Eeva Timonen-Kallio, Jolanta Pivoriene, Mark Smith &
Jorge Fernandez del Valle (eds.)

On the Borders between Residential Child Care and Mental Health Treatment in Europe

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ON THE BORDERS BETWEEN RESIDENTIAL CHILD CARE AND MENTAL HEALTH TREATMENT IN EUROPE

RESME
On the Borders between
Residential Child Care and
Mental Health Treatment

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CONTENTS

EDITORIAL

The rights of looked after children to express their wishes and feelings and to participate in achieving their potential are clear principles for all professionals in child welfare services. However, implementing these principles into practice varies a lot across Europe for several reasons. One obstacle is that collaboration between child protection services and mental health care services is often random and lacks clear functions and responsibilities. This is linked to the professional competencies of staff working within the field. It can be a challenge for professionals working with children and young people with complex and chronic needs to share mutual objectives and to advance the service in the best interest of the child. Practitioners can be challenged to understand their own professional role as an integral part of a continuum of the child protection services. Problems in working together between child protection and mental health services need to be understood in the context of the quality and effectiveness of care.

The main idea of the RESME project (2012–2015) was, firstly, to research the residential child care[1] and mental health systems in the participant's own countries and secondly to draw upon practitioners' professional knowledge; experiences and perceptions of collaborative practice to create a continuing education manual for borderline work. Experienced academic experts conducted national research in each of the six partner countries Denmark, Finland, Germany, Lithuania, UK(Scotland) and Spain to collect professional knowledge through individual interviews and group interviews for collation and to exchange good practice.

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1. By *residential child care* we mean care provided in any non-family-based group setting. This includes small group homes, transit/interim care centres, children's homes, and boarding schools used primarily for care purposes and as an alternative to a children's home. The *residential child care work* means the professional care and treatment in these non-family-based group settings.

For children and adolescents to be effectively helped, professionals need to draw on perspectives and approaches from a variety of disciplines and to work together with other professionals. Boundary work is related to professional excellence and to differences in the distribution of tasks: how experts understand their competences, responsibilities and authority in a particular field in relation to other professionals in the field. Boundary work and the crossing of boundaries are at the core of inter-professional collaboration. Surprisingly inter-professional training for *borderline work* does not exist in a single partner country; so, practitioners have a high demand for educational opportunities relating to borderline work between mental health services and child protection services and residential child care.

The first chapter gives an overview of the historical and policy contexts in partner countries and presents the results of the country research carried out, identifying a number of key themes and issues. The research question for the literature review was what kind of collaboration is there between mental health services and child protection among staff working in the different domains. The results of this investigation is presented in the second chapter. The third chapter describes the national contexts and current issues in borderline work in partner countries. In the fourth chapter inter-professional an on-the-job training course "On the borders between residential child care and mental health treatment" is presented and evaluated as well. A concluding chapter summarises the starting points for the RESME project and its results.

I would like to thank the experts and contributors on the editorial board Jolanta Pivorienė, Mark Smith and Jorge F. del Valle whose advice and help has been invaluable. I will also extend my gratitude to all the other contributors Amaia Bravo, Heikki Ellilä, Denise Carroll, Gunter Groen, Astrid Jörns-Presentati, Mari Lahti, Alina Petrauskienė, Eigil Strandbygaard Kristiansen and Jan Jaap Rothuizen who have made this publication possible with their interesting thought provoking articles and comments. Lastly, I would like to thank our RESME project management: project coordinator Hanna Sirén and financial secretary Milla Roininen, who have kept all of us coordinated and focused on the aims of the project.

It is our hope that this present publication will inspire debate on how collaboration could be developed further in *borderline work*. We offer this publication also to open up some of our recommendations for applying a RESME model of training and better targeted on-the–job education for *borderline work*.

I am pleased to welcome you for interesting reading

Turku, 27 January 2015

Eeva Timonen-Kallio
RESME project manager, research & content issues
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EUROPEAN CONTEXT OF THE RESME PROJECT

Mark Smith & Jorge F. del Valle

INTRODUCTION

In this article we bring together data on the interface between mental health and residential child care services across different welfare state regimes spanning social democratic (Finland, Denmark), corporate conservative familial (Germany), Catholic, Mediterranean (Spain) central and eastern European countries (Lithuania) and liberal (Scotland). There are also differences in the size of the partner countries in terms of population: Lithuania is a small country of three million inhabitants; three of them (Denmark, Finland and Scotland) have about 5 million inhabitants, while Germany and Spain, with 81 million and 46 million inhabitants respectively, are among the most populated countries in Europe (although both have complex systems of administrative de-centralization).

Gilbert (2011) notes two broad orientations to child welfare practice across different welfare regimes: child protection, common in liberal regimes, which frames child abuse in legalistic and individually pathologising ways and where services are seen as more residual and less accessible; and family support, found in continental European countries, where child abuse is seen as a problem requiring professional help for families on a partnership basis. Gilbert (2011) notes a convergence in the above orientations to practice over time and the emergence of a third orientation named "child development", characterised by the state's investment in children and seeking to shape childhood through early intervention.

The two orientations noted above remain evident, however, and are manifest in different understandings of terms such as child protection between liberal (generally Anglo-American) states such as Scotland, where it is heavily legalised

and proceduralised and focussed upon ascertaining abuse and identifying perpetrators of that abuse, and more common European approaches within which child protection fits within predominantly welfare based systems where practice takes greater account of social need and seeks to offer support.

One of the most important frameworks of child residential care practice is social pedagogy. As Grietens (2014) says:

> *Social pedagogy is a profession and academic discipline in Continental Europe and Scandinavia. In some countries (e.g., Germany) it is part of social work, in others (e.g., The Netherlands, Spain) of pedagogy and educational sciences. Residential child care is one of the major fields of practice social pedagogues are involved in. Social pedagogues working in residential children's homes are having a bachelor degree and are employed as group care workers. They live together with the children on a daily basis. Social pedagogues with a master degree are employed as staff members in children's homes. They co-ordinate care plans, supervise teams of group care workers and have supportive contacts with the children's families.* (p. 288).

Social pedagogy is a term used mostly in Nordic Countries and Central Europe but in the Mediterranean areas such as France, Spain and Italy the term Social Education is used to denominate the profession of attending vulnerable people in both institutional contexts (children, disabled or elderly people, etc.) or in open community programs. In English speaking countries there is no tradition of this academic and professional framework, relating pedagogy and education to the most concrete area of formal education (schools, etc.). In countries such as the UK without a tradition of social pedagogy, those who work directly with children in settings such as residential child care are rarely professionally qualified and are heavily regulated. The status of such workers is lower than that of social workers and mental health professionals.

The model of social pedagogy or social education is a key piece in the RESME Project as those professionals working in the context of daily living are regarded as the main resource to promote changes in children, through intervention on behavioural and emotional problems. The idea of cooperation between mental health and child care systems is facilitated when that model is implemented and residential care services have qualified professionals working in a model where concepts such as resilience, attachment and conflict management might be managed in the context of a social education or social pedagogy framework.

In most countries there has been a shift away from institutional care towards greater use of family or community based resources. Nevertheless, there remain marked differences according to welfare regime. In liberal regimes (Scotland) use of residential care is particularly low (less than 10% of the total numbers of children in care), while social democratic and Mediterranean regimes tend to use residential care more often (in Finland, for instance, 38% of the total numbers of children in care are in residential care and in Spain, 40%). So, while there may be country differences across the six partner countries, five of them draw upon broadly socio-pedagogical or socio-educational traditions of practice, with only Scotland falling within the category of liberal welfare regime.

These different welfare regime orientations provide an important context to the focus of this project, which is to consider the interface between mental health and residential child care services, analyzing particularly the way that children in care are referred and attended to by therapeutic services.

While there are differences in what kind of data is recorded across the different countries all of them indicate increased prevalence of mental health difficulties among children. It has been estimated that about 10 to 20 % of children and adolescents suffer from mental health problems worldwide (Braddick et al. 2009). Children and adolescents in out-of-home care are at much higher risk of mental health problems (Shin 2005, Besier et al. 2009). In some studies, as many as 80% of young people involved with child welfare agencies are adjudged to have emotional or behavioral disorders, developmental delays, or other indications suggesting mental health intervention (Burns et al. 2004). Moreover, these young people living in out-of-home care with mental health problems continue to experience mental health problems in adulthood (Shin 2005). The World Health Organisation Mental Health Declaration (2005) for Europe highlights the need for comprehensive evidence-based policies targeted especially for vulnerable groups such as children and adolescents.

Against this backdrop of a growing awareness of the need to address mental health issues for the population of children in residential child care, all of the countries involved in the RESME project identified difficulties in inter-professional working between mental health and residential child care services.

RESULTS OF RESME EMPIRICAL RESEARCH

The country research carried out in the early stages of the RESME project identified a number of key themes and issues that are outlined below.

Understanding of role

Psychiatrists and related workers in mental health services had a clear understanding of their main tasks as counselling, assessment, diagnoses and treatment (especially medication). However, residential workers (which fell within different professional groupings across different countries according to their different models of professionalization and service delivery) found it much more difficulties to define their main role and activities; they spoke about everyday life, home routines, preparing young people to become citizens and support for reflection but defining what it meant to work as a professional with young people with severe behavioural problems became harder. Many participants felt their job was difficult to define and sometimes unpredictable requiring a flexible and spontaneous approach. Some of them felt that this reality can make them appear less assured in their position when engaging with mental health staff. On the other hand, some believe that this is one of the most exciting features of their job but the general perception in most countries is that residential work is very demanding, covering lots of different responsibilities and tasks. As a consequence, while mental health staff had a clear idea of the tasks and limits of their role, residential workers' job is far more diffuse and workers can feel that are expected to do everything related to children.

The attempt to create a "family home" type atmosphere was particularly pronounced in countries where social pedagogy has a strong influence. In Spain, for instance, the growing numbers of young people admitted to children's homes with severe disruptive behaviours and the consequent demands on staff to be more specialised or therapeutic could be seen as representing a breakdown of the family model (Bravo y Del Valle 2009). Therefore, specialization was criticized and clinical contributions were evaluated as stigmatising and contrary to the socio-educational model by some professionals, triggering an exciting debate (Whittaker, Del Valle & Holmes, 2014).

