

**FACING MENTAL HEALTH PROBLEMS IN
CHILDREN'S HOMES**
Voices of caretakers

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ABSTRACT

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The aim of the study was to describe what kind of mental health problems caretakers' face in children's homes. The study comprises various approaches and working methods used in the care of adolescents with mental health problems.

The study follows qualitative research methodology, primarily utilising theme-interviews. Eight semi-structured interviews were conducted with a psychiatrist and seven caretakers. The psychiatrist worked with adolescents taken into custody and the caretakers worked with children and adolescents in two different child protection units.

The main findings were that the caretakers were insecure about the subject of mental health. The most common problems they faced were depressive and aggressive behaviour. Moreover, the mental health service-network turned out to be complicated. The caretakers and the psychiatrist suggested more co-operation between professionals working in the fields of child protection and mental health.

Keywords: qualitative research, children's home, reception unit, mental health problem, adolescent, caretaker

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1. INTRODUCTION

The motivation for the study stems from my work experience in children's homes. I noticed that many of the children placed in child protection institutes were in need of intensive care. During my studies in child protection and psychology, I found out that according to many professionals, mental health problems among adolescents have increased. Furthermore, there have been a lot of societal debate and discussion on adolescents not doing well in the Finnish society and there being a range of mental health problems. Relating to this context, my focus is on the situation in children's homes.

What are the caretakers' experiences in relation to mental health problems? What kind of problems do they face in their work and how do they deal with them? Moreover, what do caretakers consider important in the care of adolescents suffering from mental health problems? These are the main research questions of the study.

At present, if you are working in a child protection institute, you need to be able to deal with children and adolescents with multiple behavioural and emotional problems. As Sourander, Hukkanen and Piha (2002) point out, the traditional idea of a residential institution simply providing an alternative living environment has almost disappeared. Institutions are increasingly dealing with children who have a range of complex social, emotional, educational and behavioural problems. Moreover, a large number of children in residential care have faced deprivation, abuse or life in a chaotic domestic environment. The children have often experienced traumatisation. (Sourander et al. 2002.)

Ordinary children's homes were selected for the study, instead of specialised ones (for example, children's homes focused on psychiatric treatment of adolescents). The reason for this was that most of the children taken into custody are placed in ordinary children's homes that are not equipped to deal with psychiatric disturbances.

What kind of behavioural, social or emotional problems are children's homes then dealing with, and how do the caretakers experience those? Furthermore, how could the

well-being of adolescents be improved in children's homes? Could multi-professional work or a community educational approach help in improving the care of the adolescents? These issues will also be elaborated in the study.

Data was collected in two children's home units located in Southern Finland. Both of the places are small, accommodating seven placed children and adolescents. The work is based on child protection legislation. The reasons for placing children into these institutes include parental alcoholism or psychiatric problems, parental disability to bring up the children, emotional neglect and violence in the family. One unit is a reception unit which focuses on short-term and reconstructive work. This reception unit has on-call reception 24 hours a day, based on the Child Welfare Act (417/2007). The other institute focuses on long-term and supportive care.

The aim of this study is to give an overview of mental health problems in children's homes, especially among adolescents aged from 12 to 17. The study describes the situation in two child protection units, and points out the opinions and experiences of caretakers and a psychiatrist. In addition to these opinions, it highlights the working methods and approaches used by the professionals. I hope that this study will help future professionals to be prepared for the challenges in child protection and, moreover, to find the motivation to develop the care in children's homes.

2. CHILD PROTECTION

This chapter discusses the Child Welfare Act (417/2007) and the current situation in child protection in Finland. The chapter describes the child protection field and the regulations related to it. The concepts of children's home and substitute care are defined in the first sub-chapter and the following sub-chapter continues with aspects of the Child Welfare Act (417/2007). The third and the fourth sub-chapters describe the situation in the child protection field at the present and the last one points out special arrangements related to the context of children's homes.

2.1 Children's home and substitute care

Children's home can be defined as a child protection institution where social and health care professionals take care of children placed outside their home. In this study, the professionals are called caretakers. The caretakers' work includes basic care of the children, co-operation with the parents, schools and other important networks, for example social workers. Depending on the focus of the child protection institute, the work can also include, for example, family work. Children's homes have changed a great deal over the past few years: they have become more home-like and the units are now smaller. It can be said that children's homes have become less like institutions. (Törrönen 2005, 129.)

The care given in a children's home can be called substitute care. Substitute care is defined in the Child Welfare Act (417/2007) as follows:

A child's substitute care means arranging the care and upbringing of a child that has been taken into care, placed urgently or placed on the basis of an interlocutory order (section 83) away from the child's own home. A child's substitute care may be arranged in form of family care, institutional care or in some other way required by the child's needs. (Child Welfare Act 417/2007 Section 49 1 §, 2 §)

Making the children's everyday life stable and secure is the basic aim of substitute care. The child protection substitute care differs from, for example, hospital care, where the

main aim is to cure a disease or illness. The aim of substitute care is to provide basic care to the children. In addition, the children's relationship with their parents and other important social networks are supported. In this way, the work relates not only to the everyday life but also to social relationships, activities and identities of individuals. It can be argued that the aims of the substitute care also include treating, rehabilitating and bringing up children and adolescents. Lately, especially the expectations relating to a therapeutic approach have become important due to the increasing acuteness of children's psychosocial problems. To this end, more specialised institutions focusing on psychiatric problems have been founded. (Pösö 1995, 206.)

2.2 Child Welfare Act (417/2007)

The main objective of the Child Welfare Act is to “protect children's rights to a safe growth environment, to balanced and well-rounded development and to special protection” (Child Welfare Act 417/2007, Section one).

Child welfare is defined in the Act and, according to it, the child welfare provision is child-specific and family-specific comprising “an investigation of the need for child welfare measures, the provision of support in open care, emergency placement of the child and taking the child into care, as well as substitute care and after-care” (Child Welfare Act 417/2007, Section three 2§) .

Taking into care is always the last option. Before placing a child outside home, other child protection interventions are practiced to support the family. The most relevant in relation to placing children outside their home are sections 40, 37 and 38 of the Act. Section 40 describes the regulations of taking into care.

Children must be taken into care and substitute care must be provided for them by the municipal body responsible for social services...

- 1) If their health or development is seriously endangered by lack of care or other circumstances in which they are being brought up, or
- 2) They seriously endanger their health or development by abuse of intoxicants, by committing an illegal act other than minor offence or by any other comparable behaviour. (Child Welfare Act 417/2007, Section 40 1§.)

Taking into care is always temporary. The reasons for placing the child outside home define the evaluated time of the custody period. During the time of the custody, the reasons for the custody must be evaluated continuously. If the conditions change and improve and there is no need for custody and substitute care, the social worker responsible of a child's affairs must prepare the termination of custody. When the child turns 18 years old, the custody is immediately terminated. (Saastamoinen 2008, 42.)

The decisions of placing a child under care and substitute care are prepared by the social worker who is responsible for the child's affairs, in a co-operation with another social worker or some other employee who is familiar with child welfare. The social worker having prepared the case, the decisions are made by municipal officeholders as determined by section 13 (1§). Moreover, before any decisions are made, the child's point of view and perceptions must be taken into consideration, for example, the social worker can interview the child. Also the opinions of the child's parent(s) or custodian(s) have to be established.

Relating to emergency placement, the case is different;

...It is not necessary to ascertain these views and perceptions if the resulting delay in dealing with the case would harm the child's health, development or safety (Child Welfare Act 417/2007, section 38, 3§).

Emergency placement concerns, as the name indicates, more acute situations than taking into care. If a child is in immediate danger for a reason referred to above (section 40, 1 §) or he/she is otherwise "in need of urgent placement and substitute care, the child may be placed with urgency in family care or institutional care, or the care and custody the child requires may be arranged in some other way." (Child Welfare Act, Section 38, 1 §) Many of the children placed into the reception unit are fall under this regulation. There might be a need for emergency placement, for example, if a child's custodians are temporarily unable to take care of their child because of intoxication. The need can also be related to the child's own behaviour. (Saastamoinen 2008, 47.) The

emergency placement terminates when “the basic intent of placing the child outside home ceases” or when emergency placement expires in accordance to the regulations defined in Child Welfare Act (417/2007, section 39, 1 §, 2 §, 3 §, 4 §).

Furthermore, placing a child in an institution or in family care can take place as placement support in open care. It differs from the regulations above because it can be arranged for a child together with his/her parent.

Family or institutional care may be arranged as support in open care for a child together with a parent, custodian or other person responsible for the child’s care and upbringing, in the manner referred to in the client plan and in the form of care in which the need for support is assessed or in the form of rehabilitative care (Child Welfare Act 417/2007, Section 37, 1 §).

On a short-term basis, the placement as support in open care can be arranged for a child alone. Open-care placement requires a mutual consent with the child’s custodian and, if the child is twelve years of age or more, a mutual consent with the child as well (Section 37, 2 §). An open care solution differs from taking into care and emergency placement by being an open care intervention. The situation in the family is not as acute as in the two other alternatives and basically the responsibility of the child is still on parents or custodians. Open care interventions are support interventions which are intended to improve and support the capacities of the family and parents.

2.3 New Child Welfare Act (417/2007)

Finland’s Child Welfare Act was revised in 2007, replacing the Child Welfare Act from 1983. There are 30 new regulations in the new Child Welfare Act, but that does not mean that the Act would contain anything completely new within the child protection field. The revision means mainly elucidating, amending and updating the regulations. (Mahkonen 2008, 32.) The Child Welfare Act is referred to in this chapter as either “The Act” or the “new Act”.

The main changes in the new Act are increased emphasis on parent responsibility and preventative work. The goal of the Act is to protect a child's rights and the best of the child when practicing child welfare actions. It can be said that the aim is that the child's voice would be more heard in the process of practicing child protection interventions. The new Act requires that special attention is paid to the views and wishes of the child. For example, a social worker has to meet the child personally, before any decisions are made. And even though a parent would be against the meeting, the social worker can meet the child.

The aim of the Act is to promote the co-operation between authorities in relation to promoting the well-being of children and adolescents as well as child-focused and family-focused child welfare work. It can be said that the Act aims at improving multi-professional work. Multi-professional work means in practice that different professionals are working together to improve, for example, the well-being of an adolescent.

