European Parliament Interest Group on Mental health, Well being and Brain Disorders

Tuesday 24 April 2012, 12.30 - 15.00

Mental Health and Well-being in Children and Adolescents

REPORT

Antonyia Parvanova MEP opened the meeting, welcoming participants and announcing that the Interest Group is delighted to welcome Francoise Grossetete as the fifth Co-Chair. This means that all major political groups are represented in the Interest group now.
As regards the topic of the meeting, Mrs Parvanova underlines its importance, stating that the mental health and well-being of young people is not very often referred to and does not seem to feature high enough on the EU and national policy agendas. The prevalence of mental health problems is children and adolescents is worrying, the impact of mental health and well-being problems in this age group is devastating. Mental health in young people was one of the themes of the European Pact on Mental Health, which is now entering a new stage; this means that the meeting is timely as it could help focus future initiatives. It should be seen as a part of a process to drive change, bringing together the various players and stakeholders and working towards a holistic and practical approach By having representatives of three Commission DG's and one Member State it can help ensure that mental health ins being addressed in all policies rather than only in those targeted at public health.

Key note speaker **Professor Michael Fitzgerald (Trinity College Dublin)** provided a overview of the extent of mental health problems with children and adolescents, stating that if all mental health disorders are taken into account, 8 % of those of pre-school age 12 % of pre-adolescents and 15 % of adolescents are affected. Bipolar disorder is extremely rare in childhood, but affects 1 % of adolescents. For depression, 1 to 2 % of those in pre-puberty, and some 3- 8 % of adolescents suffer from this condition. Anxiety disorder can be seen in 1.9% of adolescents, social phobia in 1.1%, and generalised anxiety disorder in 3.6%. Deliberate self harm and risk of repetition occurs in 5-15% of adolescents.

Psychosocial problems have clearly increased since the Second World War, with young offenders showing higher rates of ADHD (varying from 20% to 40%) and conduct disorder affecting 5 to 10%. In relation to child sexual abuse, in the UK 27 % of female and 11 % of male children and adolescents are victims of contact abuse; and penetrative and coercive abuse happens to 4 % of female and 2 % of male children and adolescents.

There are a number of risk factors that can contribute to the development of mental health problems in children and adolescents, and these factors are both genetic as well as environmental (nature and nurture). Genetic factors contribute in 30-50% of the cases of depression in adolescence, 60-90 % in the case of ADHD and even 93 % and in the case of autism and Asperger syndrome. Children of parents affected by depression, bipolar disorder, schizophrenia, ADHD and Asperger syndrome have a high risk of developing these conditions themselves. Environmental factors such as psychosocial adversity and poverty can also have an impact, as can bullying, domestic violence, migration, war, and child maltreatment. Prenatal smoking and alcohol abuse can also have an impact on the development and wiring of the brain. In terms of the effects of gender, women have a greater risk of depression in

adolescence (and this risk is increasing with age) which relates to hormones and environmental stresses. Women also have a greater risk of eating disorders.
In relation to the diagnosis of ADHD, the onset can often already be seen in primary school: there are problems with inattention, concentration, hyperactivity, impulsivity and disorganisation. ADHD often goes together with anxiety, depression, autism, tics, oppositional defiant disorder, conduct disorder, dyslexia, and speech and language problems. Surveys have shown that the general public is not well-informed about ADHD; problems with stigma and inappropriate blaming the mothers for their children's problems are widespread.
There are various ways of treating children and adolescents with mental health problems, such as non directive counselling and formal psychotherapy. In many cases, the use of volunteers or mentors is also effective. Direct group work in schools can be effective too, as well as parent training. Combinations of medication and psychosocial treatment are used in relation to many conditions, such as depression, psychosis, behavioural problems, autism and bipolar disorder, with varying levels of success.
Prof Fitzgerald underlined that there are problems in the delivery of adolescent psychiatry services. First of all, there often is a lack of continuity (different doctors are seen with every visit), and there is room for improvement in patient-physician interactions, for instance in the treatment of ADHD. Additional interventions are required, such as tailored family education systems, decision aids to assist physicians and patient portals (online healthcare-related applications) to facilitate monitoring. Furthermore, there are huge compliance problems in Europe (with non-compliance ranging between 13 and 64 %).
In terms of prevention policy, Prof Fitzgerald listed a number of areas where action should be taken, such as reducing risk factors, reducing poverty, treatment of parental depression, earlier identification of high risk factors (e.g. isolated families and families in severe poverty with drug and alcohol addicted parents and parents with severe mental illness. 'Mentor Mothers' can be very effective; these are peer led parenting support programmes which can be as effective as interventions delivered by professionals. Trained volunteering is a cost effective model for all countries where financial restraints cause governments to withdraw from providing professional services.

