irish Mental Health Commission, 509 admissions of children to inpatient psychiatric care units were recorded, with an average length of stay of 60 days.

In Latvia, 3.4% of children aged 0-14 were hospitalised for mental and behavioural disorders for a capacity of 157 beds in a specialised ward.

In the response studied for Estonia, of the 1,921 hospital discharges in the category of diagnoses related to mental and behavioural disorders, 198 (10.31%) involved children under 14 years of age, and 277 (14.42%) involved 14-19 year olds. Mental illness accounts for 1.62% of the total number of children under 14 treated in hospital, and 1.95% of children aged between 14 and 19.

Waiting periods for up to 18 months for treatment in an outpatient unit are reported in Iceland.

For the vast majority of respondents, this situation is also due to a **change in social demand with respect to psychiatric treatment**, and in particular to child psychiatry. Some disorders, such as hyperactivity disorder, have acquired particular clinical status, raising the level of awareness among the general public. However, medicinal treatment is often proposed to manage these disorders. As such, respondents report a sharp increase in medication use among children and adolescents. In this regard, Iceland reports that prescriptions for drugs for Attention Deficit Hyperactivity Disorder (ADHD) **are also much higher than in the neighbouring European countries**, with about 13% of boys aged 10-14 taking this type of treatment.

With regard to **school phobia**, which manifests itself in various forms and can be very disabling given that it is likely to have social repercussions after the child leaves school, the fact that it is increasingly brought to the attention of the general public has led to an increase in the number of people seeking treatment. School phobia suffers from a lack of service development, despite the fact that programmes are launched to ensure earlier intervention. According to the epidemiological data, 65% of adolescents affected are boys<sup>11</sup>. In France, for example, these young people are able to access a home education support service or special arrangements - the Personalised Education Plan (PAI), whereby the adaptations to be made to the child or adolescent's life in the facility (crèche, primary school, secondary school, or leisure centre) are established.

<sup>10</sup> <http://drees.solidarites-sante.gouv.fr/IMG/pdf/dt129.pdf>

<sup>11</sup> "Bien-être et santé des jeunes" ("Youth Well-Being and Health") report, Marie-Rose Moro, November 2016.



# 3. Rights and participation of children and adolescents

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The responses studied have provided information on the rights of children and adolescents hospitalised in health care establishments for mental and/or behavioural disorders. Despite the principles established by the CRC and the European charter on the rights of children in hospital<sup>12</sup>, which state the right to parental presence and respect for children's privacy, many difficulties are reported by European children's ombudspersons.

Current legislation rarely recognises the specific rights of minors and the provisions implemented cannot guarantee the fundamental rights of children and adolescents receiving treatment. This lack of reference to children in hospital and their rights raises questions as to the real willingness of the various legislators to provide the countries with a law capable of changing the practices of hospitals that do not respect the principles of the CRC and the European charter on the rights of children in hospital.

The difficulties reported by respondents mainly concern young people's right to consent, the right to information, the right to maintain family ties, etc. The situations in terms of admission for hospital care vary, and the presence of minors in adult services is frequently noted.

## 3.1 The low consideration of the consent of minor patients

While admission in the context of inpatient treatment is governed by a legal framework for adults, the provisions are insufficient where minors are concerned. **The notion of the consent of minors is therefore particularly delicate regarding admission to psychiatric care.**

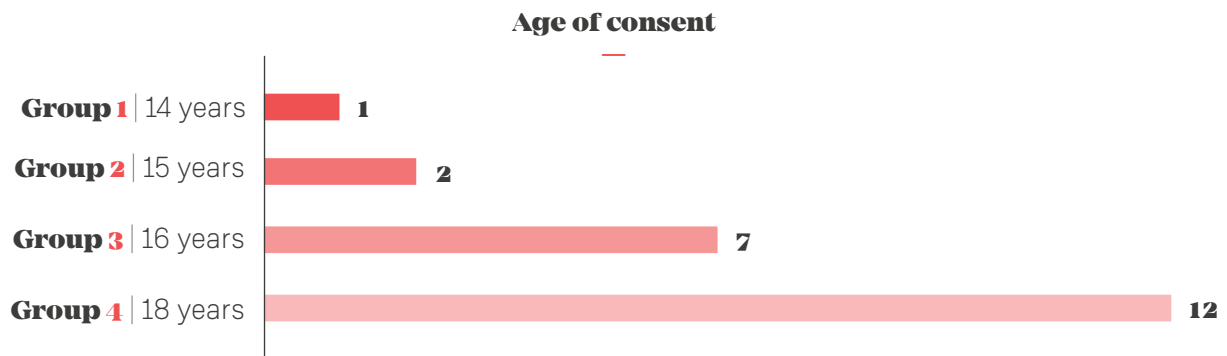
Most countries of the responding institutions do not have specific consent provisions for minors in hospital. In contrast, some subject the hospitalisation decision to the agreement of the minor patient, from a certain age, considering that involvement is an important condition in the respect of his or her rights as well as the success of the care plan. While seeking the child's opinion on the proposed treatment is sometimes difficult in the field of psychiatry, the absence of provisions enabling him or her to be consulted nonetheless seems disrespectful of his or her rights and does not guarantee effectiveness of the principles stated by the CRC, in particular Article 12, which specifies that any child capable of forming his or her own views has the right to express those views in all matters affecting the child<sup>13</sup>.