2.4 Child protection today

In the 1990's, Finland suffered from a deep economic recession and the whole decade was "an era of strong cuts in public spending". During the recession, the increase in unemployment was greatest among families with children. (Hukkanen, Sourander, Santalahti, Bergroth 2005, 481.) The recession had profound effects on child-protection, as Hukkanen et al. (2005) notes:

By the end of the 1990's, all the available placement settings were fully occupied and shortages of places were reported (Hukkanen et al. 2005, 482).

Today, both in Finland and on a global level, there is increasing concern and discussion about children taken into custody. It seems that the on-going financial crisis/recession and its effects on the social and health services as well as on families and the employment situation speed up the discussion. Social and health care professionals are worried about the cuts in public spending on the health-care sector, especially regarding

the basic services for children and young people. According to a study (Juvonen 2009) of social and health care organisations, the recession is already affecting every fourth of the child-protection organisations, in the form of increasing number of clients and decreasing budgets.

If we look at the statistics (table 1) and compare the numbers of children placed outside their home in 1995 and 2007, we can see that the numbers have increased every year. According to the Statistical Summary (Statistics Finland 2008), the number of children taken into custody 2007 was 50 per cent higher than in 1997. Table 1 also indicates that the number of children placed in institutions has increased yearly.

1. Table: Children and adolescents placed outside their home 1995–2007

Year	Children placed in families	Children placed in institutions	Other type of care	Total	Children Taken into custody
1995	5,340	3,921	1,694	10,955	6,389
1996	5,478	4,126	1,770	11,374	6,509
1997	5,679	4,646	1,511	11,836	6,785
1998	5,654	4,835	1,490	11,979	6,810
1999	5,693	4,591	2,010	12,294	6,946
2000	5,776	5,011	2,074	12,861	7,327
2001	5,910	5,376	2,235	13,521	7,509
2002	5,912	5,971	2,299	14,182	7,991
2003	5,738	6,302	2,340	14,380	8,412
2004	5,569	6,857	2,403	14,829	8,786
2005	5,529	7,331	2,491	15,351	9,295
2006	5,594	7,646	2,534	15,774	9,605
2007	5,526	8,095	2,438	16,059	10,207

2. Table: Children placed outside their home for the first time (2007)

Children (age range)	0–6	7–11	12–15	0–16
Emergency placement	444	274	529	1,434
Custody	112	119	190	486

Children may have been placed prior to this as support intervention in open care.

(Tables adapted from Official statistics of Finland, Statistical summary 23/2008)

It seems that most of the children taken into custody for the first time in 2007 belonged to the age group 12 to 16-year-olds (Table 2). At present, According to the YLE news (The number of children taken...) the children taken into custody are more often 13–17-year-olds. In the Helsinki area, taking into custody has increased the most among children over 10 years of age. Moreover, behavioural problems among adolescents have increased notably. It is argued that throughout Europe, the awareness of the serious psychological problems of children in care has increased, although at the same time the services provided for them are limited.

3.4 Special arrangements

Different types of restrictions in substitute care are defined in The Child Welfare Act (417/2007). There are children in child protection units who need more intensive care-models. These children behave aggressively, run away from children homes, take intoxicants and have self-destructive tendencies, for example. The basic care offered by children's homes is not sufficient for them. The Child Welfare Act (417/2007) describes and defines some special arrangements which can be used as tools for a more intensive care-period. Examples of the arrangements are "special care" and "restraining a child physically".

Special care means special multi-professional care to be arranged in a child welfare institution for a child in substitute care, during which care the child's freedom of movement may be restricted...

During substitute care, special care may be arranged for children if their extremely important private interest so necessitates in order to interrupt a

vicious circle of intoxicant abuse or crime or when the children's own behaviour otherwise seriously endangers their lives, health or development. The purpose of special care is to stop behaviour that harms children themselves and to allow provision of comprehensive care for them. Special care may be arranged for a maximum of 30 days. For an extremely pressing reason, special care may be continued by a maximum of 60 days. (Child Welfare Act 417/2007, Section 71, section 72 1§.)

The main aim of this type of care is to stop a child's harmful behaviour and establish contact with him/her. The special care can be arranged in a limited number of the children's homes. It requires resources (for example a multi-professional team and enough employees) and permissions from municipality. The child protection units that are included in the study are not able to practice special care.

Child protection institutes take care of children whose behaviour might harm the child itself or other children. As a consequence, the child might need to be physically restrained. The Child Welfare Act (417/2007) has defined in which circumstances this is allowed.

In order to calm a child, an institution's director or a member of the care and upbringing personnel may restrain children physically if it is likely that they may, judging from confused or threatening behaviour, harm themselves or others and if restraining is necessary to prevent immediate danger to the child's or some other person's life, health or safety or significant damage to property. Restraining must be therapeutic in nature and justified in view of the overall nature. Restraining must cease as soon as it is no longer necessary. (Child Welfare Act 417/2007 Section 68 1§.)

Need for this type of practices has been growing during the past few years, as the problematic behaviour among adolescents seems to be increasing.

3. MENTAL HEALTH

This chapter discusses different topics related to mental health. The first sub-chapter establishes the context of the study: adolescence. The second chapter presents definitions for mental health and the third continues by describing the nature of trauma. Moreover, some actual mental health disorders are described. There are many mental health problems which can endanger an adolescent's development. This chapter gives a view of some of those and points out some aspects of mental health.

3.1 Adolescence

Adolescence can be divided into three stages which have their own developmental tasks: early adolescence (12–14 years old), actual adolescence (15–17 years old) and post-adolescence. The study focuses on adolescents between the ages from 12 to 17.

Adolescence is one of the most fascinating and complex transitions in the life span; a time of accelerated growth and change, second only to infancy; a time of expanding horizons, self-discovery, and emerging independence; a time of metamorphosis from childhood to adulthood. Its beginning is associated with biological, physical, behavioural and social transformations. (Kipke 1999, 7.)

From puberty, as the citation above brings out, starts a period of great changes. The main developmental functions of adolescence are loosening the individual's ties to his/her parents, forming a sexual identity, finding educational and vocational goals and, all in all, finding own personal adulthood (Aalto-Setälä & Marttunen 2007, 207).

It is not an easy task to achieve one's own personal adulthood. Consequently, adolescence is a typical age when different mental health problems manifest themselves. Every fifth adolescent is suffering from a mental health disorder. The most common ones are mood, anxiety and conduct disorders, and substance abuse is common as well.

Any concerns relating to the mental health condition of an adolescent must be evaluated comprehensively, because a mental health disorder is a serious threat for development.

The difference between dysfunctional and normal behaviour related to the developmental stage might be difficult to define, but it is crucial to identify and treat disorders at an early stage, so that the developmental chances will not be misplaced (Aalto-Setälä, Marttunen 2007, 207). Laukkanen et al. (2003) point out in a study of adolescent psychiatric services in Finland that those persons who treat adolescents should be familiar with “the psychological and biological developmental processes during adolescence.” (Laukkanen et al.2003, 37).

The same study reveals that Finland was the first European country to give high priority to the development of specialised psychiatric services for adolescents. The study describes:

...Adolescent services developed rapidly in the late 1980’s. Now the services extend throughout the country and adolescent psychiatry has been recognised as an independent psychiatric speciality (together with adult, child and forensic psychiatry) since 1999. Adolescent’s mental health has been a focus of major health political debate in Finland since 1999-2001. (Laukkanen et al. 2003, 38.)

There are many problems in “the functioning of the chains” of treatment for adolescents (Laukkanen et al.2003, 37). However, the number of adolescents utilising open psychiatric care in Finland increased in the period 1995–2003 from 58,615 adolescents to 104,215 (Pirkola & Sohman 2005, 21).

3.2 Mental health

How is mental health defined? It can be defined from different point of views. Colightley suggests this type of definition:

Mental health is a difficult term to be categorical about as it is far more than absence of illness. I suggest that it is about achieving your potential as human being. (Colightley 2006, 22)

Mental health is the strength of an individual. It has great effect on the individual's quality of life and, furthermore, on the whole society. From a narrow point of view, it means the absence of mental health problems. But in actual fact, the concept of mental health is much wider. Mental health can be defined as a process and stage of balance, to which different life-events and social situations contribute:

It is important to remember that mental health is not a static state, good mental health is dependent on several factors and a change in these factors may lead to changes in mental health status. It needs to be emphasised that there is a continuum between mental well-being and mental disorder or mental illness. At one end is complete mental health and at the other severe mental illness. The continuum between that range of "normal" human experience and mental disorder means that the cut-off between what is normal and abnormal can be hard to define. (Dogra, Parkin, Gale, Clay 2002, 18.)

Furthermore, the World Health Organisation has defined child and adolescent mental health in particular:

Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the level reached and competence achieved in psychological and social functioning. (WHO 2005, 23.)

WHO broadens the definition by describing what this exactly includes. Accordingly, child and adolescent mental health "contains a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn and a capacity to use developmental challenges"(WHO 2005, 23).

Varilo (1992) points out the importance of the environment in the description of mental health. A child's mental health is the relationship between the environment and the child: the environment has to provide possibilities and challenges for the child, while the child has to be able to develop and grow under those circumstances. This occurs in continuous, changing interaction between the child and the environment. Upbringing has a major effect on a child's mental health. (Varilo 1992, 81.)

As described in the previous chapter, when discussing adolescence, it may be challenging to recognise or understand the difference between dysfunctional and normal, age-related behaviour. What symptoms and ways of behaving can be said to be signs of mentally healthy behaviour?

Two aspects help to identify this; whether the symptoms cause the young person (or others) a significant degree of distress, and second, whether the symptoms have an adverse effect on social or educational function. A third factor may be assessed in long-term issues: that of the effect on the young person's psychological or physical development. (Dogra et al. 2002, 128.)

Dogra points out, for example, that as there can be “inability or unwillingness by young people, parents and professionals need to recognise that distress is a component of human experience and not necessarily a mental health problem” (Dogra et al. 2002, 19).

The actual mental health disorder is;

...conceptualised as a behavioural or psychological syndrome or pattern that is associated with distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) (Kaplan & Sadock 2007, 16).

There are two accepted systems/manuals of classification which are used broadly. Those are, the “Diagnostic and Statistical Manual of Mental Disorders” and the “International Classification of Diseases” (Dogra et al.2002, 23).