There are a number of policy implications if the mental health of children and adolescents is to be addressed more effectively. According to Prof Fitzgerald, low cost, simple interventions are the future. There is a need for more research in low income countries as most research has been done in high income countries, and this research needs to focus on cost effective programmes. As the largest amount of gain in psychotherapy is in the first few sessions, short term psychotherapeutic interventions and chronic care models of intervention should be considered. Practice shows that there is little difference in outcome between experienced and less experienced therapists (with experience possibly more relevant to severe cases). Interestingly, there is little difference in the effect of expensive and low cost psychotherapies. This means that in the future, volunteers with brief training and supervision by professional therapist could offer therapy. Volunteer counsellors and therapists who operate under supervision of experienced therapists (e.g. Samaritans) should be supported. Moreover, the myths of the benefits of child psychiatric clinics and multi-disciplinary teams should be challenged as the benefits of excessively long treatments are by no means clear.
All referrals should be seen initially by one professional. Then other professionals should come in as necessary (e.g. educational psychologists, social workers, speech therapists, psychotherapists, occupational therapists) on an individual basis. Another recommendation would be to do away with the vast numbers of meetings between professionals. Often meetings conclude with a decision to have another meeting – and this leads to a massive waste of resources which does not benefit patients; moreover, this current practice results in waiting lists. As many meetings as possible should be conference calls.

Another way to prevent mental health problems is to teach children problem solving skills; suicide attempts are dysfunctional problem solving methods. Early identification and intervention with behavioural problems leads to better outcomes, and this also makes economic sense. And lastly, all services for children should apply evidence-based interventions and these should be assessed for cost effectiveness as

well as this could increase the output in the number of children assessed and treated by some 30 to 40%. However, this statement should be seen as a hypothesis needing to be evaluated.

The next speaker**, Hilary Luxford**, shared her experiences of her daily life with her daughter, who is affected by ADHD and Dyslexia. Her daughter was a healthy normal slightly busy with some sleep difficulties and as time progressed, some difficulties were noticed in sitting still, not progressing with reading and writing at school and at home. Some additional help was provided in school to catch up on reading and writing. At Junior School her daughter attended special needs lessons aimed to boost reading and writing, but these were stopped because the school felt that there were children that were more in need of these classes.
At the age of 8 she was diagnosed with ADD and Dyslexia. She was prescribed medication – and this made a huge difference.
A local Dyslexia trained professional was also found for 2 mornings per week. Hilary's daughter really benefited and this boosted her confidence. Hilary herself found support in support groups; these gave confidence and provided a feeling of not being alone. When her daughter went to Senior School, a school was found that seemed at first to be the right one. However, due to a fall she started school on crutches, which was not a good start. Then she became unwell and was diagnosed with glandular fever, which caused her to miss a lot of school in her first year. This lead to unsatisfactory results (for the school) and it was decided that the school was unable to support her level of ADHD and dyslexia. It was devastating to lose her friends, and her already fragile confidence in learning was further damaged – in fact, the school had done more harm than good. Hilary herself was desperate as well. She kept up her search for a school environment which would be good for her daughter and that would be able to help and accept her daughter's Dyslexia and ADHD; a school that would not demand a set level of results but be flexible in playing to her daughter's strengths, suit and understand her needs, provide appropriate education, rebuild learning confidence and provide her with all round skills for her future.

Fortunately, Hilary found such a school: it is a mainstream independent school, where 50% of children access learning development Education is more tailored to her daughter's needs, encouraging, sympathetic but firm management. Her daughter is now achieving and feels a sense of academic achievement for the first time in her life - at the age of 15.