Concerning **the definition of a threshold age of consent for minor patients, practices vary as shown in the next graph.**

<sup>12</sup> Adopted by the European Parliament on 13 May 1986, leading to the adoption of the Charter of the European Association of Children in Hospital (EACH) : <https://www.each-for-sick-children.org/each-charter/each-charter-annotations>.

<sup>13</sup> 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.



**Group 1** | Latvia

**Group 2** | Denmark, Serbia

**Group 3** | Basque Country, Catalonia, Iceland, Lithuania, Northern Ireland, Norway, Poland

**Group 4** | Belgium, Cyprus, Estonia, France, Hungary, Ireland, Italy, Luxembourg, Malta, Montenegro, Scotland, Sweden

Member countries of respondent institutions that did not provide the age of consent: Croatia, Finland, Georgia.

In some countries, consent may be required from the age of 14. This is the case in Latvia where the law states that a young person gives his or her consent from the age of 14. However, in case of a disagreement, his or her parent can give consent to hospitalisation. The young person has no further recourse if the doctor and the parent agree to hospitalisation. .

Other respondent institutions state that while **the age of consent is 16, children must be consulted from the age of 12** (Iceland). From the age of 16, the minor may contest any decision taken or complain about services provided at the hospital or centre where he or she is being monitored. If the legal representatives do not consent to the treatment required, the health care service provider may request assistance from the child protection authorities, in order to provide a child with necessary health services.

**Scotland recognises that a minor under 16 years of age has the legal capacity to consent on his or her own behalf to any surgical, medical or dental procedure or treatment<sup>14</sup>.** Where a child under the age of 16 is unable to understand the nature and possible consequences of the procedure or treatment, the legal representative may make decisions in terms of care. If a child does not want to accept treatment, an order under the 2003 Mental Health Act can be made to require the child to accept the proposed care.

The responses studied show that **hospitalisation decision is in most cases made by legal representatives**, and it is sometimes requested by the management of a child protection institution or judicial authority. However, admission procedures do not always offer sufficient guarantees. The hospitalisation decision may be pronounced without a clear demonstration of the need for hospitalisation in view of the seriousness of the disorders.

In Ireland, no consent of the minor is required in the 2001 Mental Health Act. Recommendations have been made on this topic by the Law Reform Commission of Ireland. The Committee considered that the practice of admitting a child “into voluntary care” (or free choice care), solely on the basis of the consent of the legal representatives, is contrary to the rights of the child and in particular to the principles set out in the CRC. Furthermore, the provisions of Article 25 of the 2001 Act, which provides for forced admission, are not suitable for children and adolescents in legal custody.

[The Ombudsman for Children in Sweden has criticised the situation of children and adolescents in hospital.](#) According to Chapter 6 of the Swedish Children and Parents Code, the legal representative has the right and obligation to take decisions including decisions on medical care to be given to the minor, without taking into **account the level of maturity of children**, in particular where adolescents are concerned.

<sup>14</sup> Article 2 of the Age of Legal Capacity Act.

This type of difficulty is also noted in Georgia. According to the Georgian Mental Health Care Act, **patients under 16 years of age are placed in voluntary hospital care at the request of legal representatives**. The signature of the consent form is sufficient for a psychiatric facility to consider a child's treatment as voluntary, even if the patient under the age of 16 objects to being hospitalised. This regulation is widely criticised, particularly by health care professionals.

In Poland written consent of a minor's statutory representative is required. If the minor is over 16, their consent is also required. If these declarations contradict, court decision is required.