In the study, in addition to the concept of mental health disorder, the terms “symptom of mental health problem” or “mental health problem” are used. These terms refer to symptoms or problems described, for example, by the caretakers, and those are not necessarily disorders diagnosed by a psychiatrist.

3.3 Trauma

There are many factors which can affect the mental health of an adolescent. These factors can be divided into risk and protective factors. (WHO 2005, 27.) What are the risk factors that can lead to a condition that endangers an individual's mental health? This chapter discusses one risk factor: a trauma. Other risk factors are not further

discussed in the study. A trauma is as such not a factor which necessarily leads to mental health problems, but it is seen as a one of the factors which can influence and endanger a child's development.

Trauma occurs when an individual's "ability to integrate his or her emotional experience is overwhelmed, or an individual experiences a threat to life, bodily integrity or sanity". Traumatic events may occur only once, or they can be ongoing, repeated and relentless. (Wainrib 2006, 25.)

The psychiatrist who was interviewed for this study pointed out that all of his clients were traumatised by some kind of life-incident, and most of those were related to serious shortcomings on the side of the parents. There may have been continuous violence, sexual abuse or the care has been insufficient due to, for example, mental health problems as well as alcohol and drug problems. This is a common situation among adolescents taken into custody. According to research data from children's homes in the Turku area:

A majority of children (66% in 1996 and 70% in 1999) had experienced more than one kind of traumatic or stressful life event before entering the children's home (Hukkanen 2002, 45).

Reactions to traumatic events vary, ranging from relatively mild reactions, creating minor disruptions in the person's life, to severe and debilitating. It is common to experience "anxiety, terror, shock or an upset, as well as personal or social disconnection and emotional numbness". Often people do not remember everything that has happened and they might have physical and psychological flashbacks. Moreover, nightmares of the event are common, as well as depression. (Wainrib 2006, 25.)

In addition, individuals who have been exposed to trauma have been found have elevated rates of psychiatric disorders, including major depression, alcohol and drug dependence and PTSD. The negative impact of trauma extends beyond psychiatric morbidity and encompasses multiple realms, including functioning, quality of life and physical health. (Wainrib 2006, 87.)

The abbreviation PTSD in the text above, refer to post-traumatic-stress-disorder which can be caused by trauma. It is a psychiatric disorder that can develop after the direct, personal experiencing of a traumatic event, which is often life threatening.

3.4 Mood disorders

Mood disorders are a large group of disorders. The term “mood” refers to an emotional state. The reason can be described as such:

Mood may be normal, elevated or depressed. Normal persons experience wide range of moods and have an equally large repertoire of affective expressions; they feel in control, more or less, of their moods and affects. In mood disorders the sense of control is lost, and there is a subjective experience of great distress. (Kaplan & Sadock 2007, 534.)

Depression is probably the most common mood disorder, other mood disorders include bipolar disorder and anxiety disorder. The number of children and adolescents receiving in-patient (institutional) care because of depression has more than tripled during the 1990s (Hukkanen 2002, 53).

Symptoms of depression fall into four categories; “mood, cognitive, behavioural and physical”. To put it more simply, depression affects how individuals feel, think, and behave as well as how their bodies work. Depressed individuals describe their mood as “sad, depressed, anxious, or flat” and they often report feelings of, for instance, “emptiness, hopelessness, pessimism, uselessness, worthlessness, helplessness, unreasonable guilt and apathy”. (Ainsworth 2002, 7.)

Their self-esteem is usually low and they may feel overwhelmed, restless, or irritable. Loss of interest in activities previously enjoyed is common, and is usually accompanied by diminished ability to feel pleasure. (Ainsworth 2002, 7.)

Depression is more than a mental illness; it is an illness of the whole body. People suffering from depression experience changes in their bodily functions, for example their “energy levels fall and they fatigue more easily”. Insomnia is common, as well as

appetite changes. Physical symptoms related with depression “can occur in any part of the body” and can include for example pain, gastrointestinal problems (nausea, stomach pain) and neurological complaints (dizziness, memory problems). Depression can occur in childhood, but more often it occurs for the first time during adolescence. (Ainsworth 2002, 9, 10.)

3.5 Conduct disorders

"Conduct disorder" refers to a group of behavioural and emotional problems among adolescents.

The biggest client group of the psychiatrist interviewed for this study was adolescents with conduct disorder, which he described as the most challenging group to work with. The psychiatrist described that often the behaviour of these adolescents is aggressive and impulsive, their emotional-life is unstable and they run away from children's homes and, for example, substance abuse is common. Moreover, an adolescent suffering from conduct disorder often suffers from another disorder as well, for example anxiety disorder or depression. This makes the concept of conduct disorder more challenging.

The IDC-10, which is an International Classification of Diseases, describes the symptoms of conduct disorder as follows:

Disorders characterized by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations; it should therefore be more severe than ordinary childish mischief or adolescent rebelliousness and should imply an enduring pattern of behaviour (six months or longer). Features of conduct disorder can also be symptomatic of other psychiatric conditions, in which case the underlying diagnosis should be preferred. Examples of the behaviours on which the diagnosis is based include excessive levels of fighting or bullying, cruelty to other people or animals, severe destructiveness to property, fire-setting, stealing, repeated lying, truancy from school and running away from home, unusually frequent and severe temper tantrums, and disobedience. (WHO 2007.)

To simplify, adolescents with conduct disorder have great difficulties in following rules and behaving in a socially acceptable way. These symptoms were often cited as reasons when child protection workers contacted the psychiatrist and asked for help.

3.5 Previous studies

When reading international studies about psychiatric problems among adolescent in children's homes, there is an increasing trend in psychiatric problems in substitute care.

In British studies from the 1970s, presented by Hukkanen (2002), emotional and behavioural disturbances were found in 30–40% of boys and 23–29% of girls in residential care. In more recent studies, the percentage of children with behavioural and emotional disturbances in residential care has been 40–80%. (Hukkanen 2002, 13.)

Moreover, other studies have revealed that children in residential care have often “behavioural and emotional problems, difficulties in learning and poor interaction with peers”(Hukkanen, Sourander, Bergroth, Piha 1998, 268). In a British study (McCann, James, Wilson, Dunn 1996), nearly 30% of the children had a diagnosis of conduct disorder, one fourth had overanxious disorder and one fourth had major depressive disorder (Hukkanen 2002, 13).

Only few studies have been made on emotional and behavioural problems of children in children's homes in Finland, but the findings of Finnish studies seem to be similar with the international studies;

In Finland, in spite of the varied study methods, a common finding has been that half of the children had psychological problems. In most cases the problems had lasted for years.
(Hukkanen 2002, 15.)

Girls' emotional and behavioural problems have increased. Symptoms of mental health problems among girls in children's homes increased considerably during 1993-1999. (Hukkanen et al. 2005, 481.)

In Finland, the substitute care in children's homes is a responsibility of the social services sector, and it has been argued that too little attention has been given to the psychiatric needs of the children placed in children's homes. The number of children in need of treatment for their psychiatric problems has increased both in ordinary and in specialised children's homes. These children, who are placed outside their home and suffer mental health problems, would need "integrated psychiatric care and careful treatment plan" and, at the same time, a home-like environment where they could live their everyday lives. (Hukkanen 2002, 62.)

The traditional form of children's home, even when the environment is planned to be more suitable for children, such as small in size with only six to eight children in each home, seems not to be enough for these children to improve psychologically. The problem may be the small number of primary care workers per child and the lack of psychiatric education of the staff. (Hukkanen et al. 1998, 270.)

Ward (2006) conducted a study concerning the care of adolescents in children's homes in the UK, and the findings were similar to Hukkanen et al (1998). Furthermore, he describes that the children's homes in UK are mainly "ordinary children's homes", with no specific aims or methods for the care and upbringing:

...with no more specific remit than to admit children with wide age range and to provide accommodation for them within broad categories such as "short-stay" or "long-stay" (Ward, 2006, 337).

According to these studies presented above, there is a clear need in children's homes for more intensive care. The studies point out various problems among adolescents taken into custody, such as learning problems, conduct disorders, poor interaction with peers, depression and anxiousness.

4. APPROACHES

This chapter introduces three different approaches which can be applied when working in child protection and with adolescents. Strength-based approach and behavioural

therapy were suggested by the psychiatrist Community education is an approach which could be used in the children's home context. This idea is further evaluated in the discussion chapter.

4.1 Strength-based approach

There are several approaches you can apply when working in children's homes and with adolescents. Strength-based approach was mentioned by the interviewees and recommended by the psychiatrist interviewed for the study. Sharry (2004) describes the approach from the point of view of attitude or way of thinking.

We are invited to think in terms of resources, skills, competencies, goals and preferred futures about our clients, their lives, the communities they belong to, the therapeutic process itself and the professional context in which we find ourselves. We are invited to become detectives of strengths and solutions, rather than detectives of pathology and problems, and to honour the client's expertise and capabilities as well as our own (Sharry 2004, 8-9.)

Kaplan and Girard (1994) suggest that "people are much more motivated to change when their strengths are supported". Instead of asking from the family members what their problems are, a social worker could ask what are family members' strengths, what they all bring to the family. This way the worker can "create a language of strengths, hope and change". (Kaplan & Girard 1994, 53.)

The aim of the strength-based approach is quite similar to the concept of empowerment. Perkins and Zimmerman (1995) have described empowerment as a psychological feeling.

Empowerment is a psychological feeling that individuals have when they feel they can accomplish chosen goals. Empowerment occurs when ordinary people discover that they have the capacity to solve the problems they face, control the means to do so, and have final, authoritative say in decision making. (cited in Rubin & Rubin 2008, 12.)

It can be argued that especially in child protection there is a need for a more empowering approach. When people are empowered, they are motivated to change and gain control over their lives. Rubin and Rubin (2008) state:

Empowered individuals are willing and able to assert their collective wills to gain control over their lives (Rubin & Rubin 2008, 61).

The clients of the child protection services have often lost control of their lives because of mental disorders, alcohol, drug abuse or other problems. For example, parents have basically lost their power; children have been taken into custody, there may be unemployment. Under such circumstances, a change is needed in order to take care of the children and maintain stability in life.