Hilary underlined that, as a motivated and informed parent she has struggled. But what happens in the many cases where parents are unable to guide their children? These children get ignored; trouble at school, exclusion and more trouble will be their fate. The risk of these young people turning into ADHD adults with the resulting increases in drug, alcohol and mental health problems is huge and the problem needs to be addressed as early as possible.
Her daughter's ADHD has seriously affected Hilary's professional and personal life but her efforts have worked and her daughter is 'a happy healthy confident troublesome but normal teenage daughter'.

The next speaker, **Prof Veronique Delvenne (Université Libre de Bruxelles)** addressed issues in relation to supporting adolescents in crisis. She stated that the adolescent is neither a child, nor an adult; adolescents are in turmoil, due to a combination of several factors: physical changes and sexualization and the need to become autonomous and let go of childhood. The ego is fragile and adolescents go through a period of intensive psychic change; it is a testing period and acting out is very common. Social and familial relationships are changing and there can be intergenerational conflicts; school performance is another crucial factor. Why do crises occur during adolescence? Many different factors come into play; there are the psychological aspects, with the fragility of narcissism and the possible recurrence of the fear of separation (experienced in childhood as well); and there are conflicts with the parents, with adolescents wanting to be autonomous on the one hand side but needing to be supported on the other. Then there is the crucial role of the peers. In cognitive terms, it needs to be recognised that the brain is going through changes as well.

The midlife crisis of the parents is another strong influence. Parents need to come to terms with their ageing process and related changes, such as health issues and loss of their own parents. Couples often go through a

difficult and challenging phase at the same time as the adolescence of their children: there can be problems in the relationship, professional problems and loss of employment and conflicts with their children.
The combination of all these factors has their impact and can lead to crisis. The quality of the early child-mother relationships is crucial as stress and distress early in life play a role in the development of the brain. The impact of physical or psychological neglect or abuse or of marital discord and violence cannot be underestimated.
In relation to the risks of the adolescent's crisis, Professor Delvenne referred to sleep and nutrition problems, difficulties in school performance, and relational difficulties within the family and the peers. These in turn can lead to psycho-pathological problems, such as depression, anxiety, drug or alcohol addiction, impulsive and/or aggressive behaviour and acting out, criminal behaviour and suicidal ideas.
Adolescents in crisis need a specific approach, which addresses various levels of suffering whilst respecting personal space. It is highly important to listen to the adolescent (as well as to his/her parents), to not diagnose or treat immediately and to take the environment and the school into account. Adolescents in crisis require specific care structures, which aim to detect problems early, take a multidisciplinary and holistic approach and seek practical and timely solutions. Any intervention should aim to de-stigmatise and focus on the positive. Networking is hugely important. While prevention is better than treatment, it is never too late to act.

The first speaker in the panel of policy makers panel was **Isabel de la Mata (DG SANCO, Principal Advisor with a special interest in public health**), who started by underlining the importance of mental health, not only in terms of public health but also in terms of costs and sustainable health systems;; A large proportion of those costs could be avoided if efforts to promote mental health and prevent mental ill-health would be increased;; This is particularly relevant in these times of economic crisis, which also impacts on mental health. Isabel de la Mata emphasized the importance of the first phases of life for building the foundation for good (or bad) mental health. Health promotion and disease prevention interventions targeting this age category will have the greatest benefits, and this was recognised by the European Pact of Mental health, launched in 2008. This devoted a conference to the topic of mental health of children and adolescents, and three of the major conclusions were:

- there is a need to strengthen the capacity of health and mental health systems to better respond to mental health needs in this area
- there is a need for partnership between health and other sectors (e.g. education, social policy)
- there is a need to understand determinants of mental health in young people as well as determinants.

The upcoming Joint Commission/Member States Action will also address this theme; a proposal for such an Action is currently being evaluated. It includes work in relation to bringing together the health sector and other sectors (e.g. schools) in order to promote mental health. A small workshop will be organized together with DG Education later this year on schools and mental health, which will include the perspectives of educational and health policies and practitioners. The Commission is also funding some projects, such as PROYOUTH (addressing eating disorders).