In France, **no provision specifically addresses the consent of the minor in psychiatry**, as the law does not set an age and uses vague concepts such as “maturité” (“maturity”), “l'aptitude à exprimer son opinion” (“the ability to express his or her opinion”), etc.<sup>15</sup>. As such, consent must be sought but is not a requirement for admission of the minor<sup>16</sup>.

In Belgium, the “Law on Patient Rights” provides that a minor who is considered capable of a reasonable judgement of his interests has the right to information and the right to decide on a treatment, even if there is no set legal age.

## 3.2 A limited right to information

Health care professionals' obligation to inform is intended to enable patients to make free and informed choices, and entails placing greater emphasis on patient autonomy and informed consent. By way of a reminder, Article 12 of the CRC recalls the right of every child and adolescent to express his or her views in matters affecting him or her, whether these matters be collective or individual. The provision of information to, and consultation with, children and adolescents on issues that directly affect them can encourage their involvement in their own health.

According to the European charter for children in hospital, the right to information must “*promote the participation of minors and adults under guardianship in making decisions affecting them, and they should be informed of the procedures and examinations required for their health care, according to their age and ability to understand, independently of the essential information given to their legal representatives.*”. However, the text does not specify the way in which practitioners should inform children and adolescents for this information to be as appropriate as possible.

In practice, minors' right to information is insufficiently implemented, particularly in the field of health, as it is in most cases aimed at legal representatives. Despite approaches that vary from one country to another, the responses studied show that the right to information is enshrined without there actually being **specific provisions regarding the provision of information to minors in the field of psychiatry**, which is the only medical discipline in which a person can be treated against his or her will.

Some respondents clearly state that minor patients have **no rights to information and are therefore not involved in care**, which severely limits their rights. In this respect, respondents were able to identify practices that often deny minor patients the right to express their views, with some health care teams even considering that “young people are incapable of telling an objective truth”. In these cases, information is only provided to legal representatives.

Countries of responding institutions have implemented provisions aimed at guaranteeing a right to information regardless of age. The terms of these provisions vary; in Belgium, information must be given to patients “in clear and understandable terms” and “provided on time”, while in France it must be “clear and honest”, etc. In Denmark, in a study from 2013 by the National Council for Children, children using psychiatric services have claimed not feeling informed enough on their rights as patients.

**The provisions are vague in terms of the content of information in the field of psychiatry**, and in practice, patient information depends on the good will of health care teams.

<sup>15</sup> “[Les droits fondamentaux des mineurs en établissement de santé mentale](#)” (“The Fundamental Rights of Minors in Mental Health Institutions”), Contrôleur général des lieux de privation de liberté (CGLPL), November 2017.

<sup>16</sup> Article L 1111-4 of the French Public Health Code .

**In Finland, minor patients are notified to some extent but there is no legal obligation to date.** Work is underway to formulate recommendations for improving children’s and adolescent’s right to information. The objective is to provide them with clear medical information adapted to suit the level of maturity of children and adolescents for better adherence to care.

In Sweden, children and young people consulted by the Children’s Ombudsman reported **a lack of information in the planning and delivery of psychiatric care** proposed. **Information on their rights did not seem sufficient to the young people.** The Swedish Ombudsman alerted the government so that measures could be taken to clarify the legislation.

**Information is provided to legal representatives and minors via health care teams** (primarily nurses), however, as in the case of Malta, minors are not necessarily informed of their full rights in the absence of any real obligation to do so.

When a child is first hospitalised, Icelandic health care teams hold interviews with the representatives and the minor to build trust and ensure that relatives are informed of the hospitalisation arrangements and play an active role in the care given.

In France, teams have set up “parental guidance” sessions, which bring together legal representatives and nursing staff, and whereby information is provided on the care that the child will receive, in order to reassure relatives. However, these teams are not sufficiently deployed throughout the country.

In Cyprus, a brochure on the rules regarding hospitalisation is given out to the parents of minors with severe mental disorders upon admission. This brochure does not, however, seem to be a sufficient communication tool.

### 3.3 The presence of minors in adult services

The presence of minors - primarily adolescents - in adult services is not uncommon. **This situation is inherent in the lack of appropriate structures and the shortage of child psychiatry beds**, with some regions having none at all. Young people are hospitalised in conditions that do not always guarantee their best interests or ensure that care is provided in age-appropriate services with professionals trained in child psychiatry.

Usually put in individual rooms to ensure their safety and to prevent them from being exposed to adult patients in a critical condition, young people may sometimes find themselves in isolated rooms. Respondents report that minors and adults are sometimes put in rooms together, which goes against the best interests of minor patients, the protection of whom is problematic in such conditions.