4.2 Community education approach

Törrönen (2005) remarks that there is a need for a community approach in child protection and child welfare research (Törrönen 2005, 129). There are several approaches on the social work field which focus on the community or use the community as a tool; community care, community development and community education, for example. This chapter focuses on an approach called community education. The community education approach can be applied in a children's home context. It has been developed and used in a same type of organisation. Moreover, a children's home is a community where children are brought up and educated.

The term "community education" can be used to refer to different types of practices. This sub-chapter starts by clarifying, firstly, the term "community" and, secondly, the term "community education" used in this study.

The term "community" has several aspects and it can be defined in several ways. It is used as a common term to describe different groups of people, and the deeper meaning of it comes clear from the context where it is used. The term can be used to describe a whole society or few people, and its geographical extent can vary from the whole world to one family. (Haapamäki et al. 2000, 11.) In a children's home, community consists of

the children and the caretakers who are responsible for the care and education of the children. According to Kaipio (1995), when a term community is discussed in the context of community education, the concept “educational community” can be used. An educational community consists of a group of educators who practice education in a community. (Kaipio 1995, 64).

Community education can be described in this way:

Community education is up-bringing and treatment approach where all the resources of community are directed towards new kind of behaviour. This means that all caretakers and those who are taken care of, together (by norms defined together) develop and up-bring each other and themselves. Towards honesty, openness, equines, equal division of power and responsibilities, and all in all higher humanity of the community. (Kaipio 1997, 57.)

The community education approach came into being in Finland during the 1970s and it has been used in different institutions and communities. The main principles of the approach can be seen in the last sentence of the citation above. Kaipio (1999) started to develop it in a reform school of boys, when he realised that problematic behaviour in the reform school would not change without employing a different kind of approach. He saw that a traditional authoritarian exercise of power was ineffective in influencing the boys’ behavior. It became clear that without negotiating with the children about common norms, rules and values it would not be possible to influence their behaviour. This was an important starting point of the approach. (Kaipio 1999, 38.)

When norms, rules and values are developed together, based on the real needs of the community, everyone is much more committed to them. Moreover, these principles of the community have to be continuously evaluated, discussed and reformulated if needed by community meetings. (Kaipio 1999, 39.) This is one of the basic methods of the approach. Another method is dividing the work done in the community; everyone has a responsibility and a task in the community. The motivation for the method can be described, for example, in this way; when a person is authorised, he/she is at the same time empowered. Developing community education in reform schools or child

protection institutes has had a positive impact on the dynamics of the communities and on the behaviour of the adolescents. (Kaipio 1999, 243, 86.)

Why is this approach relevant when discussing communities like children's homes? Kaipio (1999) states that interaction, group-power and feeling of belonging are the beginning of personal freedom. People need a sense of community, which is not suppressing the individual, but directing towards growth. Sense of community is a fundamental element of a society. (Kaipio 1999, 25.)

4.3 Behavioural therapy and peer-group

The psychiatrist stated also that the community can be used as a beneficial resource to achieve changes in the behaviour of adolescents. He suggested that behavioural therapy form could be used in a collective way. The main focus in this therapy form is not on the inner world, but in the actual behaviour and its consequences.

This focuses not on the inner world of the young person but on the actual behaviours. Here the cause is less important than the manifestation of the behaviours and there is a belief that the causes may not be able to be changed but the behaviours can be altered. The therapist or social worker will work with the person to help them to identify negative and counter-productive thoughts and replace them with more positive frame of mind. (Colightley 2006, 90.)

The basic idea of the therapy form is quite simple. The therapy form focuses on the behaviour, replacing negative behavioural models with positive ones. It is based on simple learning; when a behaviour is rewarding, it is repeated and when a behaviour has negative consequences, it is diminished.

The psychiatrist pointed out that, for example, in a children's home, the idea of the behavioural therapy could be used in a collective way. This means in practice that the workers in children's homes could collectively and actively find positive options for a negative behaviour of the adolescents. The community could be used as a tool for finding different ways of behaving. In this respect, the psychiatrist emphasised the importance of a peer-group during adolescence. He stated that it influences the

individual's behaviour; an adolescent learns behaviour from peers, and he/she behaves the way the group requires. Kaipio (1999) also points out the peer-group aspect. He states that it should be more used as an educational instrument, because it has great influence on the process of learning and internalising, for example, norms (Kaipio 1999, 220).

5. THE RESEARCH PROCESS

The research process is described in this chapter. Questions relating to data collection, methods of research, the role of the researcher and research ethics are elaborated.

5.1 Data collection

Data was collected in two children home units in Southern Finland. These two places are under one and the same organisation but they are located in two different places and their manner of work differs from each other. One of the homes focuses on long-term care and the other one on temporary care. Both of the places are small, with seven placed children and adolescents. The work is subject to the child protection legislation. The reasons for placing children into these institutes, includes alcoholism or other psychiatric disturbance of the parents, parental disability to bring up the children, emotional neglect and violence in the family.

The unit focusing on temporary care is a reception-unit where the emphasis is on short-term and reconstructive work. The aim is that the children and adolescents can go back home or move on to independent life. This reception unit has an on-call 24 hour service a day, based on Child Welfare Law. This means in practice that the home responds to crisis situations; children can be placed here by emergency placement (Child Welfare Act 417/2007). There are also family workers in the reception unit. The family workers are co-operating with parents and practicing open care family work. The open care

family work can be described as supporting the families by different interventions designed individually per family.

The other unit is focused on long-term and supportive care. The main focus is on living everyday life with the children, but co-operation with parents and other networks is practiced as well. The nature of the work differs from the reception unit because children live in this children's home unit longer.

The interview with the psychiatrist and psycho-therapist was conducted to diversify the background knowledge. The psychiatrist works with adolescents, from 13 to 17 years old, placed in children's homes. He gives consultation to child protection workers, organises work counselling and meets personally with the adolescents taken into custody. The focus of this interview was on disorders and diagnoses, and which kind of support and help adolescents taken into custody need.

5.2 Getting in contact with the organisation

Contacts to the child protection units were established by working in the reception unit. I introduced my research idea to the head of the place and to the caretakers in the reception unit. Everyone was interested in giving interviews and participation to research process. After that I called to the other unit and introduced the idea to one caretaker. This person passed on the idea to other workers. The interviews were made individually. Every interview was recorded and transcribed. The recording was always discussed with the interviewee in advance.

All in all, there were seven interviews conducted in the children home units: four in the reception unit and three in the long-term unit. The backgrounds of the interviewees differed. Most of the interviewees had completed two separate educations related to social services, health, nursing, family work or child care. There were two substitutes, who did not have education related to social work, but who were studying a degree related to social services, education or child care. Two of the interviewees had been working for more than 20 years in child protection. The work experience of the other

interviewees varied from six months to ten years. One of the interviewees was the head of the institute and one was a caretaker and a family worker.

The psychiatrist has been working in psychiatric care for ten years. He has three years' work experience from adolescent psychiatry. In addition, he is a psycho-therapist.

5.3 Type of the study

This study follows a qualitative approach. It can be described as a case-study of the interviewed caretakers, their experiences and ways of working. The study is not comparative.

A type of the interviews was thematic interview. As Kvale (1996) points out;

...qualitative research interview is theme oriented, and the purpose is to describe and understand the central themes the subjects are experiencing and living toward. Moreover it aims at gaining nuanced explanations from the different qualitative aspects of interviewees "life world": it works with words, not with numbers. (Kvale 1996, 29, 32.)

Qualitative interviewing can be described nondirective, unstructured, non-standardised, and open ended interviewing (Taylor 1998, 88). These adjectives can be said to describe the interviews made for this study as well. Basically the interviews were structured into three main themes but the exact order of the themes was not fixed. This is typical for thematic interviews; the topics and themes are known before the interview but the exact order of questions is not decided beforehand.

Semi-structured interview was decided to be the best possible form of interviews to be used in the children's homes. This form of interviews was chosen, when the research was introduced in the institutes and it was noticed that the topic was sensitive and difficult for many of the interviewees. Semi-structured interview is well suited to situations where sensitive or intimate issues are discussed (Metsämuuronen 2006, 115).

It was crucial to ask in the end of the interview if the interviewee had something in mind relating to the topic that he/she wanted to bring out. At this point, many of the interviewees, and especially those who seemed to have difficulties in answering, voiced more opinions, experiences and suggestions related to the topic. The interviews with caretakers are marked in the study by a letter and a number: W1, W2, W3...(W=worker).

The interview with the psychiatrist was also semi-structured. It could have differed from the interviews with the caretakers, but the semi-structured way of interviewing was considered to help the interviewee to talk freely about the subject. This interview is marked in the study by a letter P (psychiatrist) and a number one (1).

All of the interviews were transcribed and the data was analysed. The idea of data analysis is to concentrate the data: to summarise, structure and outline it so that nothing relevant is removed (Eskola 2007, 173). In the first stage, all the issues which were relevant to the topic of the research, were underlined. Then, clear themes about these issues were formed. At this stage the data is not diminished, but structured afresh (Eskola 2007, 170). There were several themes and a lot of material. After going through it several times, it was possible to concentrate the data, so that some themes were paired together and new themes were formed. Mind maps were used as tools for a clearer analysis of the data.

5.4 The role of the researcher and the ethics of the research

The role of the researcher differed in the two child protection units. The workers in the reception unit were familiar with the researcher and the workers in the long-term unit were not. None of the participants from the long-term unit had ever met the researcher. The caretakers who were interviewed in the reception unit decided by themselves to take part to the research and showed motivation. In the long-term unit the responsible caretaker had decided the dates when the interviews were conducted and assigned the participants. This is an issue which will be further discussed in the chapter validity and limitations of the study.

Before the study was conducted, issues concerning confidentiality were discussed with the head of the institution. Permission to gather data from the children's home units was issued in writing, but it is not attached as an appendix to this study, because of confidentiality concerns. It was decided that the study will be conducted so that the institution and the clients will be anonymous. In a children's home context, it is crucial to take confidentiality into account. Issues related to clients cannot be discussed outside the children's home without permission. On one hand, the confidentiality affected the study so that it was not possible to include example cases of the clients. Furthermore, the information concerning the organisation had to be selected carefully. On the other hand, because the institution was not named, it gave the researcher more freedom. For example, the organisation did not influence the goals and objectives of the study.