Status (and language)

Status differentials were evident across all countries; residential workers perceive that their profession is undervalued by society, certainly in terms of salaries. Beyond just financial recompense, though, psychiatrists enjoyed a generally higher professional status than child care workers. This differential is perceived as a serious handicap by child care workers in reaching a position of real cooperation as they perceive mental health professionals as having the last word on decisions about a child. Specific manifestations of this status differential were evident in the expectation that joint meetings were always held in mental health offices, reflecting a belief that psychiatrists' time was more valuable than their own.

In every country there were tensions around whether a particular case was considered to reflect a clinical problem or a social/environmental one. Often child care staff might refer a child, believing that there was a clinical issue requiring specialist intervention only for mental health professionals to conclude that the problem was due to social and environmental factors and there was no diagnosable mental disorder. As a result they do not offer the kind of specialist intervention that child care staff are looking for and essentially refer the case back for the kind of socio-educational or care response that they believe care workers ought to offer. Residential care workers hence regularly feel let down by mental health professionals.

While it may be understandable that the decision about whether a case is clinical or not must come down to psychiatric criteria, it is also the case that psychopathology rarely operates to clear cut delineation of mental health or social problems and the decision as to whether a case requires psychiatric input is often a matter of professional judgment on the part of the psychiatrist. On the other hand, some mental staff commented that they would expect children's homes staff to have the skills and expertise to manage difficult cases; in some cases children who had suffered extremely negative family conditions and whose crucial need is to have a home with adults able to care them properly and with love may indeed be more appropriate that a psychiatric diagnosis. Irrespective of the rights and wrongs of the respective positions there was a sense among residential child care workers that decisions made only by mental health professionals were perceived to reflect a power imbalance. This imbalance could be compounded by a perception that psychiatry has an academic language which functions as a barrier for communication and

cooperation. Some residential workers think that it is used as a way of showing power and hierarchy but in general residential workers agree that this is a serious obstacle for cooperation.

When talking specifically about knowledge related to mental health issues there was common agreement between professional groups about the need for more training. In one of the cases recounted, however, a psychiatrist commented the clear need for child care workers to be trained in mental health issues, but no need at all for psychiatrists to get more knowledge about child care issues and social pedagogy. In most countries residential staff commented they feel that MH professionals don't know what kind of place a children's home is, with many different children, a lot of pressure and a lot of tasks to do. A consequence of this lack of knowledge about what residential workers do is that mental health workers can also fail to realize that sharing everyday life with children can afford a privileged access to observe and know children.

In most countries child care workers felt that initiatives to bring about better cooperation invariably come from the child care system. Yet, when child care services did organize training courses about residential care and mental health problems and invited mental health professionals to attend there could be a struggle to get them to do so.

Divergent attitudes and expectations

There were concrete examples from the research of the tensions between roles and the status differentials between the two groups. Mental health staff across all countries felt that care workers harboured unrealistic expectations of what they could do. There was a sense that they *"ask for miracles", "wait for a miraculous medication", "want very fast results"* … Of course, child care workers make such demands under pressure and in circumstances of acute anxiety, sometimes asking for concrete interventions and diagnoses to support their own perception that behaviours and needs are so extreme that they must signify some psychiatric disturbance. It is perhaps understandable that they are annoyed when mental health professionals do not agree.

On the other side, mental health staff often complained that residential workers visiting with children have a serious lack of information about the family background, medical history, and personal circumstances of children. Moreover, when treatment extends over long time it is very common that

residential workers accompanying children change and different people appear. Without knowing essential information and without stable adults to refer to makes any therapeutic intervention difficult. An example of the paucity of information that can be provided was offered by a psychiatrist who commented that a child had been moved to another residential placement and only the child talked about this fact to the therapist.

However, while recognising this concern from mental health workers, residential workers also complained about the lack of information given back by psychiatrist in the process of therapy. In some countries child care staff say they don't receive follow-up or even final reports. For example, someone commented that mental health staff like to see you at the beginning and at the end of treatment but they don't count on you during the process. In general, they perceive an unbalanced situation where psychiatrists need information to be received from child care workers but they don't see the need to feed back on their own work.

Lack of useful knowledge

There was no common view about the knowledge residential workers have or ought to have about how to manage behavioural problems. There was a unanimous opinion across countries about the expectation and need for guidance and advice about how to work with challenging children. A common perception was that residential workers lack practical advice or strategies as to how to work with the most challenging children. When mental health professionals did offer advice it could be felt to be overly simplistic and general, such as *"the child needs love"*. Yet care workers looked for a greater clarity. One respondent commented that *"we need to know how to do not only what to do"*. This kind of clarity of advice was rarely felt to be forthcoming, contributing further to the sense of mutual frustration in the relationships.

A further frustration among residential care workers emerged around the services they can expect from mental health systems. A repeated comment is that assessments are too short and carried out in a very routine way. According to most of them, the most useful service you can expect is medication and the most disappointing response is when it is related to how to manage disruptive behaviour – as mentioned above, this was felt to be too general to be of any concrete help.

Discussion and ways forward

Despite being one of the main objectives of this study, we actually found few examples of good practices that might be rolled out more widely. Most of those examples we did find related to specific professionals devoted to children in care and very few experiences were found from public psychiatric services. As social psychology showed many years ago, the best way to break down prejudices between groups is to maintain close relationships between them. The examples of better practice that we found in the project seemed to be those where the different professional groups actually knew each other and worked closely together, perhaps on the same site or within the same project. In some countries a professional works as a mediator between both systems to improve communication and cooperation and in other cases good practices are related to some specific mental health units to treat children in care.

The obstacles to better joint working between the different sectors are complex and are related to the status differentials between the two groups but also perhaps to wider professional and perhaps epistemological differences in how the two groups understand their respective tasks.

What is perhaps evident from our project is that a positivist epistemological paradigm appears to be dominant. Those professions, such as psychiatry, based around what can be thought of as "hard" scientific knowledge are thought to possess a more robust and useful knowledge than professions such as social work and residential child care which operate on territory where knowledge is messy and harder to pin-down.

Residential workers might be thought of as experts in the everyday, generalists rather than specialists. But, when they are dealing with difficult behaviours they often fall back on a quest for "scientific" knowledge of what to do in a particular situation and they can experience frustration when this doesn't materialize. Perhaps the expectation that such solutions are readily available through mental health services is misjudged and that residential care workers need to become more confident in their own skills in dealing with behaviours they may not entirely understand. Mental health services may provide advice and support but are not likely to provide the firm answers that can sometimes be looked for.

Conclusion

This review concludes that the main objective of the RESME project to improve cooperation between mental health and child care system is based on a clearly identified need detected in all the participant countries. Children in residential care in all countries need more and better therapeutic intervention and cooperation between professional from both sides becomes crucial.

However, there remain obstacles to cooperation, often related to mutual attitudes and ways of communication. These might be improved by means of increasing spaces for joint discussions and training (as was the intention behind the RESME project). Examples of good practices found in the course of the project included the use of mediator professionals, which has been perceived as really valuable from both sides.

It does seem, however, on the basis of this project (and in light of growing evidence of what it is to be a professional) that bringing about better collaborative working is not simple. Such an aspiration assumes an equality of status between professionals that does not always exist, especially amongst social pedagogues and mental health professionals. In addition to status differentials there may also be epistemological differences between the professions. The distinction between the generalist and the specialist is one that needs to be taken into account in any attempts to get professionals to work more closely together.

There are also challenges in seeking to roll out "best practice" across disparate sites, either internationally or locally. Askeland and Payne (2001) note, *"the creation and use of knowledge within social work is a social process, constructed in localized contexts by those involved in professional practice"*. The starting point for any improvements needs to take into account particular local contexts and to find spaces to promote dialogue and common and realistic understandings between the professional groupings

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COLLABORATION AMONG CHILD PROTECTION AND MENTAL HEALTH CARE STAFF: A SYSTEMATIC LITERATURE REVIEW

Mari Lahti & Heikki Ellilä

ABSTRACT

Background: Mental Health Declaration (WHO 2005) for Europe highlights the need for comprehensive evidence-based policies targeted especially for vulnerable groups such as children and adolescent. There are more than 2 million children in institutional care around the world. There is need for better collaboration among child welfare services and mental health care. However, little is known what kind of collaborative ways are working for staff personnel.

Aim: Aim of this literature review is to describe collaboration among mental health services and child protection services.

Method: Systematic literature review. Search was conducted electronically in CINAHL (1981-2010) and Eric (1966-2010) for publications in English on December 2012. The search was up-dated in January 2013.

Result: There were N=99 papers identified throughout the search. Initially n=5 papers were included to the literature review. Four main methods for collaboration between services were raised; 1) knowledge, 2) forms of collaboration, 3) liaison between agencies and 4) joint working.

Conclusion: There is need for collaboration in between child protection and mental health services in staff point of view. Moreover, there are different methods used for collaboration but also several hindering factors for it.

BACKGROUND

Mental Health Declaration (WHO 2005) for Europe highlights the need for comprehensive evidence-based policies targeted especially for vulnerable groups such as children and adolescent. European Communities (2005) have stated that it is worldwide concern is to focus on adolescent mental health services. It has been estimated that about 10 to 20 % of children and adolescents suffer from mental health problems worldwide (Braddick et al. 2009) and 4-6 % of these young persons are need of clinical placement and observations (WHO 2005). It has been estimated that as many as 80 % of young people involved with child welfare agencies have emotional or behavioral disorders, developmental delays, or other indications of needing mental health intervention (Burns et al. 2004).

There are more than 2 million children in institutional care around the world, with more than 800,000 of them in Central and Eastern Europe and the Commonwealth of Independent States (former Soviet Republics) (Unicef 2009). Children and adolescent in out-of-home care may live in several different of possible settings (Akin et al. 2013). These include for example, foster homes, and residential care (Huefner & Ringle 2012).

Nurses constitute the largest health care professionals group (OECD 2011), who are delivering mental health care (WHO 2011). Moreover, social workers are main persons to offer child welfare care and they take part in decision making in child protection (Stokes & Schmidt 2012). There is increasing problem with growing number of children (Bolten 2013) and adolescent's mental health problems (Ford et al. 2007). This affects the need for coordinate across systems and increase child welfare staff to involve in mental health services (Leathers et al. 2009).