**There are other reasons explaining the presence of minors in adult services.** For most respondents, the case of young people approaching the age of majority can be problematic as they are at the crossroads between the child and adult care systems. This can result in individuals being unsuitably placed in adult units. Lastly, minor patients may be admitted to adult units while waiting for a place to become available in a child psychiatric unit.

According to respondents, in practice, people as young as 16 may be treated in adult units. In this respect, it should be noted that under the CRC, a child is a person under the age of 18. The average duration of admissions in adult units is shorter than that of admissions in child units; it rarely exceeds 15 days.

The Department of Health in Northern Ireland has stated that **children and young people should have treatment and care delivered to them in an age-appropriate environment** to meet their physical, emotional, social, spiritual, educational and psychological needs<sup>17</sup>.

In 2011, following visits to psychiatric hospitals, the **Estonian Children’s Ombudsman made recommendations** to ensure the treatment of minors separated from adults, restrict the practice of restraint, and encourage young people to maintain contact with the outside world (legal representatives, siblings, friends, etc.).

<sup>17</sup> A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community (Stratégie pour les services de soins pédiatriques assurés dans les hôpitaux et au niveau local) (2016 - 2026).

A public inquiry by the Swedish Children’s Ombudsman has given rise to a **bill which prohibits the admission of children into adult psychiatric facilities** except in cases where it is deemed that this would be in the best interests of the child.

In France, the texts that advocate the admission of children and adolescents into hospitals take into account variable “age limits”. However, hospitals usually ensure that **children are admitted to child psychiatry and paediatric units up to the age of 15 years and three months, and up to the age of 18** depending on their pathology. In its annual report on the rights of the child for 2017, the Children’s Ombudsman recommended “*that the Minister of Health define in a legislative provision the threshold age of 18 for admission to an adult unit, regardless of the service concerned, unless an adolescent requests otherwise*”. **The report stresses the need to avoid hospitalisation of minors in adult psychiatric units and advises organising units** for adolescents within hospital services for the establishment of a youth-specific care network.

In Belgium, a young person can be admitted to an adult unit from the age of 16 depending on needs and the availability of places. In order to guarantee appropriate care for these older adolescents, hospitals sometimes offer care units for adolescents, deeming that this age group requires specific care.

In Italy, because of the shortage of beds (there are only 325 beds at the national level), some regions have accepted that young people older than 16 years can access adult services. However, this can also happen for young people who are less than 16 years when no other solution can be found. In this way, depending on the region, between 10 and 30 % of intakes of minors are done in an adult service.

In such situations, however, the appeals available to minors and their legal representatives are limited and sometimes unknown to those who could potentially use them. Several types of appeals are possible: administrative appeals before the authorities responsible for supervising health care establishments; judicial appeals (such as the juvenile court judge). Lastly, in most cases, individuals appeal to the independent administrative authorities for the defence of children’s rights. These are the competent authorities for dealing with any situation where there is a possible infringement of the rights or best interests of the child, including mental health complaints.



# 4. Stigma and mental illness

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People with mental disorders are still too often stigmatised and children are not spared from the taboo surrounding mental illness. **Children and adolescents face many prejudices that fuel stigma and even discrimination.** Furthermore, the stigma surrounding mental illness may lead people not to seek the help they need. Families may then give up on care for fear that their child will be “blacklisted” and tarred with the stigma associated with mental disorders. Mental health stigma is a **common source of concern for respondents.** Children and adolescents in vulnerable situations (disabled, migrants, etc.) who are more exposed to these issues need special attention. According to the respondents, **schools play a pivotal role in mental health promotion** in order to raise awareness among young people and change perceptions of mental disorders. In order to guarantee the inclusion of children and adolescents in society, a **wide range of initiatives has been launched** both at the political level and by associations within the countries of the responding institutions.

## 4.1

### Awareness raising campaigns to combat stigmatisation

Despite advances that have led to a better understanding of mental health, stigma against people with mental disorders persists. In recent years, the fight against discrimination has been a major challenge and is now a subject of research in the countries of the responding institutions.

Many initiatives at international and European level have been launched to combat stigma and improve well-being. For example, the [WHO European Ministerial Conference](#)<sup>18</sup> focused on combating the stigmatisation of people with mental disorders, which it considers to be a major problem. The WHO recognises the need “to meet the needs of the population, at-risk groups (including children and adolescents), and individuals with particularly diverse mental health problems.” The [European Mental Health Action Plan 2013-2020](#) reaffirms the principle of equal well-being for all and encourages the launch of measures to change the way people with mental disorders are viewed.