6. FACING MENTAL HEALTH PROBLEMS

This chapter presents the results of the study. The findings are divided under the topics "Insecurity", "Problems and symptoms", "Ways of working with the adolescents", "Values" and "Approaches". The first and the second chapter focus mainly on the research question "what kind of problems do caretakers face in their work?" The rest of the chapters goes on to answer the questions "How do caretakers deal with the problems?" and "What do caretakers find important in the care of adolescents with mental health problems?"

6.1 Insecurity

The care-takers seemed insecure when discussing mental health disorders and mental health problems. The insecurity with regard to the mental health problems was seen in the interviews in the way that interviewees explained that they lack knowledge about mental health problems. As a consequence, the caretakers have difficulties in understanding the behaviour of the adolescents.

Because I'm not psychologist, so I don't know...Many times I wonder where this comes from, why a child behaves like this? (W1)

Often then when a child is here, it is difficult to think what this thing is? (W4)

It bothers me that we are always talking about depression but what is it? It is hard to define. (W2)

The lack of information was also expressed in the interviews in the way that the interviewee was unsure about what mental health disorder was exactly, how it could be defined, as in the last example above. Some of the caretakers were, for example, unsure about at what age depression can occur. One of the interviewees mentioned that:

...we can't treat children with mental health problems because we don't have enough knowledge for that" (W1)

Moreover, another interviewee suggested that a psychiatric nurse be part of the working team, so that they could better evaluate and seek help for a child.

Many of the interviewees pointed out that it is not easy to define what normal behaviour is and what goes beyond that. The line between normal and abnormal was said to be vague. In addition, many of the interviewees saw that it is more challenging at present to understand what is normal and what is not. According to them, there seem to be so many different diagnoses you can make. As Dogra et al. (2002) point out, when describing mental health, there is a continuum between mental health and mental health disorder.

The continuum between that range of "normal" human experience and mental disorder means that the cut-off between what is normal and abnormal can be hard to define. (Dogra et al. 2002, 18).

Moreover, with adolescents it can be even harder to define what normal behaviour is because this age-stage has wide and challenging developmental functions, and finding the difference between dysfunctional and normal behaviour can be challenging (Aalto-Setälä, Marttunen 2007).

Insecurity can arise from the fact that caretakers do not view treatment of mental health problems as part of their work, as part of the care in children's home. The mental health problems were more seen to belong to a separate expertise, psychiatric care.

Of course when you do child protection work, you can see those. But somehow...you would like to see it that way that it is the separate, special-part, that in child protection we concentrate on the basic security...that you don't need to concentrate on that one...(W4)

What ever the diagnosis is, the first important thing is to aim to as normal activities as possible, act normally, guide to normal activities. (W7)

Children home's basic function is to secure a normal and stable life for children. Taking care of mental health problems seems to belong to special children's homes. For example Hukkanen et al. (1998) and Ward (2006) argue that "normal life" is not enough for adolescents placed in children's homes. These adolescents need "various assessment and treatment services" and there has been a tendency to think that secure placement in itself is enough for the children's psychological recovery (Hukkanen et al.1998, 269). Ward (2006) argues that in the UK, despite a great amount of emotional and behavioural problems, there is a tendency to emphasise "ordinary" and "normal" experiences of the adolescents taken into custody, rather than special, individual and therapeutic needs of them (Ward 2006, 337).

One caretaker pointed out that there is not enough time to take care of the adolescents' mental health problems:

We do not have time to get to know someone's mental health problem, there are not enough employees and our time is spent playing with little kids and protecting them from these kinds of adolescents. (W1)

The psychiatrist pointed out that there should not exist children's homes where adolescents and small children live together. He sees this as a structural conflict which causes problems.

An adolescent with behavioural problems "terrorises" the care of the little ones and he/she does not benefit from the young children's company at all.

He/she might start to show more symptoms because the caretakers' time is spent on the little children. In addition, this sort of situation can even be a traumatic and frightening experience for the little children. (P1)

To some extent, the data from the children's home supports the psychiatrist's view. One interviewee described and criticised placing adolescent with behavioural or other kinds of mental health problems in these normal children's homes.

...one adolescent can make others show symptoms too and he/she can ruin the other children's well-being. (W1)

One of the caretakers mentioned that there can be situations where the little children imitate the older ones by using, for example, phrases and language which frighten caretakers.

...Then come these situations that little children are imitating older ones...they use phrases and language which they have seen that frightens us. "I kill myself" for example...because they know we are going to pay attention to them then.(W4)

Most of the interviewees said that if an adolescent has behavioural problems, she/he can not come to the children's home. There had been in both of the units, however, many cases of children and adolescents with, for example, behavioural problems.

6.2 Problems and symptoms

Mental health disorders which were mentioned in the data were; depression, attention deficit disorder (ADHD), conduct disorder, eating disorder and personality disorder. The eating disorder and the personality disorder were exceptions; those were mentioned only by one interviewee. Two of the interviewees, who have been working in child protection for more than 20 years, said that depression seem to be at the present a common thing among mothers and adolescents. They were wondering, if it is the increased knowledge of it that increases the number of people suffering from it. Depression was mentioned in every interview and described, for example, in this way;

For example with adolescents, girls especially, they might cut themselves, have self-destructive behaviour and thoughts, and they withdraw, they are unwilling to do anything, and they don't have future plans or dreams. (W3)

The care-takers described that often the care-takers think that an adolescent is acting as depressed, although he/she does not have a diagnosis of depressive-disorder, but then there are also those adolescents who have the diagnosis from a psychiatrist. When an adolescent arrives to the children's home, he/she may already have the contact to a mental health service, such as a psychiatrist, a psychologist, a psychiatric nurse or a therapist.

If the contact does not exist, normally contact to some kind of mental health professional is searched, especially if the adolescent will stay in the children's home for longer than just a short period. There were various opinions on how easy it is to get help for the problems, but there were two repeated themes. Firstly, it is easier to get help for the adolescent when workers in the children's homes apply for it than if it is the family that asks for it. Secondly, queues in adolescent psychiatric services are long.

The caretakers described various symptoms of mental health problems, such as aggressiveness, restlessness, impulsiveness, withdrawing from friends and other people, self-harm, anxiousness and substance abuse. Traumatic experiences were pointed out in many interviews. Traumatic events were seen, for example, as reasons for anxiousness and mental health problems.

Then we have clear mental health problem adolescents who have serious problems on that side, and often those problems are coming from childhood traumas (W4)

Then they have un-dealt trauma-experiences, which bring anxiousness and inexplicable bad-feelings (W3)

In relation to traumas, two of the interviewees pointed out that there should be more acute or crisis services in the mental health sector, so that adolescents would get help and support immediately if needed.

For example, the traumatic events should be dealt with at an early stage.

(W4)

Aggressiveness was the most described symptom or problem, it was manifested by using a word or then by describing case-examples of adolescents with aggressive behaviour. In these cases, the workers could not calm the child down, and they had to call extra help.

Very often these children have aggressiveness, I mean real aggressiveness.

(W1)

With this child it went so that the anxiousness just grew and grew, first it was just oral, then it was associated to things, and finally it became physical aggression. (W4)

He just got so mad and started to rage, we first called the parent of the adolescent, but the parent could not calm him down, then we had to call the police and ambulance. (W2)

This “extra help” was in many cases the police or ambulance. A few interviewees mentioned acute psychiatric help-lines.

The psychiatrist divided his clients, the adolescents, in two groups. The groups were; adolescents which have behavioural problems; impulsiveness, instability of emotional life, criminality, violence and substance abuse. They have been diagnosed with conduct disorders. In addition to conduct disorders, there can often be depression, anxious disorder. If the clients do not have behavioural problems caused by conduct disorders, then they have anxiousness and depressiveness. Most of the clients have a traumatic background which can include sexual abuse and violence, and most often serious breakdown of parenting.

A child protection worker will contact the psychiatrist in a situation where the adolescent is “out-of-control” and the worker does not have any tools to work with him/her anymore. The psychiatrist gives consultation to working groups and gives work counselling, as well. The consultation from the psychiatric sector was mentioned in

many interviews with the caretakers as a good tool to get support in problematic cases in the children's homes.

The psychiatrist pointed out that most of the adolescents who have been taken into custody are not motivated or capable to deal with and address their issues in separate, individual visits in psychiatric care. Moreover, medication is not the best solution either. For this reason, the psychiatrist expressed the view that there should be more co-operation and psychiatric work-counselling for those who spend the most time with these adolescents.

...The care should include aims from the psychiatric side as well. The care should have rather treatment approach.(P1)

The psychiatrist did not suggest that everyone working with adolescents need to be highly educated, but he argued that there has to be a clear connection with professionals from the psychiatric field.

For some of the workers in the children's home units the contacts were clear. But all in all, the conclusion from many interviewees was that the service network is complicated, and which place to contact when there is a need for psychiatric or mental health services depends on several factors. One interviewee did not know any services of the mental health service network around the unit, and one was confused of the number of different contacts.

6.3 Ways of working with the adolescents

The children home units do not have any special working methods or therapeutic settings concerning mental health problems.

We don't have any magic tricks here, we go with supporting in everyday life. (W7)

Still, some of the working methods were seen to be related with the mental health problems. Those are “intensive period”, “clear routines”, “anticipating”, “secure-working” and “discussions”. These can be seen essential for the target group. In addition, some special cases were described, for example, restrictions on freedom of movement and restraining a child physically. But practicing these types of methods is not common in the units.

When an adolescent who has a diagnosis of mental health disorder is admitted to a children’s home unit, the caretakers described that in the beginning of the care the adolescent has an intensive care-period. In the reception unit this meant a period of intensive work not only with the adolescent but with his/her family as well. It was emphasised that when the adolescent knows that the workers from the children’s home are co-operating with his/her parents and they accept each other, this information helps the adolescent. This was important from the psychiatrist’s point of view as well. He emphasised also the importance of evaluating, in the beginning of the care, the psychiatric or mental health needs of the adolescent.

In both of the units, consultation from psychiatric or mental health professionals was emphasised in cases where the adolescent has a diagnosis. One of the caretakers found it very important to consult the psychiatric side to establish a framework for the care, which makes easier to anticipate the symptoms. Another caretaker mentioned the benefits of network meetings, where professionals from different fields get together to share the concerns and ways of working related to adolescents.