Children and adolescents in out-of-home care are at higher risk of mental health problems (Shin 2005, Besier et al. 2009). Although, mental health problems are causing extensive use of health service among normal population, young people living in residential care settings are often lacking adequate and continuous mental health treatment (Besier at el. 2009). Moreover, these young people living in out-of-home care with mental health problems continue to experience mental health problems in adulthood (Shin 2005). Young people who have contact with child welfare agencies but remain in their homes, experience lifetime rates of serious emotional disturbance similar to young people who have been in foster care (Burns et al. 2004).

There is need for better collaboration among child welfare services and mental health care (Darlington et al. 2004) to ensure effective child protection services (Sloper 2004). Collaboration among these two agencies can improve children's mental health service use (Bai et al. 2009). This brings challenges to the staff to know how to use these collaborative methods (Ward 2006). Darlington et al. (2005) has reported some difficulties to the collaboration between these services, such as, information sharing, communication, and negotiating issues of confidentiality. Nevertheless, collaboration can benefit both workers and clients (Darlington & Feeney 2008).

Sloper (2004) has identified in his research several different joint collaboration methods for child protection and mental health services e.g. 1) strategic level working, 2) consultation and training and 3) multidisciplinary and multi-agency teams. Darlington & Feeney (2008) reported in their study that communication, professional knowledge and skills but also adequate resources are needed to have a good collaboration among child protection and mental health services.

AIM

Aim of this review is to describe collaboration among mental health services and child protection services. Review question is:

What kind of collaboration there is between mental health services and child protection among staff personnel?

METHODS

Reporting the review methods, QUOROM Statement checklist (2005) were used to ensure that factors in reporting has been noticed (Turpin, 2005).

Data sources and searches

We electronically searched CINAHL (1981-2010) and Eric (1966-2010) for publications in English on December 2012. The search was up-dated in January 2013. No restrictions were placed on date of publications and each database was searched as far back as possible.

As each database has its own unique indexing terms, individual search strategies were developed for each database. Consideration was given to the diverse terminology used and the spelling of keywords as this would influence the identification of relevant trials. The search strategy used in English were: (Staff OR Mental health Nurse OR Nurse OR Social worker OR Youth worker) and (Mental health services OR psychiatric nursing OR Mental health care) and (Social work OR Child welfare OR Child protection OR Foster youth OR Child custody) and (Collaboration OR Collaborative OR Cooperate OR Cooperation) limit to (abstracts and English language). The reference lists and bibliographies of retrieved articles were reviewed to identify any additional research. To complement the search strategies keyword searching was done also in the World Wide Web.

Inclusion criteria

We included studies where either mental health staff members or social workers or child protection workers have been used as a study population. Interest was put to studies that focused on mental health services and child welfare services. Outcomes listed were collaboration between mental health services and child welfare services. All experimental studies were included both quantitative and qualitative methods used.

Data abstraction

Two reviewers independently extracted data relating to purpose of the study, sample, outcomes used, and reference standard. Each study was assessed against the inclusion criteria independently by two reviewers. The full text of studies relevant for the review was obtained. For studies with unclear titles and abstracts, the full text was obtained as well. Decisions to include a publication in the review were made independently by two reviewers. This was followed by evaluation of the full text of all retrieved papers. Any disagreement was resolved by consensus with close attention to the inclusion criteria.

RESULTS

Study flow

A systematic literature review profile is summarized in the flow chart diagram.

A total of 99 papers were identified from the databases. A review of the reference lists and bibliographies of the items retrieved identified 1 additional paper relevant to the topic. All together from 99 papers, 83 papers were excluded because they did not meet the inclusion criteria. Thus, 16 papers were read in full. Eleven papers were excluded due to method (n=6) and a wrong participant group (n=5). Thus, a total of 5papers were included in the systematic literature review (Figure 1.)
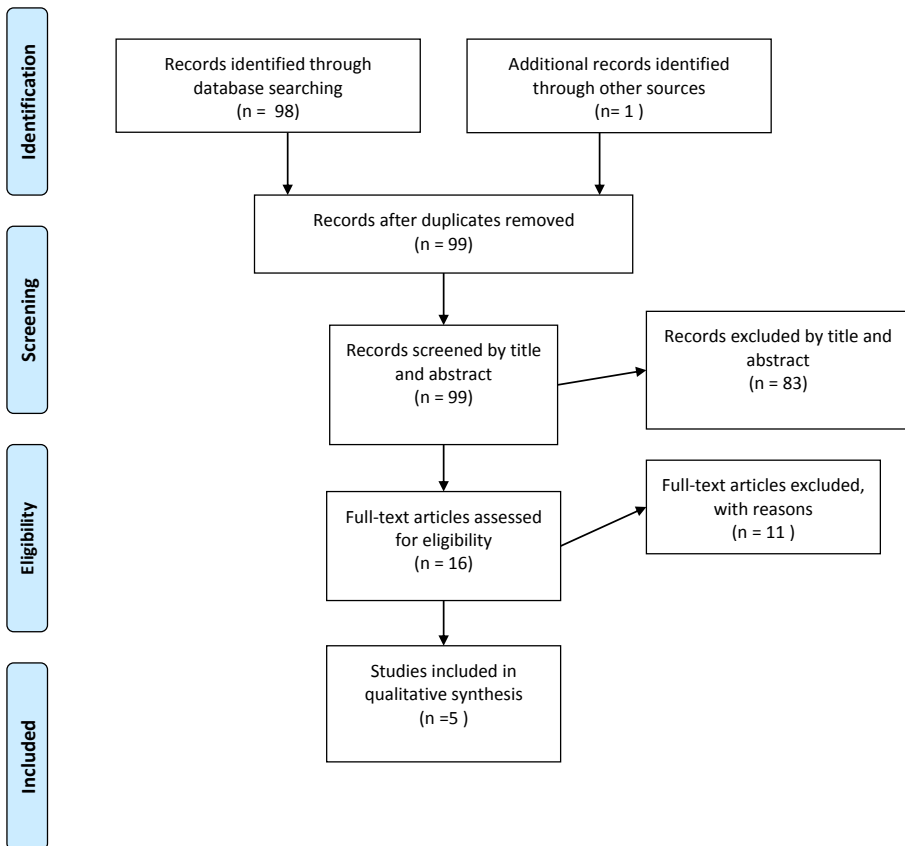

FIGURE 1. *Flow chart.*

Characteristics of included studies

As the result of systematic literature search only five research articles were found (Darlington et al. 2005, Brener et al. 2007, Janssens et al. 2010, Berzin et al. 2011, Davidson et al. 2012). Two articles were from USA (Brener et al. 2007, Berzin et al. 2011). Both reported about the relation between mental health and social work in primary - , middle - and high schools from the perspective of mental health - and social workers. Articles were publishes in Journal of School Health. One of the five articles (Darlington et al. 2005) was from Australia and published in Journal of Child Abuse and Neglect. The article described collaborative work between mental health and child protection services in situations of parental mental health problems. Likewise, the fourth article (Davidson et al. 2012) was published in Journal Child Abuse Review, and was investing collaboration and educational needs of mental health and child care workers when working with families with parental mental health problems. The target group of these two studies (Darlington et al. 2005, Davidson et al. 2012) was professionals working in mental health and social services. Fifth article (Janssens et al. 2010) was from Belgium and published in Clinical Child Psychology and Psychiatry. The article was describing about collaboration between children's services and child and adolescent psychiatry.

A questionnaire was used as research instrument in four studies (Darlington et al. 2005, Brener et al. 2007, Berzin et al. 2011, Davidson et al. 2012). One of the studies (Davidson et al. 2012) collected both quantitative and qualitative data so that qualitative data was obtain from open questions in questionnaire. Janssens et al. (2010) used qualitative approach and used focus group interview to collect the data. Collected data was analysed by using descriptive statistical estimates such as pre cents and frequencies in all of the four quantitative studies (Darlington et al. 2005, Brener et al. 2007, Berzin et al. 2011, Davidson et al. 2012). In addition, Darligton et al (2005) used multivariate analysis of variance and factor analysis. Qualitative date was analyzed by thematic analysis (Davidson et al 2012) and by latent class analysis (Berzin et al 2011). Moreover, Janssens et al. (2010) used grounded theory approach to analyze their qualitative data.

TABLE 1. *Characteristics of included studies.*

Author, Journal, country and year	Title	Methods	Participants	Data collection and analysis	Instrument
Darlington et al. Child Abuse and Neglect Australia 2005	Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers.	**Design:** A self-administered, cross-sectional survey **Location:** Multi center	**Participants:** N= 232, response 21%. 38 % statutory child protection workers, 39% adult mental health workers, 16% child and youth mental health workers 4% were SCAN Team medical officers	**Data collection:** Collected via mail, self-administered questionnaire **Data analysis:** Statistical descriptive estimates % frequencies. Associations measured by multivariate analysis of variance. Principal components analysis by SPSS FACTOR.	**Instrument:** Self-developed questionnaire. Questions about current agency, practices of consultation and collaboration, attitudes toward other workers, training on mental health problems, attitudes about parents' mental illness, barriers of collaboration, successions for service development and demographic details

Brener et al. Journal of School Health USA 2007	Mental Health and School Services: Results From the School Health Policies and Policies and Programs Study 2006	**Design:** A national covering survey on mental health and social services in Schools **Location:** Multi center	**Participants:** State education agencies (N=51) response 100% School districts (N=702), n=445 response 63 % Schools (N=1315), n=873 response 66%	**Data collection:** Collected by Computer assessed telephone interviews or mailed self-administrated questionnaire. The questionnaires were sent to participants two weeks before interviews. **Data analysis:** Descriptive statistical estimates %, frequencies.	**Instrument:** Questionnaire (different to every service level, state, district and school) Assessing staffing characteristics, collaboration between professionals, promotion of services, co-ordinating arrangement of the services, involvement of the students families in services.
Janssens et al. Clinical Child Psychology and Psychiatry Belgium 2010	Conceptuali-zing collabora-tion between children's services and child and adolescent psychiatry: A botttom–up process based on a qualitative needs assess-ment among the professionals	**Design:** Action research **Location:** Multi center	**Participants:** N=26 staff member in child and adolescents psychiatric center, N=30 staff members in children's services	**Data collection:** 8 focus group interviews **Data analysis:** The collected data, transcripts and field notes were analysed using a Grounded Theory approach	**Instrument:** A flexible topic guide containing four prepared open-ended questions was at the moderator's disposal to maintain and guide the discussion in the groups

Berzin et al. Journal of School Health USA 2011	Meeting the Social and Behavioural needs of Students: Rethinking the Relatioship Between Teachers and School Social Workers	**Design:** Part of National School Social work Survey. **Location:** Multi center	**Participants:** School social work associations (n=1639) from 47 states.	**Data collection:** Collected via mail, questionnaire **Data analysis:** Descriptive statistics %, frequencies, latent class analysis	**Instrument:** National School Social work survey Questions were about the frequency of collaboration with different professionals in different occasions.
Davidson et al. Child Abuse Review UK 2012	Championing the interface between mental health and child protection: evaluation of a service initiative to improve joint working in northern Ireland	**Design:** Evaluative study **Location:** Multi center	**Participants:** 12 Champi- ons in mental health, 12 Champions in child care, 59 mental health team members, 26 child care team members	**Data collection:** Questionnaire **Data Analysis:** Quantitative data were analyzed using SPSS and qualitative data using thematic analysis	**Instrument:** Self-developed questionnaire.