Programmes have thus been developed in various forms depending on the country: generalist campaigns to change perceptions of mental disorders, mental health promotion initiatives, websites with information for the general public, declaration of a day dedicated to the rights of people suffering from a mental illness, consultation of the general public, etc. The objectives are to ensure better inclusion in the community, change care practices and disseminate information to users.

As such, in Croatia, the 6 June was declared “Day of the Rights of Persons with Mental Disorders in the Republic of Croatia”. As part of the “Ensuring optimal health care for people with mental disorders” project, over 275 mental health practitioners received training in the form of workshops.

As part of the Master Plan on Mental Health and Addictions in Catalonia, a survey collected peoples’ perceptions with regard to people suffering from health problems. Public policies support this type of initiative, in most cases launched by NGOs and/or associations specialised in the field of mental health.

In France, the psychiatric/mental health plan for the period 2011-2015 aimed to reduce the stigmatisation at the time considered likely to prevent people affected from seeking help and receiving treatment<sup>19</sup>. Public establishments such as “*Psycom*” carry out initiatives to provide information to users and practitioners. This has led to the **publication of tools and training modules for professionals**

<sup>18</sup> Helsinki (2005).

<sup>19</sup> Plan psychiatrie et santé mental (Psychiatric and Mental Health Plan), 2011-2015.

**working with young people** (educators, teachers, nurses, etc.) based around a guide entitled “*la tête dans les nuages*” (“[Head in the Clouds](#)”). In 2005, the [the WHO Collaborating Centre for Research and Training in Mental Health \(WHOCC\)](#) launched, in partnership with stakeholder associations,<sup>20</sup> an awareness raising campaign entitled “*Accepter les différences, ça vaut aussi pour les troubles psychiques*” (“*Accepting differences also applies to psychiatric disorders*”). The aim was to encourage a change in the general public’s perception of mental disorders (posters, TV ads, information leaflets, etc.).

In 2016, a **mental health promotion project was launched in Iceland by medicine and psychology students**, with the aim of helping young people to be stakeholders in their health and to promote their well-being<sup>21</sup>. An awareness raising campaign funded by the Ministry of Welfare (health and social affairs) is currently being developed.

A national campaign entitled “ONE OF US: no more doubt, silence and taboo about mental illness!” has been launched in Denmark by the Health Authority in order to improve the lives of all by promoting inclusion and by fighting against discrimination based on mental health.

Funded by the Scottish government and the British [Comic Relief](#)<sup>22</sup>, Foundation, the “See Me” programme **focuses on three specific areas**: education and young people, access to health care and access to employment. A survey conducted alongside this programme highlighted that two-thirds of people in Scotland feel they have no one to talk to when it comes to personal problems such as mental health<sup>23</sup>.

In 2017, a public campaign entitled “**Stopstigma**” was launched in Malta to raise awareness and **disseminate information on mental health and health issues**. Local NGOs who are very active in this field are working to reduce stigma by means of raising public awareness.

In 2016, the Irish programme “[Time to change](#)” created a training kit to help reduce discrimination against people who use mental health services. “Time to Change” was developed in partnership with mental health stakeholders and patients with a view to changing professional practices. A website contains information with support documents which can be used in the context of supervising health care teams.

According to respondents, while there are many initiatives that go beyond declarations of principle, **these initiatives lack coordination and are impeded by a shortage of dedicated resources, which limits their impact**. Nonetheless, they do help to raise awareness and to reaffirm the principle of non-discrimination in the field of health.

## 4.2 Children and adolescents particularly vulnerable to stigma

General comment No. 15 of the UN Committee on the Rights of the Child states that “children in disadvantaged situations and under-served areas should be a focus of efforts to fulfil children’s right to health. States should identify factors at national and subnational levels that create vulnerabilities for children or that disadvantage certain groups of children. These factors should be addressed when developing laws, regulations, policies, programmes and services for children’s health, and work towards ensuring equity.” This declaration highlights the particular attention that the various Member States should pay to children and adolescents in particularly vulnerable situations who face multiple disadvantages and who are particularly at risk of being stigmatised and even discriminated against.