The caretakers and the psychiatrist found routines important, with all adolescents, and especially with those who have restlessness and behavioural problems (for example conduct disorder). The reason for the routines was that they bring security for the adolescent. The adolescent knows the daily routines and knows what is going to happen next. In this way, the adolescent will not have as many behavioural problems. If everything is not logical and activities come “without warning” for the adolescent, the activities and the whole day are chaotic in his/her head. One caretaker described cases where a weekly schedule was developed together with an adolescent and clearly written down.

Rules and limits can be related with the routines as well, those were repeated in every interview and emphasised as an important aspect in the care of all adolescents. Here is a good description of the overall meaning of rules and limits:

...That we have here limits and rules, secure limits. It is a very important part of the care, it does not count if the child is depressed or hyperactive or just a normal child who does not show symptoms. We have limits, those might have lacked at home, or those have been too strict or the child has decided those by him/herself. We have noticed that having secure limits brings security. (W3)

Two of the interviewees saw anticipating as one way of working which takes the mental health problems into account. One interviewee described this from the point of view of sensitivity to anticipate.

That you anticipate, it can be like hiding knives or...that when you see that now the child's mood is changing and revs are arising, that you anticipate and you can insure what is coming...or at least sense what is coming and protect yourself and other children. (W2)

Working in a safe way came out also and it was mentioned in many interviews. When you are working with an adolescent with problematic behaviour and, for example, aggressiveness, you have to remember to work in a safe way. You have to know who you call for help or consultation and you do not intervene alone in situations where an adolescent is aggressive or in a surge of emotion.

To talk and discuss with adolescents were described in many different ways. One interviewee described it so that she sees it as effective way of dealing with mental health problems, more effective than medicines or therapy. And one of the caretakers mentioned that he had seen that it affects the adolescents' behaviour if caretakers do not have time to discuss with them.

...I saw how adolescents started to show symptoms when a little child came here and we did not have time to discuss with the adolescents.(W1)

In both units, there was a method used with all the children and adolescents to have discussions, it was called "children's meeting". In practice, this was a meeting where

common issues were discussed and the children and adolescents were able to decide together about common living and rules.

6.4 Values

In addition, the caretakers described different kind of values what they found important and crucial to carry out through the care of the adolescents. For example, it was described in many cases that when discussing with the adolescents, the situation needs to include a warm, appreciating and understanding atmosphere. It is important to communicate to the adolescent that she/he is valuable, precious and good the way she/he is and that the caretakers have time for her/him.

The way how a caretaker encounters the adolescent and communicates to him/her how valuable and unique he/she is and that he/she has a right to be him/herself...All this...our basic or even most important value. (W3)

These aspects were emphasised in a study, presented by Hukkanen (2002), in four European countries (Finland, Ireland, Scotland, Spain).

All together 80 children living in residential care were interviewed. The children in the study sample stressed especially the importance of the relationship with the staff which took care of them. The warm, interested and fair attitude of the staff and the feeling of being listened to were experienced as crucial for their wellbeing. (Hukkanen 2002, 27.)

The “warm, interested and fair attitude” can be said to be in a relation to the importance of “humanity” or “equality”, what was pointed in a few interviews. Two of the interviewees clearly pointed out the aspect that it is important to remember that the mental health problems or problems related to behaviour are not a child’s own fault.

We have to remember, if we are talking about children with mental health problems, that the behaviour of the child is not his/her fault. That is the first thing. (W1)

Humanity anyhow...that even though sometimes we have really difficult children...that you remember that there is a little child inside, and he/she has not caused these things. (W7)

Furthermore, individuality was mentioned in the interviews, as one of the most important aspects in the care of the adolescents. This has been listed as one of the most important principle in the relationship between social worker and service user, already in the late 1950s (Banks 2006, 33). Individuality in the care of the adolescents was mentioned from different point of views.

It is difficult...I have worked with more than 100 children and it is really less what I can say like “this and this” is the way you have to work and act. Because when the child comes, it has its own needs, individuality is very important. We have these limits and frames but inside those you have to be able to take the child’s individuality into account. From which kind of conditions the child comes. (W4)

Individuality...that you need to know from where the child is coming. Is he/she from another culture or something. (W6)

The starting point for our work is that we make for every family a really own kind of care-plan, there is no such kind of book or manual from where you could find that “this is the way how to deal with this child...”. That it differs. (W3)

This individuality was also pointed out as being complicated for a new worker, for example, especially for a substitute. It was mentioned that it at first can be demanding to see the clear line and structure in the work because the ways of working with children differ.

6.5 Approaches

Approaches can be more difficult to internalise and carry forward to the work, if you are a new worker in the children’s homes. The values can be described as important principles in social work field. But there are several approaches which you can apply on the work in children’s homes, and it can be said that child protection institutes are free to develop their own approach to work. Two terms concerning the approaches to the work were described in some of the interviews: “solution-focused approach” and “strength based approach”. These approaches were described by some of the interviewees and were not approaches or guidelines which every worker follows.

Solution-focused approach has become increasingly popular in recent years in social work and it has influenced the child protection field as well. The main idea of it is to focus on solutions instead of problems, and the aim is to try to see problems as strengths. (Saarnio, 2004, 247.) The solution focused approach was emphasised in the interviews as a good framework for the child protection work, with the adolescents and when practicing family interventions.

Discussing...It is a little bit like solution focused...that we start try to find solutions and see the future, not only complaining and going through the past. (W2)

Everything starts from the question that what IS working, what is good...that kind of positive, respectful and supportive approach. There are always things which are working, and those can be strengthened...you should never look at only problems. (W3)

This type of approach in working with adolescents in the children's homes was encouraged by the psychiatrist as well. He used the term "strengths-based approach" but in both, the idea is the same: to look at the positive aspects and strengths of the clients.

Strengths-based approach is good. They have enough problems and if you start to talk and talk about the problems, you make them feel even worse. That you should be able to balance, to find positive things and exactly that kind through which they get experiences of success, aspects which support their self-esteem. It is one kind of approach, to move on by supporting strengths and positive interaction, by those you get more forward than through the negative side. (P1)

In the two children home unit studied, the approach to the work was similar with the psychiatrist's point of views. In practice, for example, different active-based methods practiced in the children's homes aim to support the idea of getting experiences of success.

7. DISCUSSION

This chapter establishes the main results of the research. It also elaborates on how the care of adolescents with mental health problems could be improved in the child protection units. The proposals for improvement are presented in Table 3. In addition, the last sub-chapters describe how the research was conducted and evaluates what kind of professional development was achieved during the process.

7.1 Mental health in children's homes

This study has established that the number of adolescents taken into custody has increased and that mental health problems among them are common. This is not only a challenge for the child protection sector in general, but also for the psychiatric field in particular. The need for knowledge about the care of adolescents' mental health problems in children's homes has been identified in the previous chapters. Furthermore, the study aimed to present that the opinions of different professionals can be connected.

The first result, presented in the chapter above, is that the caretakers feel insecure about the subject as a whole. This insecurity had different aspects such as the lack of knowledge or information about the subject, the vague difference between normal and dysfunctional behaviour, separate expertise, and limited time. The concepts of mental health problem and mental health are complex, especially in the context of children's homes. Adolescents in the child-protection institutes come from a traumatic background and suffer from various symptoms. However, in order to give effective care in children's homes, it would be crucial that the personnel can feel confident in their work and evaluation of an adolescent's situation.

The caretakers said that queues in the mental health or psychiatric services are long and acute, and crisis services are not adequately available. The mental health service network seems to be complicated. There are services and places focusing on adolescents' problems, but the network available for the children's home units is not clear or simple. Moreover, according to Laukkanen et al. (2003) this can be said to be a characteristic of the adolescent psychiatry.

Basic mental health services have been divided in small units under different organisations following a local division of tasks and often a local procedure. The incoherent service organisation may also remain unclear to the young user. (Laukkanen et al. 2003, 42.)

The service provider, from where the help is requested for an adolescent living in the children home units, differs case by case. Co-operation with the psychiatric field can not be described intensive or continuous, instead it varies a lot and is not systematic. Many of the interviewees described a situation where they had had to call the police, ambulance or other help because of an adolescent's aggressive behaviour. Furthermore, the psychiatrist described that many times he is contacted by child protection workers because an adolescent's situation is out of control and the workers do not have any tools to handle him/her.

There were not many working methods which the interviewees identified as methods which respond to the special needs and mental health problems of the adolescents. According to Ward (2006), this is a characteristic of most of the children's homes in the UK as well. He claims that most of the children's homes describe themselves as "general purpose" and very few can identify specific methods. Moreover, adolescents in children's homes come from extremely troubled backgrounds, they "carry high levels of distress and anxiety", and, therefore, providing good supportive and empowering care is a great challenge for substitute care. A significant aspect of this challenge is the question how we can balance between the needs for ordinary living and for special treatment. (Ward 2006, 337, 338.)

This seems to be a crucial question in this study as well. How can we balance and integrate the normal everyday life and special needs of the adolescents? This question is elaborated in the following chapters.

7.2 Multi-professional work

The approaches and working methods suggested by the caretakers and by the psychiatrist were quite similar and those could be developed further to be more comprehensive. For example, strength-based approach and behavioural therapy could form a good base for the care of adolescent suffering mental health problems. Applying these approaches, could change the care towards more treatment oriented or therapeutic approach. The approaches should be developed so that the whole team would be familiar with the approaches and committed to the principles of those.

Developing the approaches and the care of the adolescents with mental health problems is not, however, possible without multi-professional work. My suggestion is that the voices of caretakers and the voices of psychiatric field should be more connected in order to develop the care of adolescents with mental health problems. The co-operation should be smoother and more effective. For example, there ought to be only one psychiatrist or other mental health professional, who would give advice, information and counselling related to the mental health problems of adolescents. This would also make it easier to take contact with the psychiatric side. In this manner, the professionals would be familiar with each other and the resources available on each side. This idea was strongly supported also by the psychiatrist.

Another method of multi-professional work was suggested by a few of the interviewees: a psychiatric nurse could be part of the work team in children's homes. This could help the evaluation of a child's situation and his/her therapeutic needs. This might also help the work to be more integrated, resulting in a better balance between the special and the basic needs of the adolescents. The insecurity experienced by the caretakers might change into confidence by introducing effective co-operation between professionals in the fields of child protection and psychiatry (Table 3). Moreover, multi-professional work would promote the implementation of the new Child Welfare Act (417/2007) in practice.