Collaboration

Collaboration between services was reported in all the studies. Three of the studies (Berner et al. 2007, Berzin et al. 2011 and Davidson et al. 2012) reported about moderate amount of collaboration between child protection and mental health services of minor, and Darlington et al. (2005) between adult mental health services and child protection services. Berzin et al. (2011) showed that 90 % of social workers worked in collaboration with teachers, parents and social and mental health services, although the level of co-collaboration varied broadly from non-collaboration to well-balanced, everyday collaboration with all the actors. Similarly, Brener et al. (2007) found solid co-operation between mental health and social services in schools hence, over 70 % of all the states and districts had a co-ordinator for school mental health and social work, although vast majority of mental health and social services were provided in outside of school services. Moreover, Janssens et al. (2010) found that there is collaboration but the true need is in solid open collaboration, not in irregular and case-based collaboration.

Synthesis of collaboration between services raised four main categories; 1) knowledge, 2) forms of collaboration, 3) liaison between agencies and 4) joint working. Knowledge were described as sharing knowledge between these two agencies, using different kind of consultation to share and ask information, provide information to the other agency and to have joint education and training. Forms of collaboration were described as structured collaboration, mutual collaboration, supportive collaboration, reciprocal collaboration, and direct collaboration. Liaisons between agencies was described as getting to know each other's to be able to work together, communication between agencies, pursue the same goal and to have enough resources to able all these activities. Joint work were described as working with different agencies, follow-up with agencies, and contact the other service when needed. See Table 2.

TABLE 2. *Summary of collaboration.*

Knowledge	Forms of collaboration	Liaison between agencies	Joint working
1. Sharing knowledge	1. Structured collaboration	1. Getting to know each other's	1. Working together with different agencies
2. Onsite consultation	2. Mutual collaboration	2. Communication	2. Follow-up with agencies
3. Consultation	3. Supportive collaboration	3. Pursue the same goal	3. Contact the other service
4. Provide information	4. Reciprocal collaboration	4. Resources	
5. Training	5. Direct collaboration		
6. Joint education			

There were several difficulties pointed in the collaborative work specially with interface work and communication between child care and adult mental health work (Davidson et al. 2012) In addition, collaboration between the educational staff and mental health- and social services was not on satisfied level and gaps in interagency process was found (Darlington et al. 2005). Two of the studies included in the final review (Darlington et al. 2005, Davidson et al. 2012) examined also the barriers which hinder collaborative working

between child protection services and mental health services. In both of the studies hindering factors were found, such as inadequate training and lack of knowledge from the area of other disciplines. Moreover, both studies reported about inadequate resources for co-operation and unclear structure inside both service systems, and about unrealistic expectations towards other professionals. In Darlington et al. (2005) the questions around confidentiality were mentioned as one of the main hinders for collaboration and furthermore, lack of time and gaps in transferring information between partners were mentioned as hinders (Davidson et al. 2012).

DISCUSSION

Our systematic literature review aimed to describe collaboration among mental health services and child protection services focusing on staff point of view. To the authors knowledge this is the first review done to explore this phenomena focusing on staff personnel and collaboration between different agencies. As the preliminary evidence suggest that collaboration can benefit both workers and clients in mental health and child protection (Darlington & Feeney 2008). We found only 5 studies out of 99 papers reporting collaboration between mental health and child protection services. This is interesting finding itself as Mental Health Declaration (WHO 2005) for Europe has highlighted the need for evidence-based policies targeted for children and adolescent.

The result of this literature review showed that there are different possibilities for collaboration between mental health and child protection staff member's i.e. knowledge sharing, different forms of collaborative actions, liaison between agencies and joint working. The finding is in line with previous literature (Sloper 2004, Darlington & Feeney 2008) where different methods for collaboration has been described. However, in our literature review there were several barriers and difficulties for joint collaboration also highlighted as inadequate training and lack of knowledge from the area of other disciplines. Moreover, inadequate resources for co-operation and unclear structure inside both service systems, and unrealistic expectations towards other professionals were mentioned as barriers for collaboration.

Based on our literature review it can be stated that collaboration between teacher and school social worker and mental health services was warranted. However, there was an obvious need for further research on the collaboration

between social workers, teachers, and mental health workers working in child protection and mental health services. In the other words, there is need for research to show what kind of collaboration works and how. But also, our review raise the need for joint education and training for staff working in child protection and mental health services (Darlington et al. 2005). The need to improve education and training of all the workers of all services, aiming to increase the knowledge and understanding about professional knowledge and methods of the co-operative partners (Davidson et al 2012, Berzin et al 2011).

Strengths and limitations of the literature review

This literature review has both strengths and limitation. First, the strengths of this literature review include a systematic approach to all stages of the review process. Second, the search area was also large and the inclusion criteria broad enough to encompass the broadest range of papers reporting collaboration between child protection and mental health services.

This literature review also has some limitations. Although every effort was made to locate published studies our findings may still include selective reporting. The literature review also involves assessments made by the review authors, and this may lead to bias. In addition, the research papers in this literature review used self-developed questionnaires except Bezin et al. (2011) and this may hinder the results of this review. Due to these limitations there is a risk of overestimating the results of this review. Therefore, there is still a need for further research to evaluate and explore what kind of collaboration there is between child protection and mental health services among staff members.

CONCLUSION

There is need for collaboration in between child protection and mental health services in staff point of view. However, there are different methods used for collaboration but also several hindering factors for it. Based on the literature review, in future there is need for well-structured research to investigate this phenomenon. Lastly, as part of structured collaboration staff members in child protection and mental health services are in need of well-tailored continuing education training.

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NATIONAL CONTEXTS
Current issues in residential child care workers and metal health practitioners working together

THE CONDITIONS AND CIRCUMSTANCES OF PEDAGOGICAL WORK WITH CHILDREN AND ADOLESCENTS WITH DEVELOPMENTAL DISTURBANCES OR MENTAL DISORDER

Eigil Strandbygaard Kristiansen

ABSTRACT

The cost of child and adolescent psychiatry has in Denmark increased 5% and the number of patients increased from about 15000 to nearly 23000 over 3 years together with an increase in the number of outpatient treatments. At the same time we see a decrease in the placement of children in residential care. Changes in policy influence conditions for working with the target group, not only in residential care where relatively more children now have a medical diagnosis. On the basis of key policy reports and professional challenges, the article will suggest possible future team-work and the importance of the municipal authority for action planning and collaboration. The situation in and around residential care institutions has been examined also through interviews with the expert group and employees in residential care during the RESME-project. The article will underline and discuss some challenges, especially for social and pedagogical work during the ongoing changes.

INTRODUCTION

The article focuses on how processes of change and current strategies for work with vulnerable and disturbed children in Denmark. The RESME-project has a focus on collaboration between residential care and health care/psychiatry but it is important to recognize changes in policy and strategy for the regional and municipal authorities (social and health services) in order to examine possibilities in social care work. The article highlights factors which may be important in the future cooperation for actors in the service field and challenges to the continuing education. Residential care institutions are under pressure from changes in placement policy and from the fact that children and young people entering residential care have increasingly severe developmental and welfare problems.

One question is whether the effort to promote a coordinated and coherent collaboration will be strengthened by political means, given that everyone seems to identify this collaboration as a difficulty and a need? You can easily find good will as we found in the RESME project to communicate and cooperate across borders. For many years the requests to do it better have been made, but changes seem not to take place adequately. In addition to these efforts there is a discourse of how to look upon people, in general, with social or mental problems. Officially it is emphasized to change attitudes and approaches to people with mental disorders, to underline e.g. the importance of a common language that will bring focus on the "person" and not the "condition". This indicates good will, but it seems to be difficult to practice such an attitude and avoid the risk of stigmatizing.

To illuminate the situation and structure of institutions and authorities in DK the article will introduce some figures regarding placements in residential care and some strategic aims for cross-professional collaboration. It is important in examining possibilities for changes in social care work to seek to influence the municipal authority and regional founded psychiatry in parallel systems.

The article will aim at some proposals that can be identified regarding collaboration on care work with children and young people. Proposals will take into account experiences from the RESME project and involve efforts from development work to solve cross professional difficulties. Finally the article will discuss the challenges of the future education of pedagogues working in residential care.

This article is based on meetings and interviews with actors from and partners around residential care locations, including the participants in the counseling group for the Danish part of RESME, as well as 3 participants in a training course. The article strives to be true to the informants' statements, but of course in an interpretive or annotated description and contextualized with a critical commonsense (see Kvale, 1994). The conclusions also refer to reports from central authorities about the psychiatric field. Other sources are included in the overall analysis of findings.

SOCIAL WELFARE SYSTEM AS A "REQUESTOR-PROVIDER-MODEL"

Social work in Denmark is broadly taken care of by "social advisors" or "social-pedagogues". The advisors are typically employed in municipal authorities and with family support agencies??. The municipal authority has the formal responsibility for action plans, decisions and management of social work and social measures. Children with disturbances or disorders are identified as children having social problems and treatment is looked upon as social measures. The local authority has the budgetary responsibility and the ability to initiate interdisciplinary and cross-sector initiatives, which might include residential care.

Formally, the municipal authority can obtaining and pay for different kinds of expertise and can call for coordination meetings and for child-descriptions for the action plan. Other actors and partners have an attendant obligation to contribute. We speak therefore of a "requestor-provider model".