The second panelist was **Philippe Cupers** (European Commission, DG research), who emphasized the support of the current 7th EU Framework Programme on Research and Development (FP7) to mental health research. In this context, he underlined that:

- ✓ some 150 million euro has been invested in different type actions under FP7 in the area of mental health collaborative research, with a focus on a variety of topics, such as mood disorders, psychosis and a number of others.
- ✓ these actions have also targeted children and adolescents. For instance, a platform for schizophrenia has been set up, and some 25 million has been spent on projects addressing genetic and neuro-developmental processes as well as optimisation of treatment and disease management. Another project is addressing the link between inflammation and mood disorders.

- ✓ Actions are also taken at the level of Public-Private Partnerships, such as the e-Innovative Medicines Initiative Joint Undertaking (IMI JU) which was specifically set up for the establishment of new methods and new tools to improve drug development process. One project in this initiative deals with the development of databases that will help designing better clinical trials in the future in the area of schizophrenia.
- ✓ The Commission is also funding public health research and suicide prevention (4 different projects with a total support budget of 12 million euro). Public health research will remain addressed in the future FP7 agenda.

Philippe Cupers informed the meeting that the last call of FP7 will be published before the summer. In the area of brain research, mental health will be addressed in two topics:

- ✓ Development of effective imaging tools for diagnosis, monitoring and management of mental disorders;
- ✓ Paediatric conduct disorders characterised by aggressive traits and/or social impairment: from preclinical research to treatment. This also includes ADHD.

Philippe Cupers also informed the meeting of the EU proposal for the future EU research and innovation programme entitled Horizon 2020, which will run between 2013 and 2020. This will address societal challenges, such as “health, well-being and demographic change", where mental health is expected to find its place - including the mental health of children and adolescents. Lastly, the audience was informed that the Commission will organise a Month of the Brain in May 2013. More information on this initiative will be available soon.

The next speaker was **Sergej Koperdak** (**European Commission, Head of Unit Youth Policy, DG Education**) who started his statement by underlining that DG EAC are by no means experts in the area of mental health and that work in this area is just starting . However, it is an important topic for any youth related policy initiative. The Commission has limited powers as regards youth policy, but methods for cooperation and working towards common goals in this area are in place.
The Commission is currently implementing a programme on youth policy which contains 8 fields of action, including employment, education and training, volunteering, health and well being, participation and social inclusion. These are addressed in synergy, and the priority areas are chosen by the EU Presidencies. Other initiatives include ‘Youth week’, where young people meet with MEPs and other policy makers to discuss and debate their issues.
Tools to effectuate actions and change relate to structured dialogue, evidence based policy making, and cross-sectoral cooperation, involving young people themselves.
Mental health factors are not to be neglected in any of the fields addressed. Youth work should be considered as social work outside the class room. There are limited studies and data available on the benefits of participation outside the class room and this documentation is urgently needed. DG EAC works with DG Employment and Social Affairs as well as with DG Sanco, as healthy lifestyles, sport, physical activity and social activities and employment are crucial for mental health and well-being in young people.
There are indications of deteriorating mental health and well-being in young people. The effects of isolation and alienation need further study, for instance. A recent Australian study has clearly demonstrated that young people being connected will increase self esteem and self confidence; the mental health benefits are self-evident. The current crisis and its effect on the employability of young people (and related effect on mental health) constitutes a real challenge. Youth Policy recognising that what they do can help better mental health for young people and that is a message that needs to be shared.

The final speaker was **Teresa Di Fiandra (Ministry of Health, Italy)** who informed participants of the upcoming Joint Action on Mental Health, which will also address mental health in children and young people.
This Joint Action is based on both the 2005 stakeholder consultation on the Commission's “Green Paper on Improving the Mental Health of the Population” and the work and recommendations resulting from the 2009-

2011 thematic Conferences that were organized under the "European Pact for Mental Health and Well-being". The aims of the proposed Action – which will be implemented during 36 months – are to

- formulate a set of policy recommendations and build a sustainable commitment for their implementation
- establish a process for structured collaborative work analysing past achievements and limitations,
- develop an endorsed common framework for action to promote mental health and well-being, prevent mental health problems, tackle mental disorders.