7.3 Community education

In addition to multi-professional work, community education could be developed in the children's homes. It seems that the work in children's homes contains some of the key aspects of community education. For example, methods like children's meetings are applied to empower and to hear the voices of the children and adolescents. This type of methods was not emphasised in the interviews as methods in the care of adolescents. Could these methods be developed further, however, by applying principles of community education? (Table 3)

Developing the community education approach in children's home could help in implementing the new Child Welfare Act (417/2007). The new Child Welfare Act requires that the child's voice should be heard more in the child protection practices. Furthermore, community education aims at emphasising that everyone has to be heard when, for example, forming the norms and rules of the children's home. Children, adolescents and caretakers have to be viewed as equal, and decisions related to common living have to be dealt with, planned, decided and solved together. It makes everyone more committed to follow the rules and principles, if they have participated in developing them. The work in the children's homes has to be divided among the individuals in the community, which in practice means, for example, division of household chores.

By taking the children and adolescents as equal decision makers and giving them responsibilities, they are at the same time empowered.

It cannot be argued that mental health problems among adolescents taken into custody would be healed and treated by implementing methods from community education approach. However, I suggest that the community education approach could have an impact on the problematic behaviour of adolescents. Such effects in communities are presented by Kaipio (1999).

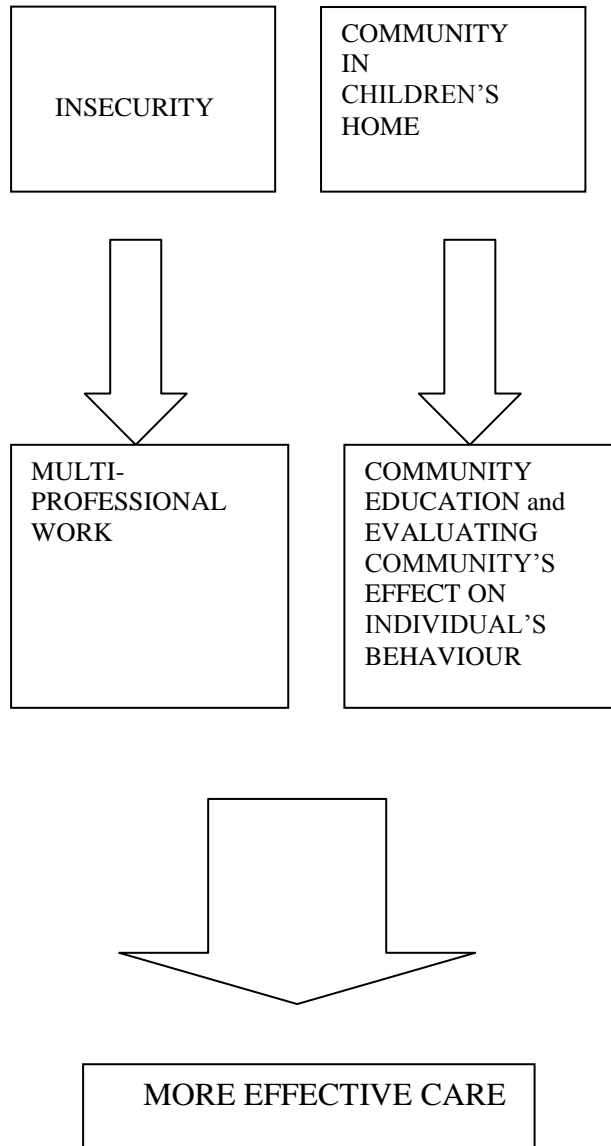
On one hand, it has to be taken into a consideration that especially the reception unit is a temporary place and children might stay there even less than one year. Developing this type of approach to the work requires resources, such as time and commitment of the

whole community, and in this type of dynamic community it can be demanding. On the other hand, the effect and influence of the community on an individual's behaviour has to be taken into consideration in the work in places like children's homes.

The dynamics, values, norms and rules of the group inside a children's home have a crucial impact on the adolescents' behaviour. This should be elaborated more in children's homes. As Törrönen (2006) emphasises, knowledge of networks and social bonds among children and adolescents can be beneficial for social work practice. Studies of friendship bonds among children and adolescents and other human relationships can open up new perspectives of institutional care. Elaborating social networks can help in "creating common aims and avoiding conflicts". (Törrönen 2005, 136.)

In my view, these issues – community education approach and aspects related to community in children's homes– are important and should be studied further.

Table 3: Steps to more effective care



7.3 Validity and limitations of the study

There are certain aspects which need to be taken into consideration when evaluating the validity of the research. On one hand; the situation of the children's home units is presented by seven workers and the opinions from the psychiatric field are expressed by one psychiatrist. It can be argued that the number of interviewees is very limited. For a more comprehensive study it would have been necessary to collect data from different child protection organisations and from different areas in Finland.

On the other hand, for a case study, the number of interviews in these child protection units was quite sufficient. The type of the interviews was very effective: it gave space for the interviewee to talk freely about the subject. Consequently, this generated a lot of material and structuring it was more demanding, compared to the interviews being more direct or detailed.

In the beginning of almost every interview, the interviewee pointed out the caretakers' insecurity about the subject. This required that the questions were put in such way that this lack of knowledge was taken into account and not viewed as a problem for conducting the interview. In the capacity of researcher, I felt comfortable with implementing this approving approach.

The first interviews were conducted in the reception unit with which I was familiar. Also the interviewees were familiar with me and with the study. The interviews in the long-term unit were different. The interviewees had not decided by themselves to be part of this study, and they did not have as much information about the study as the interviewees in the reception-unit. At times, steering the conversation was not so easy and probably some more knowledge and experience in doing interviews could have helped me to conduct the interviews in a more effective way. On the other hand, there was a trust between researcher and interviewees based on working for the same organisation.

In addition to interviews, I considered observations as a good research method. Because of a strict timetable, however, it was not possible to put it in practice.

7.4 Professional development during the process

The process of the research was challenging, but it included also motivating stages and interesting learning experiences. The topic of the research has been my interest since my first practical placement in a children's home. The research was initially planned to be conducted in another child protection organisation and with different focus. Because of structural changes in the organisation, co-operation was not possible and the topic of the study and the research plan had to be changed. This fact made the research more challenging by limiting the time available. Moreover, using English brought its own challenge to the research process. Translating the materials used for the study and writing academic English slowed down the writing process.

Conducting the research was a process containing a variety of aspects and I learned a lot, not only about conducting a research, but also about my own interests in the social work field. My interest to work with mental health, adolescents and children was strengthened. I found the two approaches, strength-based approach and community education approach, interesting and valuable for the child protection field.

I also got interested in developing the care in children's homes, so that they more comprehensively fulfil the needs of the children. I found the community care approach as one of the most effective ways of working towards a positive or desired change, in the context of a community like a children's home. I realised also that applying different approaches in the work requires resources, commitment of the whole organisation and a lot of knowledge on both practice and theory.

The process of the research was time consuming and many times I thought I do not have enough skills and tools to finalise the process. In the end, I am satisfied that I managed to conduct the research. I will continue studying the themes presented in the research.

REFERENCES

- Aalto-Setälä, Terhi & Marttunen, Mauri 2007. Nuoren psyykinen oireilu- häiriö vai normaalia kehitystä? In *Duodecim* 2007: 123, 207-213.
- Ainsworth, Patricia 2000. *Understanding Depression*. Mississippi: University Press of Mississippi.
- Banks, Sarah 2006. *Ethics and Values in Social Work*. United Kingdom: Palgrave MacMillan.
- Child Welfare Act 417/2007.
- Colightley, Malcolm 2006. *Social Work and Mental Health*. United Kingdom: Bell & Bain Ltd.
- Dogra, Nisha, Parkin, Andrew, Gale, Fiona & Clay, Frake 2002. *A Multidisciplinary Handbook of Child and Adolescent Mental Health for Front-line Professionals*. United Kingdom: Jessica Kingsley Publishers Ltd.
- Elliot, Julian & Place, Maurice 1998. *Children in Difficulty: A Guide to Understanding and Helping*. London: Routledge.
- Epstein, Michael H., Sharma, Jennifer M. 1998. *Behavioural and emotional rating scale*. Austin: TX Pro-Ed.
- Eskola, Jari 2007. Laadullisen tutkimuksen juhannustaiat: Laadullisen aineiston analyysi vaihe vaiheelta. In Aaltola Juhani, Valli Raine 2007. *Ikkunoita tutkimusmetodeihin II: näkökulmia aloittelevalle tutkijalle tutkimuksen teoreettisiin lähtökohtiin ja analyysimenetelmiin*. Juva: WS Bookwell Oy, 159-184.
- Friis, Leila, Eirola, Raija & Mannonen, Marjatta 2004. *Lasten ja nuorten mielenterveystyö*. Vantaa: WSOY.
- Haapamäki, Jouko, Kaipio, Kalevi, Keskinen, Soili, Uusitalo, Ilkka & Kuoksa, Maria 2000. *Yhteisö kasvattaa. Päivähoito oppimis- ja kasvatusyhteisönä*. Helsinki: Tammi.
- Hujala Anne 2004. Erityinen huolenpito. In Puonti, Anna-Maija, Saarnio, Tuula, Hujala, Anne. *Lastensuojelu tänään*. Helsinki: Kustannusosakeyhtiö Tammi, 265-269.
- Hukkanen, Raija 2002. *Psychosocial Problems of Children Placed in Children's Homes*.

Turku: Painosalama Oy.