The situation of children and adolescents in particularly vulnerable situations is a source of concern for respondents, as this population is more at risk of mental health problems. Children with disabilities face many disadvantages with services that are not able to meet their specific needs. With regard to migrant children and children in precarious situations, the respondents’ work highlights a higher prevalence

<sup>20</sup> Fédération nationale des patients en psychiatrie (French Federation of Psychiatric Patients - FNAPSY), the Union Nationale des amis et familles de malades psychiques (French Union of Friends and Families of Psychiatric Patients - UNAFAM) and the Association des Maires de France (French Mayors Association - AMF)

<sup>21</sup> <http://gedfraedsla.is/>.

<sup>22</sup> This programme is run by the Scottish Association for Mental Health and the Mental Health Foundation.

<sup>23</sup> <https://www.seemescotland.org/about-see-me/>.



of mental disorders primarily due to their economic and social situation. Let's not forget the situation of young LGBTI people or those in precarious situations for whom we do not have enough information from the responses to present an analysis in this report. As such, these children and adolescents are disproportionately at risk of being stigmatised and are in particularly vulnerable situations, at risk of exclusion and have problems accessing rights.

## ●

### **Children and adolescents with disabilities**

The shortage of professionals working in specialised establishments that receive children and young people with disabilities is particularly acute in this field. This lack of specialised services puts a strain on the capacity of medico-social establishments to receive patients. There is also a lack of training for health care professionals, which impedes the early detection of disorders. Sometimes, owing to overly long waiting times or a shortage of spaces in dedicated structures, children and adolescents are treated in psychiatric units. These difficulties reinforce the inequalities of access to care faced by this population.

According to the Croatian respondent, the main problems are: a lack of professionals trained in child psychiatry, insufficient financial resources, discriminatory behaviour, a shortage of hospital beds for acute and chronic treatment, waiting times for treatment in the medico-social sector, etc. For example, at the Split Clinical Hospital Centre, **children with disabilities have been admitted to psychiatric units due to a lack of specialised services.**

Sometimes, **the marked separation between the health care and medico-social sectors can make it impossible to provide care as part of a comprehensive approach suited** to the needs of young people with disabilities.

In this respect, the response studied for Northern Ireland reports **a lack of coordination of the stakeholders involved in support measures** for the transition from services for minors to services for adults. Professional practices sometimes appear inadequate and do not guarantee informed decision-making for children with disabilities. More generally, many children with disabilities feel that their **views are not legitimately taken into account**, particularly in regard to their health. According to the respondent from Northern Ireland, it is estimated that 20% of children and young people with physical, sensory or learning disabilities suffer from mental health problems by the age of 18 and are more likely to experience anxiety, depression, self-harm and suicidal thoughts than other young people. Research carried out on children receiving treatment has indicated that those with physical or intellectual disabilities have limited access to specialised mental health and therapeutic services.

In France, for children with specific language and learning disorders, also known as “DYS” disorders, the National Health Authority (HAS) has published recommendations to improve their health pathway. The HAS underlines that the treatment of these disorders must be based on cooperation between a range of practitioners: psychologists, speech therapists, psychomotor therapists and occupational therapists. “DYS” health networks have been created to improve the care of children and adolescents aged 0 to 20 with language and learning disorders such as dysphasia, dyslexia-dysorthograpia, dyspraxia, reasoning disorders, etc. However, these networks, which are designed to ensure coherence in interventions among this population, are not present throughout France.

**With regard to autism spectrum disorders (ASD), many issues have been detected in France.** Reports have highlighted the limited capacity of medico-social establishments, both in terms of the number of children with ASD received in Belgium and with respect to waiting lists. Facilities providing care such as day hospitals, medico-psychological centres (CMP) and independent practitioners are insufficient in number and their practices are heterogeneous. The continuing training offered to professionals in the health care sector and to social workers is not always in line with the current state of knowledge in the field of autism. A [2018-2022 National Strategy for Autism](#) was presented by the French Government in April 2018, revolving around five major commitments: putting science back at the heart of public policy concerning autism by endowing France with research of excellence; intervening as early as possible with regards to young children; catching up with other countries in the area of education; supporting the full citizenship of adults and, lastly, supporting families and recognising their expertise.



## Children and adolescents under child protection plans

According to the responses studied, health is inadequately taken into account during the various phases of the pathway of children under child protection plans. In most cases, these children are taken into care due to living conditions that are not conducive to their healthy development and with life courses marked by repeated family breakdown. **Despite their greater health needs, this population does not always have access to mental health services.** A prevalence of mental disorders is, however, observed among children and adolescents placed under child protection plans. Nonetheless, the demography of child psychiatry professionals leads to long waiting times, which are not compatible with the early age from which this population ought to start receiving treatment.