Because of increasing numbers of children examined for disturbances and disorders, the municipal authority needs to involve providers, not least therapeutic and psychiatric expertise and social-pedagogical expertise in examinations but also teachers from a child's school and other interested parties.. Complexity in collaboration is affected by the different kinds of positions and status: the social workers are formally equal, they have same level of education etc., but they have different levels of authority depending on whether they work as "requestor" or "provider". Formally, the psychiatrist as well as the staff in residential care, regarding the model, are both "providers" but with quite different status because of educational level, treatment responsibility, professional authority etc.

In Denmark most of the social welfare tasks are, on basis of social service legislation, undertaken by local authorities: the municipality or one of the 5 geographically established regions. The most important task for the regions is administration and management of the health system, i.e. hospitals and some specialized treatment institutions. The Danish health system recognises a number of approved private specialist practitioners, doctors and psychiatrists.

Residential care is organized in different sectors: by region or municipality, in a private sector by self-governing small institutions or by non-profit organizations, and finally by family care. The number of children placed in family care has increased over the years and correspondingly the placements in residential institutions have been reduced. Decisions and choice of which kind of care or treatment are always made by the local municipal authority that is also responsible for service payment.

In the RESME project we were interested in looking for continuing educational efforts at the diploma level as well as the vocational level because, to some extent, employees in the private institutions have no education at bachelors level.

THE VOLUME OF RESIDENTIAL CARE ACTIVITIES AND CHANGES

The cost of child and adolescent psychiatry has increased by almost 5% annually from 2008 to 2011 and the number of patients increased from about 15000 to nearly 23000. The figures reflect a decrease in the number of inpatient days and a relatively larger increase in the number of outpatient treatments. The number of patients in the regional child and adolescent psychiatry has increased from 8000 in 2001 to 21000. Approximately 5% of these are hospitalized.

In addition to economic reasons it is claimed that residential care does not comply with parents' and children's interests and needs, and that its outcomes are not living up to expectations. Representatives of social workers and pedagogues in Denmark express that it is positive that the authorities want social and educational measures close to where the children live with their family. But critics point out that expensive solutions seem to be deselected, although, among professionals, they may be considered to offer

the best solution. There are several references that indicate that economic considerations overrule legal aspects, professional ethics and professional assessment in social and pedagogical work (see Juul, 2010).

These concerns among professionals are especially about children with complex problems, reflecting a need for thorough examination, close follow-ups and specialized treatment since the measures and efforts in such matters are relatively costly.

It is estimated that 20 percent of children in contact with the social system have one or more developmental disturbances or disorders. It is estimated that 2 percent of a cohort may need psychiatric and specialized measures. At the same time is noted that the difference goes from 0.9 to 2.7 percent from the region with the lowest to the one with highest percentage of these very vulnerable children. The number of children and young persons who have a diagnosis has grown.

In recent years there has been a decrease in the number of placements in residential care institutions. The number of placements in 2013 dropped to 2106 from 3632 in 2008. In 2013 there were a total of 11,614 children in family or institutional care in Denmark, 1500 fewer than in 2009. In 2013, 58% of children and young people aged from 0–17 were placed in family care, 21% in public residential institutions and 14% in approved self-governing residential care.

Inadequate care in the family was the leading cause for municipal authority and social services deciding on a placement outside the home in 2013. It was the decisive cause in 53% of the decisions. The most frequent causes of child or youth for authority decision of placement in 2013 were problems with externalizing behaviors and / or adjustment problems not sure what this means. It was the decisive reason for 35% of the placements.

The cases included following assessments:

21 percent showed inward responsive behavior along with difficulties in social adaptiation, 18 percent showed self-harming, attention-seeking behavior and in 14 percent was registered with a developmental disorder like ADHD or autism. Percentages reflect the fact that there typically are more concurrent conditions in an assessment.

Most cases of child placements are established on the basis of the local authority initiative. In about every fifth case decision of placement is based solely on a child's request (Ankestyrelsen, 2014).

DEVELOPMENT IN SOCIAL POLICIES AND REDUCTIONS IN RESIDENTIAL CARE INSTITUTIONS

Municipalities generally want to place children in family care. Municipalities have taken over many of the former regional institutions and are working to install more local supportive measures instead of residential placements. The aim is that the child can stay with its family and remain at the local school. In Denmark a broadly planned social inclusion strategy is activated. One result is that children who presumably previously would be placed in specialized measures now remain in the common local day care facility or school. These measures focus on the child's institutional life and on the activation of the family's resources and coping abilities.

This policy trend will imply a further reduction of residential care institutions, and one can expect new demands on future institutions. Statements indicate that the local authorities will continue to use placement as a measure and to use specialized institutions where the cases are severe and complex. Municipalities will probably use such socio-pedagogical institutions in consultancy work and to examine types of social efforts that will not necessarily require placement outside the home. Maybe we will see a development with inter-disciplinary teams with competencies and authority to decide measures for children with mental disorders.

Interviews with the RESME counseling group and participants on the pilot course indicate that the residential care institutions are ready to meet this challenge if they can benefit from the psychological and psychiatric expertise in examination of the very vulnerable children and from support of specialists in the treatment work. Institutions that work together with psychiatrists then suggest that this cooperation should be more formal. Many institutions propose to solve the difficulties in cooperation between residential institutions and psychiatry and at the same time to develop as a consultative unit for municipalities. The plan or the hope is that with better economic support the residential care institutions can offer better solutions and solve the more complex cases for the municipalities.

How can and should the work develop with the most vulnerable children and young people and which collaborative interfaces shall prove relevant in the working field? Challenges and opportunities for social-pedagogical work may change in different ways - whatever direction this takes there will be a need for educational planning for new professional goals, contents and methods. If more vulnerable and disturbed children stay in their home surroundings it seems that a need for new social-pedagogical support in these surroundings, in family work, school, daycare etc will emerge.

The responsibility for treatment has in different ways moved from the regional health system to the municipal system, especially in the field of adults where there has been an institutionalization of social psychiatry. Municipalities may find that task slippage is inappropriate when it is defined by the regions (Dansk Sundhedsinstitut, 2011). Formally the region should deliver the specialized treatment like residential care that municipalities want them to.

Municipalities have the challenge to organize activities in a way that reflects citizens' needs for coordination and coherence and to deliver the expected specialized treatment. The basic challenge will still include the maintenance of two systems, each of which can invoke processing competence and responsibility for treatment since psychiatry is placed in hospital and the regional system. This sector problem is a basic condition for cooperation between professionals and institutions and requires some political initiative if it is to be resolved.

RETHINKING DIAGNOSES – FROM CATEGORIZATION TO ATTRIBUTION IN CHILD WELFARE

The Danish government set up a committee in 2013 that presented a number of suggestions regarding work with disadvantaged and the most vulnerable people, including people with diagnoses (Regeringens udvalg om psykiatri, 2013). The report deals primarily with adults, but some points may be important regarding children and youth. The article seeks to communicate that since the RESME project and research was started, there have been some possibly important inputs to and signals for psychiatry. Furthermore the Danish parliament has voted for better budgets so that e.g. waiting time for examination in psychiatry systems has been considerably shorter over the last couple of years.

In addition to concrete proposals, committee members emphasize some basic attitudes and approaches to people with mental disorders. People with mental disorders should not be construed as being "the suffering", but professionals must first and foremost meet the people like everyone else: all have different resources, opportunities and problems and some have mental disorders. It is essential that people with mental disorders are not seen as chronically ill.

Diagnosis can possibly deliver an explanation of or a basis for treatment of a mental disorder. Categorization contributes to a feeling of order, to some security and to create a reduction in our mental handling of complex issues. This seems to some extent to be so with children's parents, decision-makers, but also professionals. Categorization, unfortunately, has the weakness that it tends to retain and may constitute a focus on individualized "errors" and the problem of stigma and self-diagnosis (see Goffman, 1963).

Psychiatrist and the chairman of the Mental Health Fund in Denmark underlines the risks of affording the diagnosis too great importance for our understanding of what meeting and working with other people offers and demands.

> *[...] It gives a disadvantage if you think that the medical language can say a lot about people and their lives. [...] Psychiatry language must be supplemented by other forms of understanding and language of psychological, sociological and existential nature.* (see Lindhardt, 2013).

This is hardly an "either /or", but it is underlined in the mentioned psychiatry committee's report that strong categorization of citizens with different psychosocial challenges is not appropriate. Psychological difficulties, disturbances and disorders represent a broad group of conditions, and the problem should be seen as there can be a continuum from natural reactions to life's many challenges to mental disorders. The limits of what are "normal" and "abnormal" are thus both time and culture determined. Categorizations based on a currently documented reality and rigid action plans can stand in the way of support to processes of change and to focus on potentials. Focusing on diagnosis and recorded difficulties can overshadow the importance of a child or a young person's cultural and social context and the changes of possibilities in different periods and areas.

A further strand of thinking is that the citizen should be more involved and seen as self-responsible. Efforts should be based on recovery and rehabilitation activity in the context of social and cultural inclusion. In relation to children and young people the social strategy supports a position whereby they as far as possible, remain in their local surroundings, including their day care institution and school and with the needed support so that the vulnerable child can act, learn and develop there. This strategy seems to succeed with varying results, and certainly with very different views of the results. There is an ongoing discussion about the effects and about the target. It is often criticized, that the target of inclusion is not adequately supported in practice.

We can observe the fact that the regionally established psychiatry has developed from more hospital treatment to more outpatient care and from prolonged hospitalizations to short intensive care in outpatient settings. Psychiatry in the field of adults, especially, is increasingly in the municipalities in what we call the social-psychiatry. In municipal, social work, there is an increased focus on less intrusive and more preventive efforts. It is seen as an increased focus on rehabilitation and on the citizen more than the patient.

At the same time more people are diagnosed! This is the fact also for children and adolescents regarding non-psychotic disorders.

The report suggests that research and development should be prioritized along with skills development and enhanced visibility of results from local development projects as best practices. A growing number of children are identified for assessment and treatment by child and adolescent psychiatry. Many referrals are rejected by regional psychiatry because of lack of evidence or because the referral is assessed as unfounded. Parents and institutions seek help, explanation or pedagogical support by referral to the regional hospital or private practising psychiatrists.

Better cooperation on referrals could probably reduce unnecessary waiting time, waste of resources and provide a more coherent process around the individual child. In addition, visitation guidelines for child and adolescent psychiatry can make a clear division of labor and give better knowledge across the different sectors' and professionals' efforts.