- Hukkanen, Raija., Sourander, Andre, Bergroth, Lasse & Piha, Jorma 1998. Psychosocial factors and adequacy of services for children in children's homes. In *European Child & Adolescent Psychiatry* 1999 (8) 268-275.
- Hukkanen, Raija, Sourander, Andre, Santalahti, Päivi, Bergroth, Lasse 2005. Have psychiatric problems of children and adolescents placed in children's homes increased? In *Nordic Journal of Psychiatry* 2005 (6), 481-485.
- Juvonen, Jukka 2009. Lamakysely järjestöille. Helsinki: Raha-automaattiyhdistys. Accessed 15.10.2009
<http://www.ray.fi/cgi/search.cgi?nm=sub&wf=23F1&q=lamakysely>
- Kaipio, Kalevi 1995. Yhteisöllisyys kasvatuksessa. Jyväskylä: Jyväskylä University Printing House.
- Kaipio, Kalevi 1999. Kasvattava yhteisö. Jyväskylä: Gummerus Kirjapaino Oy.
- Kaplan, Lisa & Girard, Judith 1994. Strengthening high-risk families: A handbook for practitioners. New York: Lexington Books.
- Kaplan, Harold & Sadock, Benjamin. 2007. Synopsis of psychiatry: Behavioural Sciences/Clinical Psychiatry. Philadelphia: Lippincott Williams & Wilkins.
- Kipke, Michele D. 1999. Risks and Opportunities: Synthesis of Studies on Adolescence. Washington: National Academy Press.
- Kvale, Steinar 1996. Interviews: An Introduction to Qualitative Research Interviewing. USA: Sage Publications.
- Laukkanen, Eila, Pylkkänen, Kari, Hartikainen, Birgitta, Luotoniemi, Markku, Julma, Kauko & Aalberg, Veikko 2003. Focused Services for Adolescents. In *Nordic Journal of Psychiatry* 2003 (57), 37-43.
- Lehto- Salo, Pirkko, Kuuri, Ari, Marttunen, Mauri, Mahlanen, Auvo, Toivonen, Veli Matti, Toivola, Pirjo, Närhi, Vesa, Ahonen, Timo & Koponen Hannu 2002. POLKU-tutkimus. Tutkimus nuorista kolmessa koulukodissa. Psykiatrinen ja neuropsykologinen näkökulma. Aiheita 16/2002. Helsinki:Stakes.
- Mahkonen, Sami 2008. Lastensuojelu ja laki. Helsinki: Edita Publishing Oy.
- McCann, Jacinta, James, Anthony, Wilson, Sylvia & Dunn Graham 1996. Prevalence

- of psychiatric disorder in young people in the care system. In Hukkanen Raija. 2002. Psychosocial problems of children placed in children's homes. Turku: Painosalama Oy, as an appendix.
- Metsämuuronen, Jari 2006. Laadullisen tutkimuksen käsikirja. Jyväskylä: Gummerus Kirjapaino Oy.
- Miller, Scott D., Duncan, Barry L. & Hubble Mark A. 1997. Escape from Babel: Toward unifying language for psychotherapy practice. New York, NY: Norton.
- Miller, William R., Rollnick Stephen. 1991. Motivational interviewing; Prepare people to change addictive behaviour. New York: Guilford.
- National Research Council 2006. Posttraumatic Stress Disorder. Diagnosis and Assessment. Washington: The National Academies Press.
- Official Statistics of Finland. Statistical summary 23/2008. Lastensuojelu 2007. Accessed 22.9.2009
http://www.stakes.fi/tilastot/tilastotiedotteet/2008/Tt23_08.pdf
- Pirkola, Sami & Sohlman, Britta 2005. Atlas of Mental Health. Statistics from Finland. Saarijärvi: Gummerus Kirjapaino Oy.
- Pösö, Tarja 1995. Hoidollisuus ja kokonaisvaltainen huolenpito lastensuojelutyössä - välineenä sijaishuolto. In Virtanen Petri: Näkökulmia lastensuojeluun. Juva: WSOY
- Rubin, Herbert J. & Rubin, Irene S. 2008. Community Organizing and Development. Boston: Pearson / Allyn & Bacon.
- Saarnio Tuula 2004. Perhetyö lastensuojelutyössä. In Puonti, Anna-Maija, Saarnio, Tuula & Hujala Anne 2004, 240-255. Lastensuojelu tänään. Helsinki: Kustannusosakeyhtiö Tammi
- Saastamoinen, Kati 2008. Lapsen asema sijaishuollossa: Käsikirja arjen toimintaan. Helsinki: Edita Publishing Oy.
- Sharry John 2004. Counselling children, Adolescents and Families: A strengths-based approach. London: Sage Publications.
- Sourander, Andre, Hukkanen, Raija & Piha, Jorma 2002. Mental health among children in children's homes and in psychiatric hospital. In Hukkanen, Raija: Psychosocial Problems of Children Placed in Children's Homes. Turku: Painosalama Oy, as an appendix.
- Taskinen, Sirpa 2004. Lasten psykososiaaliset palvelut ja lastensuojelu. In Puonti,

- Anna-Maija, Saarnio, Tuula & Hujala, Anne: Lastensuojelu tänään.
Helsinki: Kustannusosakeyhtiö Tammi, 141-153
- Taylor, Steven J. & Bogdan, Robert 1998. Introduction to Qualitative Research
Methods: A Guidebook and Resource. New York: John Wiley & Sons Inc.
- Törrönen, Maritta 2005. Community in a Children's Home. In Child and Family Social
Work 2006 (11), 129-137.
- Varilo, Esko 1992. In Arajärvi, Terttu & Varilo, Esko: Lastenpsykiatria tänään.
Tampere: Weilin Göös.
- Wainrib, Barbara Rubin 2006. Healing Crisis and Trauma with Mind, Body, and Spirit.
New York: Springer Publishing Company.
- Ward, Adrian 2006. Models of "Ordinary" and "Special" Daily Living: Matching
Residential Care to the Mental Health Needs of Looked After Children. In
Child and Family Social Work 2006; 11, 336-346. London; Blackwell
Publishing Ltd.
- World Health Organisation 2005. Child and Adolescent Mental Health Policies
and Plans. Geneva: World Health Organization. Accessed 11.9.2009
<http://site.ebrary.com>
- World Health Organisation 2007. ICD-10. Accessed 12.8.2009
<http://apps.who.int/classifications/apps/icd/icd10online/>
- YLE-News 2009. Lastenhuostaanottojen määrä on kasvanut nopeasti. [The number of
Children taken into custody have increased rapidly]
Published 10.9.2009
http://yle.fi/uutiset/kotimaa/2009/09/lasten_huostaanottojen_maara_on_kasvanut_nopeasti_994063.html

APPENDIX 1: The interviews

INTERVIEWS/HAASTATTELUPOHJA

Perustiedot: Koulutus, mahd.lisäkoulutukset, työkokemus, kuinka kauan ollut tässä lastenkodissa töissä.

[Basic-information: education, possible supplementary training, work experience, how long in this children's home?]

1.OSIO

Minkälaisia psyykkisiä ongelmia / häiriöitä näet täällä, lastenkotityössä?

Voit mainita diagnooseja tai vaihtoehtoisesti kuvailla miten ongelmat ilmenee: minkälaisia oireita, käytöstä?

Tapaus-esimerkkejä?

Mitä mieltä olet, ovatko lasten ja nuorten psyykkiset häiriöt lisääntyneet?

[FIRST PART: What kind of mental health problems / disorders do you see in your work, here in the children's home? You can mention diagnoses or then describe how the problems can be seen: symptoms, behaviour. Case examples?

What do you think, have mental health problems among children and adolescents increased?]

2.OSIO

Entä, kun olet kuvaillut nämä ongelmat, häiriöt, oireet, voitko kertoa kuinka niihin vastataan?

Miten ne otetaan huomioon esim. jokapäiväisessä työssä (+ perhetyössä, muualla) ? Mitkä ovat ne työkäytännöt?

Entä mitkä sinun mielestäsi on neljä tärkeintä toimintatapaa näiden lasten ja nuorten kanssa työskentelyssä, erityisesti niiden lasten kanssa jotka oireilevat?

[SECOND PART: After having described these problems, can you now define how those are taken into account in everyday work (+family work, or otherwise)? What are those working methods or ways of working?

Can you mention four important things, from your point of view, for working with children in children's homes, and especially with children who have those problems what you have described?]

3.OSIO

Entä jos jonkun lapsen tilanne kriisiytyy todella pahasti (käytös todella oireilevaa, esim.suisidaalista) ja täällä ei pystytä siihen enää vastaamaan tilanteen vaatimalla tavalla, mitä tehdään? Mihin otetaan yhteyttä?

Yhteistyökumppanit liittyen lasten ja nuorten psyykkiseen hyvinvointiin?

Tapausesimerkkejä?

Entä jos jollain lapsella on jo tällainen psykiatrinen kontakti kun hän tulee tänne, minkälaista yhteistyö on tällöin vai onko sitä?

[What if a child's situation becomes alarming and even suicidal, what do you do then, whom do you contact? Who are your partners in general relating to the mental health of these children? Case examples? What if a

child already has a contact to psychiatric treatment, what is the co-operation like in that case?]

MUUTA

Onko vielä jotain mitä haluat nostaa esille painottaa tai jatkaa jotain keskustelua?

[Is there something more you would like to mention, or continue the discussion on some topic?]

APPENDIX 2. The interview with the psychiatrist

PSYKIATRIN HAASTATTELU

Perustiedot: Koulutus, työkokemus, työnkuva, millä tavalla yhteistyössä lastensuojelun kanssa?

Kuinka monesta lastenkodista tulee lapsia?

(Basic information: education, work experience, job description, nature of co-operation with child protection?)

OSA I

Minkälaisia nuoria kohtaat työssäsi? (Which kind of adolescents do you face in your work?)

Millä tavalla oireilevat? (What kinds of symptoms do they have?)

Minkälaisia ongelmia? (What kinds of problems?)

Diagnooseja? (Diagnoses?)

Masentuneiden määrä? (The number of depressed adolescents?)

OSAII

Mitkä asiat näkisit tärkeänä näiden nuorten tukemisessa? (What issues you see important in the support of these adolescents?)

Minkälaista apua he tarvitsevat? (What kind of help do they need?)

Miten heitä voi tukea lastenkodeissa? (How can they be supported in children's homes?)

Esimerkiksi masentuneiden, käytöshäiriöisten, huomionhakuinen pers häiriön kanssa? (For example, adolescents suffering from depression, conduct, attention seeking disorders?)

Voitko mainita esim jonkinlaista hoitometodia tms mitä voisi käyttää lastenkodeissa? (Can you mention a method that could be used in children's homes?)

Onko jotain mitä haluat nostaa esille aiheeseen liittyen? (Is there something you want to add, or mention, relating to the topic?)