According to the responses studied, **the way in which mental health care is organised is not suited to the needs of these children and adolescents.** Their mental health needs are complex, yet child protection professionals receive little or no health care training, because they feel it falls outside of their job description. Moreover, this population is highly mobile due to changes in placement and living arrangements that are transient, making continuous care difficult.

In Northern Ireland, **mental health and behavioural problems are considered to be the most common health problems among children and adolescents under child protection care**, 40% of whom have been diagnosed with behavioural disorders, 35% with emotional disorders, and 21% with depression and anxiety. The response also shows that **mental health training is inadequate among child protection stakeholders. These stakeholders do not, however, receive initial training that would enable them to better understand the nature of mental health problems**, detect signs of psychological suffering and refer children and adolescents to appropriate structures.

In Luxembourg, mental health training is only provided to professionals in the sector; host families are currently unable to do this training. A lack of resources means that establishments that receive these children are unable to recruit an in-house psychologist, despite needs highlighted by professionals in the sector.

The Catalan Government has set up a **special coordination programme to improve the tools of educators and families** involved in the child protection system. A specific work area is planned to help protection centres via the region's mental health services by sharing professional practices and improving coordination between the different sectors. Medical and psychiatric care is generally provided by the territory's primary care centre.

In Sweden, between 3 and 4% of children are placed in foster care or group care at least once in their childhood. Research has shown that these children are more vulnerable to suicide risks, mental health problems, addiction, etc. Young people who experience psychological suffering, as well as other mental health problems, often do not seek help for these issues.

In France, **work by the Défenseure des enfants<sup>24</sup> has brought to light the fact that background health information such as developmental disabilities, psychological suffering and disability is not systematically gathered**, even in the case of a minor requiring specific care from the beginning of his or her placement. The tools available to child protection professionals are not used owing to time constraints or because they are not appropriate to professional practice. Educators find it difficult to take health - and more specifically, mental health - into account as an aspect to be considered. For the vast majority, this is an area reserved primarily for health care professionals. As such, few projects are initiated in establishments that address the notion of well-being and "taking care" of young people. The appointment of a "child protection" referring doctor provided for in the Act of 14 March 2016 on child protection should make it possible to pay particular attention to the mental health of children and adolescents in care.

In Iceland, foster families do not receive **mental health training**. Courses focus **on children's maturity and ways to ensure that the child forms a bond of trust** with the family. Specialised mental health services are not provided in foster homes or child protection centres. Local child protection committees often have to rely on the private sector to provide appropriate care.

## ● Unaccompanied minors

**The mental health aspect is very rarely taken into account in the context of the pathways of unaccompanied minors (UAM), even though the different stages of the migratory process can be traumatic.** A large majority of these young people come from Africa and have suffered serious physical and sexual violence during their journey. As such, the symptoms of unaccompanied minors are marked by numerous traumatic episodes - violence in the country of origin, during the migratory journey, particularly when going through Libya, arriving in Europe, etc. The most common psychiatric disorder in these minors is post-traumatic stress disorder (PTSD). This disorder combines severe emotional disturbances, dissociative symptoms, somatic manifestations, alterations in self-perception (guilt, shame, etc.), in relationships with others (mistrust, re-victimisation, hetero-aggressiveness), etc. This disorder is often compounded by high levels of anxiety and depression. The risk of chronicisation of these disorders in the absence of appropriate care is therefore high.

Unaccompanied minors are primarily considered in terms of their administrative situation to the detriment of any consideration being given to their minor status. The right to health is compromised, the main concern being to manage the administrative situation.

For example, in France, many young migrants who claim to be minors but who are deemed to be adults by the reception and assessment system are unable to benefit from **the child protection regime** and find themselves in precarious situations, with no fixed abode or means to feed themselves properly. This has a significant impact on their health and considerably increases their anxiety.

The data available in the UK and clinical observations from Northern Ireland highlight how few minors use mental health facilities<sup>25</sup>. These minors face problems in accessing universal health services such as GP services and specialised mental health services.

In Iceland, any unaccompanied child applying for international protection is received by **an expert who interviews the child in order to assess his or her protection and support situation and needs**. Under Iceland's Aliens Act, any child protection committee practitioner involved in working with an

<sup>24</sup> [Decision No. 2017-235; 2017 annual report on the rights of the child](#).

<sup>25</sup> See the Northern Ireland Trauma Services Network publication of February 2018.

unaccompanied child must take into account the child's nationality, gender, language and religious and cultural background. If the applicant is in a vulnerable position, he or she must ensure that a professional with appropriate skills and experience handles the case. However, these various aspects are not always taken into account and cannot guarantee the best interests of children.