It is essential that children and young people receive the right support and guidance while waiting for examination and planning for treatment. It is emphasized in our material that the same challenge applies to children in

residential care. There are indications that staff in residential care institutions may be inclined to "wait for" investigation and possible diagnosis in the sense that they can neglect the needed care and doubt their own discretion and professional evaluation. Staff seems to do this with the expectation that a psychiatric examination contributes significantly to the pedagogical efforts or contributes to safe and secure methods.

Some of our informants mention that what is pedagogically important hardly should be changed after a psychiatry examination and that a diagnosis probably only can contribute to a small extent to determine what the child needs in his daily life for well-being and development.

Assessments and decisions must always be based on an action plan and professional recommendations based on the current view of the child's situation, difficulties, reactions and challenges. If there is clarity about the child's stress levels, sensitivity and different types of disturbances, it is less important whether the child has ADHD or autism or similar symptoms. It seems important to underline that working with a child in residential care is not working with a diagnosis or expecting that a diagnosis can tell what to do in daily life. Working with a child is working with the phenomenological challenges of the child living in in residential care, in school, in relation to parents and family and in relation to the child's friends.

A basis for an action plan should be created through systematic and consistent work based on documentation from observation, communication and synchronization of knowledge between professionals around the child (UFIDEE model: see Beier, 2012, 184).

PROPOSALS FOR BETTER INTERDISCIPLINARY COLLABORATION

In the RESME process findings identified several challenges and needs for change. One of the answers or solutions was - as a presumption at the beginning of the project - that multidisciplinary continuing education should be piloted and evaluated as a possible option to solve some important challenges in the interdisciplinary collaboration or cross-sector barriers.

Some of these were 1) the difficulties of status differences, 2) communication difficulties, 3) lack of reciprocity and understanding of partners' work conditions, 4) various profession-related cultures and work values, 5) absence of a common ethos, 6) the view upon children's efforts and life challenges and perspectives already mentioned above. One of the implications seems to be fact that workers in residential care might change the focus from the child as a child primarily with developmental and educational efforts to the child with a diagnosis.

So far for the piloting of the interdisciplinary education course has thrown up different challenges and opportunities. In VIA University College we have worked, on the recommendation from the counseling group and the work field, to test the formal and qualifying continuing education (e.g. diploma programs). The conclusion so far is, that interdisciplinary education most effectively should be work place organized and, even better, management initiated education in cooperation with e.g. VIA as a partner.

I don't know what this sentence means – could perhaps delete it. For an educational institution there are several good reasons to enter such educational projects as a partnership to develop and implement different forms of continuing education. This kind of educational effort often demands follow up and changes along the process. Of course, these kinds of partnerships between work organizations and an educational organization raise new challenges, including how to find out about financing it.

In reports from different sources it is emphasized that skills development is one of the preconditions to strengthen the work on better and coherent solutions in interdisciplinary work. The government's psychiatric board also points out the importance of searching for secure and steady solutions for coordination.

> *Since the effort for children and young people with mental health problems is organized by the need for social work and not based on diagnoses the central question in relation to support interdisciplinary cooperation is not whether there are disease-specific models for interdisciplinary cooperation. Instead, it is relevant that in the different municipalities there are implemented methods for cooperation, so that as an example there is a coordinator who can take into account relevant personnel in a case or in prevention work.*
> (Regeringens udvalg om psykiatri, p. 147)

A number of attempts have been made with coordinator functions, but apparently not with the result that it has become a widely formalized mode of work.

There have been attempts with joint visits where the treatment of children has been assessed. In joint visits it is possible to point out that minor issues and challenges can be met at the municipal level with no or with limited consultative assistance from psychiatric treatment, that moderate needs are met with limited consultative assistance while children and young people with severe problems are referred to the regional system of psychiatric treatment, and maybe hospitalization (e.g. in Aalborg municipality).

An ongoing research project in Copenhagen may later contribute knowledge in this area. It has been based on creating close cooperation on child and adolescent care and treatment based on an analysis of the current dual processing system that can counteract the desired and strongly recommended coherent efforts. The project will examine current treatment in cross-sector collaboration and develop a cooperative model. In addition, the project will help to 1) assure the work quality and 2) upgrade employees and 3) involve experiences of the children, young people and their families and will use their resources as well, for evaluation and quality assurance. We shall hopefully see some results that can help to create a functional model of cooperation and contribute to the solution of those obstacles and barriers which the RESME project has also identified. (see Region Hovedstadens ...)

An estimated 25 percent of the self-governing residential institutions have established various forms of cooperation with psychiatrists in private practice. They typically act as commissioned experts to ensure rapid investigation of a child to assess if there are basis for involving the regional psychiatric system. External psychiatrists often also act as supervisors or as instructors for the pedagogical staff in the institutions. In the most formalized cooperation agreements the pedagogical staff are closely involved in the investigative work - including parent interviews and agreement - from the very beginning of a process of treatment. In such collaborations both pedagogical staff and the psychiatrist follow the child's development closely and work on basis of a continued and coordinated assessment of the child's development and needs (e.g. "Hedehuset" in Mariager).

The article here highlights some principles of good interdisciplinary or multidisciplinary practice. There are good reasons approved through various attempts to point to the importance of a function as coordinator between members and groups of professionals around a child and a family. This establishment can function on the basis of a binding agreement between psychiatry and municipal authorities and in this case residential care. The principles of organization and cooperation match largely the problems that RESME partners have found. The description here is based on a report from Ministry of Internal Affairs and Health (Indenrigs- og Sundhedsministeriet (rapport 2011).

The guiding principles should be:

- The child and the child's welfare and development must be the main focus in the effort. It is the child's everyday life, development and the future, which must be the objective, benchmark and ground for the success criteria.

- All relevant partners should be involved, i.e. all who can contribute from the child's network. The involvement must be ensured through assessments and action plans and must be decided in a core team.

- To some extent a common or complementary objective and a consequent involvement of all in the evaluation of the actions and results are necessary.

- There must be documents of agreements and goals and explicit guidelines for the team and the involvement of the network around the child. The document must ensure continuous meeting activities, ways and methods of communication in general, requirements and intervals for follow-up and status.

- Managerially there must be a focus on and a safe space for an honest, respectful and continuous communication of knowledge and goals. Management should ensure regular training for employees.

The core team should consist of the child / family's contact person in psychiatry, contact person for the field of socio-pedagogical measures (in this case the residential care institutions) as well as the social worker, and the family counselor from the municipal authority.

The team's task is to organize and coordinate the process in order to meet a child's requirements and needs for continuous work and efforts across sectors. The task is furthermore to organize activities on the regional and municipal levels as well as in residential care work. Among the team members a coordinator with overall responsibility for contact with the child and family, for communication and follow-up across borders should be appointed. It should be assessed whether this person should be a trained professional from residential care work. This consideration is mentioned, because this person has daily contact and opportunity for close observation of the child's well-being, behavior and challenges. This person has the ability to quickly assess and act in everyday life and in the child's environment. Typically the residential institution has continuous cooperation with the child's parents, and his or her daycare or school and leisure activities. Tight cooperation between the residential care institution, equipped with psychiatric specialist assistance, and the municipal authority around the singular child could be an alternative to the formalized team for all children in a local community.

The team prepares a plan for the organization of collaborative meetings and must be able to meet at short notice. Any partner should initiate such a consultation meeting. Parents should in principle be invited to participate in all meetings.

The team formulates an agreement of cooperation and makes the purposes of treatment and measures transparent and the formulated agreement should contain a description of the responsibilities and of the methodological approach of each of the partners. The agreement must ensure clear identification of who is responsible for what. The agreement provides evaluation and evaluation points and furthermore determines who have the initiative in relation to the tasks described.

The professional partners operate within different regulatory frameworks and thus basically work in parallel processes. A homogeneous treatment strategy is therefore not available or possible, but calls instead on the need for matching or synchronizing. Each party has a formal opportunity to undertake various significant changes on the basis of legal and professional obligations. The challenge is to improve the visibility of the strategies followed so that all collaborators recognize the right and the power to organize efforts in-house and from separate professional point of views i.e. in collaboration with the parents. It is often said in the research that a common language is necessary

or wanted. It is not the point of view here, since the languages reflect the differences in professions, work theories and methods. Maybe you could say there is a need for translation.

Probably, the function of coordination must be further enhanced by institutionalizing it. In such a way it may also become the basis of a professional platform of knowledge and development. One challenge is that the residential institutions are not necessarily locally and formally and therefore they cannot formally be committed nor be represented in such a formalized team or professional platform. Especially, the self-governing institutions cannot be integrated in this version of coordination. So the interdisciplinary, authorized team must be completed and provide an expanded work team in this case, which can be based on the individual child and its family during the child's placement. The continuous authorized team must therefore accommodate social-pedagogical expertise and insight into residential care, which thus can be the connection between the residential institution and the authorized multidisciplinary team. This employee could be the one who has the continuous and coordinating contact and follow-up in relation to the residential care institution.

Cooperation and organization should be supported by the fact that a contact that support and makes priority to collaboration exists at management level. It is also based on the RESME material that an explicit managerial back up and follow function is important to facilitate e.g. supervision or competence development.

Municipalities and regions are encouraged to focus on interdisciplinary competence development. It is recommended that regions and municipalities establish interdisciplinary learning platforms for professional groups, as well as the possibilities of "common school bench" don't know what this might be across sectors should be utilized. A platform can ensure that knowledge and methods, interventions and research on prevention, social-pedagogical work are picked up and exposed. It is recommended to initiate strategic planning with a focus on education and competence development to recruit future staff for specialized work and tasks in care institutions and tasks in the psychiatry system. (Regeringens udvalg om psykiatri, 2013, p. 194)

DISCUSSION OF FUTURE PEDAGOGICAL AND EDUCATIONAL TASKS

Change does not happen readily or in a short term. It is therefore important in professions as in educational work to incorporate skills to navigate in the existing system and within the given context.

As we have seen during the RESME project conditions in residential care underline that pedagogues (still) must better understand the rules and policies of various systems, to evaluate results of their interventions, see what opportunities there are for back up in relation to action and how pedagogical work intertwines with social and health policy agendas. Loss of focus and of a comprehensive understanding can produce resignation if you get negative experiences from the lack of contribution from other professionals.