There will be actions in 5 main areas, i.e. promotion of mental health at the workplace, promotion of mental health and well-being of children and adolescents through the integration of health and education, promotion of evidence based action against depression and suicide, transition from institutional mental health services to community based care models and integration of mental health in all policies.
The Joint Action has been submitted for approval in March 2012 and is hoped to be approved soon.
The specific work on promoting mental health in children and adolescents aims to promote the individual, social and environmental skills for young people, especially in the school setting. It will also focus on the prevention of psycho-social distress which may lead to mental disorders in adulthood and the development of cooperation among the health, social and education sectors. This will be done by analyses of mental health promotion and mental disease prevention in the participating countries, mapping scientific evidence and good practices, developing recommendations for action at EU level and in Member States and actively supporting engagement and commitment of Member States and other stakeholders for more effective actions.
Italy will take the lead on this work-stream and a number of countries will be engaged, i.e. Croatia, Estonia, Finland, Iceland, Malta, Norway, Slovakia and the United Kingdom. There will also be different parties involved such as the Italian Ministry of Health, a number of NGO's, international organisations such as the WHO and OECD, experts and other stakeholders.
Teresa Di Fiandra expressed here hope for the proposal to be adopted soon. Once that has been done, examples of good practice will be selected and shared. The next step will be to formulate feasible recommendations for cooperation amongst sectors (health, social, education) and the creation of a network for cooperation. The support to the implementation of the Joint Action in the various countries will be given also through regional workshops.

<u>Discussion</u>

The following items were raised in the discussion that followed the presentations:

Some support is better than no support:
It was stressed that in terms of interventions, timing is everything; whoever is able to do something should do so, as any action is better than nothing. There are major difficulties in working with adolescents, as currently, health services are suffering. It is clear that the number of adolescents accessing services is decreasing and it is not clear what is going to happen. Mental health will suffer, both in terms of the impact of the current crisis as well as in budget terms.

The crucial importance of patient and support groups:
The experience of people affected by mental health is crucial. Patients and support groups are very important as well as they can play a role in advocacy, information and awareness as well as practical support. There are good examples of communication between the various services and sectors involved as well as between parents and professionals.

Poverty and mental health:
The clear link between mental health and poverty should be addressed by policymakers at all levels.

Inform and empower children and parents:
Children have right to be heard and this can be helped by motivated and informed parents. Social inclusion plays a major role here as well. Public services and support can strengthen this motivation and awareness, and efforts should be made to reach out to those that do not have those skills.

The need for simple and relevant research:
According to some, research has not had any impact as these seem to be a closed golden circle of research institutes at the exclusion of many others. What is required is simple and relevant research looking for simple and effective interventions, via different methods of delivery

The role of family doctors:
There is an important role for family doctors, as they have a major and critical organising role. However, in many cases training relating to psychology and mental health problems is inadequate. The services systems are failing; family members are by no means involved enough.

Focus on the early years in life:
It was remarked that 70 % of all mental disorders appear during adolescence and important indications of mental health in later life are already apparent at that stage of life (e.g. bipolar disorder, schizophrenia); health services and systems need to start to pay much more attention to early intervention and prevention. The brain is only fully mature at 25, and while the adult brain has a level of plasticity, the plasticity of the brain in younger age groups is much greater. The period between 4 – 7 years of age is crucial for the development of mental health and well-being, so the focus should be on very early childhood.

Research:
A FP7 project is developing a roadmap for mental health research in Europe which addresses fragmentation of research efforts. Childhood should be included in this roadmap and clinical practice in daily life needs to be changed.

Closing the meeting, **Dolores Gauci (President GAMIAN-Europe)** welcomed the acknowledgement by the speakers that patients and patient organisations have a crucial contribution to make in research, policy development, service delivery and service evaluation. The statement made by Profs Fitzgerald that self-help was effective and that integrated treatment includes self-help due to its empowerment principles was especially well received.
Dolores Gauci also welcomed the fact that the Joint Action on Mental Health under the lead of the Italian Ministry of Health was addressing mental health horizontally and will be working to ensure the integration of mental health in all policies. However, concern was expressed concerning the fact that employment does not appear to be included as an important pillar in Action. This needs to be the case if a truly horizontal and holistic approach is to be ensured.
Dolores thanked the representatives of the three different Directorates, which is a good omen of the success of the upcoming Joint Action in Mental Health. GAMIAN-Europe expressed its clear wish to be actively involved with the activities and implementation of the Action, as its membership in the various Member States can contribute to a valid outcome which is meaningful to patients.

Christine Marking, 14 May 2012