In Malta, reception centres offer health support measures, including the appointment of a social worker to monitor unaccompanied minors. **In cases of urgent and/or serious medical problems, the Maltese Children and Young Persons Advisory Board finances consultations and screening in private sector clinics with psychologists and psychiatrists.**

### 4.3 Good practices of awareness raising and inclusion in society

Primarily led by associations, initiatives (or good practices) **demonstrate a willingness to pay particular attention to the fundamental rights of people with mental disorders.** They aim to implement prevention measures by distinguishing the three levels of prevention defined by the WHO<sup>26</sup> and to establish networks for care adapted to the needs of minors and of legal representatives for parenting support. They can sometimes result in measures to promote better inclusion of people in the community in various aspects of daily life such as school, housing, employment, citizenship, etc.

Nevertheless, **these actions are not always assessed in order to measure their impact.** Indeed, their impact may seem minimal, and they are therefore incapable of bringing about large-scale change based on targeted objectives. Often implemented on a one-off basis, these actions struggle to last in the long term, despite all the best efforts of practitioners who come up against the non-renewal of funding for the continuation of projects.

A Maltese mental health NGO provides mental health promotion training. **These training courses, based on international guidelines, aim to inform the general public** on how to help someone who develops a mental health problem. An office was opened by the NGO to improve the professional practices of teams working in child protection services in Malta. This office provides information tools to promote child and adolescent mental health.

Sometimes designed to **tackle territorial inequalities in access to mental health care**, innovative programs have been launched in Finland that provide psychological assistance via videos to help GPs who practise in remote areas to identify signs of psychological suffering.

In terms of parenting support actions, the Estonian Government has funded the [“Imelised aastad” \(“Incredible Years”\) parenting programme](#) for the period 2014-2017. Local municipalities are encouraged to offer parenting support actions to legal representatives in difficulty in their daily lives. A platform that provides information on parenting called [“tarkvanem.ee”](#) (“smart parents”) gives advice in all areas of children's education, including mental health (bullying, risky behaviour, etc.). Parenting support actions are diverse, they are in most cases created with representatives and aim to encourage the involvement of legal representatives and provide spaces for mutual support.

Introduced within the framework of the French law of 2005 on people with disabilities<sup>27</sup>, [groupes d'entraide mutuelle \(\(Mutual Aid Groups - GEM\)](#) **are peer support mechanisms whose objective is to promote integration in the community, to fight against isolation and to prevent the social exclusion of people in highly vulnerable situations** owing to their disability, including psychological disabilities. Organised as associations and made up of people with similar health problems, GEM provide a space for exchange for mutual support in issues faced, primarily in terms of social, professional and community integration. Atypical and non-medicalised, these groups aim to combat the severance of links when patients are discharged from hospital and reduce re-hospitalisation rates by facilitating social reintegration.

<sup>26</sup> The three types of prevention distinguished by WHO are: primary prevention, which aims to minimise the risk of a disease breaking out, secondary prevention, which aims to reduce the prevalence of a disease in the population, and tertiary prevention, which occurs once the disease is fully blown.

<sup>27</sup> Act No. 2005-102 of 11 February 2005 on equal rights and opportunities, participation, and citizenship of people with disabilities.

In Northern Ireland, the “**Express Yourself**” programme for young people aged 14 to 18 enables mental health and well-being practitioners to provide training in schools, whereby participants receive first aid certification in mental health. This approach aims to enable teachers and students **to become mental health ombudspersons in their schools** putting into practice what they have learned at school.

**Anti-bullying campaigns** have also been set up in Finland ([Kiva program](#)) and in Croatia, where the “It’s not cool to be a bully” campaign raises awareness of risk and protective factors in the prevention of peer violence.

Furthermore, Iceland is one of the few countries that have **reported the implementation of a measure to monitor young people’s school progress after they are discharged from hospital**. The “*Advisory Division*” carries out follow-ups with young people and provides assistance and information to local school employees when needed.

Lastly, the Basque Country (Spain) has set up **educational therapy centres** resulting from collaborations between education and health care services. These therapy centres are aimed at school-age children and adolescents with serious psychopathological problems likely to hinder their participation in school activities and their social and family integration. They provide therapeutic and educational care for a fixed period of time with the goal of reintegrating children and adolescents back into their school. Each integration process is tailored to individual needs. The advantage of this schooling is to provide triangulation that is beneficial for the child.





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