Efforts to develop and support pedagogical judgment and discretion and place it on a stronger foundation in knowledge about mental health problems, about living with diagnoses, about work and public systems, about new methodology etc. should take place in relation to general education as well as to work place training and to continuing education and should be considered from the perspective of the several different and possible future tasks and work conditions.

Whether there is a need for new treatment strategies or more focus on theory such as neuro-pedagogy or therapy is left open here. Many well-known ways of practising surely are appropriate and effective. One of many questions is how diagnostic practice can be a help to the children in their development and their (self) developmental efforts.

Maybe we'll see the establishment of several types of multidisciplinary teams in the municipal area and several contexts in which pedagogues work with vulnerable children and children with developmental disorders. It may be that there will be significant decreases in the number of placements and that we'll see more network-based, locally established social-pedagogical measures for families, children and young people.

Another possibility may be to develop greater or more cooperative, cross-disciplinary residential care facilities. Bigger units could establish in-house interdisciplinary teams or a stronger organized involvement of psychiatry experts. This will all demand new ways of planning pedagogical work and the education of pedagogues.

The fact of increasing inclusion activities and of more children with diagnosis in the local community institutions point to increased multi-disciplinary efforts and coordination within the municipalities. The importance of inter-disciplinary cooperation must be emphasized even more to shift the focus from looking at each child's diagnosis or even difficulties towards the social and cultural context in which the child or adolescent lives.

Knowledge and experience from residential care work may be important to transform into active knowledge of local general institutions such as school and day care if still more children should stay in the local (day)care institutions - children with disturbances and disorders that we used to look upon as the cause and basis for a placement in residential care.

We should pay attention to the possibility of a multidisciplinary platform to ensure good quality work with vulnerable and struggling children and adolescents, their conditions of learning and development, diagnosed or not, included in local measures or placed in residential care. Education and continuing education of pedagogues, social workers or nurses should in the future regard the mentioned changes since they seem to be rather consistent, i.e. of what will be asked for by "deliverers".

One conclusion for future work and efforts could be to underline the need for us as a university college to engage in further developmental work and to analyze the diverse conditions for and tendencies in local policies for health, social and pedagogical work, to strengthen the educational efforts to support new social and locally measures for children with developmental disturbances or disorders.

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COLLABORATION BETWEEN CHILD PROTECTION AND MENTAL HEALTH PRACTITIONERS IN FINLAND

Eeva Timonen-Kallio

ABSTRACT

In the Finnish system, the main challenges in borderline work between child protection and mental health treatment are linked to problems with the access to the mental health services the child needs and, on the other hand, in the lack of definition of what the "border" between the institutions is. According to a report of the UN Committee on the Rights of the Child for the Finnish Government, there is a need to pay attention to the quality of child welfare services and the insufficient mental health services for children in Finland. Especially children in institutions should have better access to mental health services when required (Ombudsman in Finland 2011). The aim of this article is to present knowledge about the Finnish national situation in the "border" between residential child care and mental health care systems as well as some good and promising practices for better helping the child. In this chapter concept "child protection" means the particular statutory activities of public authorities to support/protect children by providing them special services, such as taking them into care.

GLANCE AT RESIDENTIAL CHILD CARE AND MENTAL HEALTH SYSTEMS

Finland has more residential placements than other Nordic countries. There are multiple forms of institutions: group homes, children's homes, assessment centres, transit/interim care centres, family foster homes and family centres. The terms used do not necessarily describe the nature of the institution: how it operates, what its goals are, or even how large its facilities are (Laakso 2009). Moreover, residential care provision in Finland is mixed, run by municipalities, by the state (reform schools), by the third sector (voluntary or independent associations), and by an enlarging private sector. In 2009 the private sector and the third sector provided approximately 70% of residential services and the state and municipalities 30%. In 2010 there were 614 private residential institutions and professional residential homes, of which 53 were run by associations and 560 by private companies. Kinship foster care with relatives seems, after all, to represent a relatively small group in Finland, where nearly half of the children taken into care in 2012 were placed in families, but only about 11% of those in foster care were placed under the custody of their own relatives (Child Welfare 2012).

The number of children placed in care took an upward turn in 2011. The number of children placed in care increased by nearly 3 per cent the previous year, and the number of children in emergency placement by 13 per cent. This trend continues. Recent figures show that the increase is 6.6 per cent in year 2012. It is alarming that the share of children in emergency placements of children aged 7–12 increased by as much as 9.7 per cent. As emergency placements increase, so do challenges for the quality and continuity of the care. During the year 2013, a total of 18 022 (52 per cent of which boys) children and young people were placed outside the home, and of them, 10 735 were placed in residential care. Around 81 800 children and young people had been the subject of community-based (open care) child welfare interventions in 2013, an increase of 2 per cent from the previous year. There were a total of 103 714 child welfare notifications in 2012, an increase of 6.7 per cent (6501) from 2011. Child welfare notifications in the age group 16–17 accounted for 10.2 per cent of the population of the same age. The social worker must decide no later than seven days after receipt of the notification

or other message whether to begin investigating the need for child welfare, or whether the notification does not require any measures to be taken. The time limits set in the Child Welfare Act are unconditional (Child Welfare 2012.). More than 18 000 children were living in out of home care in 2013, in contrast to 9 000 in 1991; hence increase is 46%.

A child placed outside the home may have several different placements during a year. According to the most recent reason of placement, 34 per cent (6 290) of the children and young people placed outside the home were in foster care, 16 per cent (2 697) in professional family homes, 38 per cent (6 756) in residential care and the remaining 12 per cent (2 087) in other care[1]. There is a stronger emphasis on residential care, because it covers not only children taken into care, but also children placed outside the home with an emergency care order or as part of support in community care or after-care. (Child Welfare 2012).

In Finland, 18 out of total 22 hospital districts provided child and adolescent psychiatric inpatient services in 2000. In one district there was a psychiatric inpatient service only for adolescents (Ellilä 2007). There was a psychiatric out-patient clinic for minors in every hospital district. According to the Finnish Mental Health Act, patients under 18 needing inpatient psychiatric treatment have to be placed in special units planned only for minors. In addition, many children and adolescents needing psychiatric treatment are situated in residential child care institutions (Hukkanen et al. 1999) and in paediatric wards (Piha et al. 2000). Child psychiatry and adolescent psychiatry are separate subspecialties of psychiatry. Finland is the only nation in Europe with this kind of arrangement, which leads to a situation with two separate psychiatric service systems in 20 hospital districts. The number of CAP psychiatric inpatients beds is 592 (300 adolescent and 292 children) (Laukkanen et al. 2003; Piha et al. 2000). Fifteen percent (n = 83) of the beds

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1. **Foster care:** With relatives or other kin, or a foster family
    Care in professional family home: A professional foster family home licensed as a family home or child welfare institution
    Residential care: Child welfare institution, family rehabilitation unit, reform school, institution for substance abusers, institution for people with intellectual disabilities
    Other care: Placements in the child's or young person's own home (with the parent/s), independently supported accommodation and other forms of care not classified above

were "day treatment beds" (35 adolescents / 48 children) and the rest 85% (n=504) were situated in 24 hour wards. "Day treatment beds" were situated either in special day hospital wards or in the 24 hour wards. Two of the wards were family wards, and both provide services for two families (Ellilä 2007). The average length of a treatment period is 6–8 weeks (Salenius & Salanterä 2009).

Children from the age of 2 until 12 are treated in child psychiatric services and those in the age group 12–18 in adolescent psychiatry. In child and adolescent psychiatric special care works psychiatrists, psychologist, social workers, nurses, occupational therapists and representatives of different therapists such as art therapy, psychiatric and other type of nurses being the largest single profession. The number of child and adolescent psychiatric inpatients has increased 47% between the years 1995–2004. The increase was biggest among teenagers, especially in girls. At the same time, between years 1995–2004, the treatment periods shortened from 54 days to 43. There were also significant differences in the use of in-patient treatment between hospital districts in Finland.

COST OF SUBSTITUTE CARE

The cost of substitute care increased, in particular in foster care, where they were 620 million euros in 2010. The foster care cost has increased 25% during the 2000s. The largest Finnish towns publish annual reports on the cost of substitute care and a report 2013 indicate that 80% of the all child welfare cost was spent on foster care and that a day in residential care costs between three or even five times more than a day in a foster family (Ahlgren-Leinvuo 2014).

The high cost of residential care relative to foster family care remains a significant factor in determining the place of residential child care in government child care strategies. It could be argued that the trend towards the increasing use of family-based care may reflect a "cost-led" approach to service development rather than a "need-led" approach. While the current policy in Finland emphasises that the child's needs should determine the chosen form

of substitute care, decisions are often influenced by economic issues and there is a growing interest in defining "good care" in relation to the economic costs (Francis et al. 2007, 348.). This may lead to a situation where institutions are seen as marginal and are not the first priority for development work, thus protection and psychiatric services for children might be even less available.

CHILD WELFARE ACT – ENCOURAGING MULTI-PROFESSIONAL NETWORKS

The Finnish Child Welfare Act 2007[2] is aimed at meeting the best interest of the child through support and early intervention with the family rather than through foster care or residential care. Children in Finland may be placed away from home either as part of voluntary "open care" measures, with the aim of supporting the family on a temporary basis, or as part of more formal procedures – taking the child "into care" and placing him/her in substitute care. In 2004 80% of cases where children were taken "into care" were based on an agreement by all the interest parties. The age of criminal responsibility is 15 and all cases of younger children are dealt with by the child welfare system. After the age of 15, juvenile crime is dealt with by the justice system. However, when young offenders are seen to need child welfare interventions "for their best interest", they are also dealt with through the child welfare system. (Francis et al. 2007).

The Child Welfare Act requires municipalities to arrange preventive child welfare services and child and family specific services according to necessity. The law includes regulations on reporting obligations, issuing reports on the need for child welfare, the procedures for taking children into care and foster care and after-care. The decisions for accommodating a child in substitute care are prepared by the municipal social worker who is assigned to the child and who is responsible for the child's care plan. The official decisions are made

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2.　　Finland's Child Welfare Act was revised in 2007, replacing the Child Welfare Act from 1983.

by municipal officeholders. The child welfare institutions are responsible for ensuring good quality of residential care. In residential work, residential care workers are in charge of implementing the rehabilitation processes of children and their families. The work is carried out in close co-operation with other professionals in multi-professional networks.

Substitute care is defined in the Child Welfare Act 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, Paragraph 1, Paragraph 2)

The ideological ethos prefers foster families to residential care but, on the other hand, specialised institutions are required for "the most challenging and demanding" children, when residential care is the only possibility. The Finnish Child Welfare Act 417/2007 considers in its sections 72 and 73 the provision of special care for children "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". This is done by a multiprofessional care team in a child welfare institution, with the possibility of restricting the child's freedom of movement during the provision of special care. Special care can be arranged in a limited number of children's homes. It requires resources (for example a multi-professional team and enough employees) and permissions from the municipality. "Secure accommodation" does not exist as a concept in Finland. The Finnish child welfare legislation recognises that the rights of the resident may be temporarily limited in terms of access to social contacts and free movement outside the establishment but there has been a deep unwillingness to introduce closed institutions (Francis et al. 2007). However, the concept of "special care" in residential institution is recognised.

Special care means special interprofessional care to be arranged in a child welfare institution for a child aged 12 years or more. Special care may be arranged for children if their extremely important private interest so necessitates in order to interrupt a vicious circle of substance 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 the children themselves and to allow provision of comprehensive care for them. The decision must be based on an interprofessional assessment of the child's situation made for the purpose of arranging special care on the basis of expert opinions in upbringing, social work, psychology and medicine. Special care may be arranged for a maximum of 30 days. Special care may be arranged in a child welfare institution that has sufficient expertise in upbringing, social work, psychology and medicine available for arranging special care. The institution must have personnel that the task requires and who hold appropriate professional qualifications. It must also have facilities appropriate for providing special care in terms of health and other conditions. (Child Welfare Act 417/2007 Sections 71–73)

MUTUAL CHILD CLIENTS BETWEEN CHILD PROTECTION AND MENTAL HEALTH SYSTEMS

Many children in residential care are in need of psychiatric treatment as well as child protection services, and thus the professional expertise of both sectors must be coordinated in their care. About 55–80% – depending on the instrument used for the assessment – of children in residential care settings presented a psychiatric disorder in a study carried out by Hukkanen (et al. 1999). As Hukkanen (et al. 2005) point out, the traditional idea of a residential institution providing a safe and structured living environment has almost disappeared. Institutions increasingly deal with children who have a range of complex social, emotional, educational and behavioural problems. A large number of children in residential care have faced deprivation, abuse or life in a chaotic domestic environment. These children have often experienced traumatisation. Hukkanen (et al. 2005.) 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 a children's home in Finland (Hukkanen 2002, 45).

CHALLENGES IN COLLABORATION

Although the recently revised legislation urges practitioners for multiprofessional collaboration, practices are not yet that well developed. It is again accidental where a child is cared and treated (Mahkonen 2010, 22; Taipale 2006, 171). Social workers in the child protection system could find themselves in a situation where the psychiatry system refuses to care a child with mental health treatment needs if the child *has not been taken into custody*. The argument for demanding custody is that this way the child's life situation can be stabilised, which is a prerequisite for therapeutic work. From the child protection point of view, the situation is very frustrating, when there is a clear need for psychiatric treatment but the criteria for custody are not met and treatment cannot be arranged. Social workers have no means or possibilities for forcing health care to cooperate, even though they know that the means and interventions of child protection are not enough for helping the child (HE 164/2014 vp).

Recent Finnish research indicates that child protection and mental health workers are too often in the position where neither party is "able" to offer for a child suitable care as both parties strictly interpret the laws according to their own interest. The social professionals examine the Child Welfare Act, and mental health practitioners interpret the Mental Health Act. As a result, it might happen that both parties find excuses for *not* taking the responsibility for the care and put the necessary interventions into practice. Regional differences are substantial because municipalities interpret the laws and regulations in varying ways. (Ristseppä & Vuoristo 2011).

This uncertainty recurs in workers' everyday solutions when a child is taken into custody and he/she lives in a care institution. It seems that residential care workers feel to some extent insecure in differentiating the behavioural problems and the mental health problems and thus in identifying when the child is in urgent need for help. The situation is especially problematic with the adolescents who show behavioural disorders with a high component of distress and aggressiveness in relation to the limited facilities of the institution. Sometimes residential workers do not see the dealing with mental health problems as part of their work and place the entire responsibility of addressing those problems onto mental health professionals (Enroos 2006).

DECISIONS IN CHILD PROTECTION AND MENTAL HEALTH SECTOR

A child–welfare client relationship begins when, following the initiation of proceedings in a child welfare case, child welfare measures are taken urgently or a decision is made to investigate the need for child welfare (The Child Welfare Act, Section 26). Proceedings are initiated in a child welfare case upon application or when a social worker or other child welfare worker receives a notification or otherwise becomes aware of a child who may be in need of child welfare. The social worker or other child welfare worker must immediately assess the child's possible urgent need for child welfare. In addition, the social worker must decide, no later than seven days after receipt of the notification or other message, whether to begin investigating the need for child welfare, or whether the notification does not require any measures to be taken. The time limits set in the Child Welfare Act are unconditional.

Every child who is taken into custody has a key social worker in the child's municipality who makes decisions for all child welfare and health care services for the child. The client plan must be reviewed where necessary, and at least once a year. The decisions of the foster care and placing a child in substitute care are prepared by the child's own municipal social worker who is responsible for the child's care plan. An administrative court may authorise an examination of the child by a physician or other expert if the examination is essential for investigating the need for child welfare but the custodian forbids an examination. If the child's custodian or a child of 12 years of age or more opposes the taking into care or related placement into substitute care or if the hearing has not been carried out for reasons other than those referred to in section 42(3), the case is decided by an administrative court on application by a municipal officeholder. The official decisions are made by municipal officeholders. In 2012, 80% of the cases where children were taken "into care" were based on an agreement by all the interest parties.

In the mental health sector, the decision regarding compulsory admission is made by a general medical practitioner or another physician and the patient is transferred to hospital by paramedics. A minor can also be ordered to treatment in a psychiatric hospital against his or her will if he/she needs treatment for a serious mental disorder which, if not treated, would become considerably worse or severely endanger the minor's health or safety or the health or safety of others, and if all other mental health services are

inapplicable. The treatment of a minor must be provided in a unit which has the facilities required for that treatment. A minor must be treated separately from adults, unless it is considered that it is in the interest of the minor to act otherwise. The involuntary admission of a minor is legally more complicated than the admission of an adult, because a person under 18 is legally under the control of parents or parental substitutes. They should always be informed about involuntary admission and they also have the right to appeal to an administrative court, however the minor him/herself has to be heard in all stages of the treatment (Mental Health Act 1116/1991).

COMPETENCIES FOR RESIDENTIAL CHILD CARE WORKERS

The child welfare institutions are responsible for ensuring good quality of residential care. In residential work, residential workers are in charge of implementing the upbringing and care processes of children and their families. High-quality residential care means that the work is carried out in close co-operation with other professionals in multi-professional networks. The working methods vary from individual work to group work and a variety of activation and/or creative methods are in use.

Qualifications for professionals in residential child care have a wide definition and no connection to social work: "when recruiting staff the special needs of the clients and nature of the residential work has to be taken into consideration" (Child Welfare Act 2007, Paragraph 60). That means that residential workers have different kinds of training backgrounds and the qualifications vary a lot in residential care units (Ristseppä & Vuoristo 2012). Bachelor-level education trains *socionoms* as "generalists" in social services. In children's homes they work as *counsellors* (not as social workers or educators). Psychiatric nurses are also entitled to work as social counsellors, but 50% of the personnel in a residential child care institution must have a Bachelor's degree in social services. Both degrees consist of 210 credits (ECTS) and the regular time for studying is three and a half years. Practical nurses have three years' vocational education. They can work in child welfare residential settings as child care workers. Social workers have a Master's degree in social work. Only the biggest institutions have social worker(s). They do not usually work as counsellors (educators) in children's homes but as experts with their own "practices" in institutions.

Nearly 50% of the residential workers are socionoms and held a degree level qualification in social services and 13% other degree level qualification. But even so, there are some concerns for the qualifications and quantity of the residential workers (Tuloksellisuustarkastuskertomus/lastensuojelu 2012, 79–81).

GOOD COLLABORATION – PROMISING PRACTICES

Our specific empirical research for the RESME project, including four multiprofessional focus groups with professionals from both sectors, was conducted to find some good and promising practices. Socionom and psychiatric nurse students at Turku University of Applied Sciences have written their thesis in the RESME project to collect the best practices in collaboration with these two systems. The following chapter is a short summary of the good practices of their thesis (see Carretero & Kuosa 2013; Marttila 2013).

- Decision-makers and representatives of the municipalities' outpatient care polyclinics, psychiatric ward care and senior social workers from child welfare services arrange *network meetings* to agree on the procedures for collaboration.

- Social workers and psychiatric workers make a *multiprofessional house call* together if a child welfare notification has been done. This would prevent overlaps in work and helps with the assessment of the immediate care needs of the child. In addition, here cooperation can act as preventative measure, which could ease the requests for institutional care. This way of collaboration helps the child and the family to understand the needs for the child and accept the help.

- The principle of the care is that children should be able to stay in every day context at home and go to school. On the other hand it is known that the adolescents are not always able and willing to deal with their issues on individual visits in psychiatric care. Instead, psychiatric help should go to them in children's homes. The institution is the home of the child and help should be available there. In "*on the foot model*" *practice* the psychiatric services are going where the client is. For example when the situation escalates in the child welfare institution, immediate extra staff and

psychiatric know-how calm down the possible disaster. Moreover, the practitioners realise the (limited) possibilities of "other" side to help. The ward treatment in specialised psychiatric care should only be used in extreme situations and even then as little as possible. However, when needed, the admittance to the ward could be made easier in order to reduce its reputation as a last resort. Thus, the ward treatment would be like any other means of help the adolescent can get. The admission to the ward could be made even more difficult, in order to prevent the adolescents from getting stigmatised. In an appropriate practice, the child would get the psychiatric help he/ she needs in an acute situation or distress and then continue his/her life with the mental health outpatient support and with the care of the child welfare institute they are living in.

- When acute psychiatric outpatient services are able for longer presence in institution as *co-workers* on a regular basis, they could notice possible problematic situations in a more neutral manner and via clinical supervision and educational interventions guide the personnel of the child welfare institution to unravel the situation.

- Well-functioning collaboration requests professional dialogue and the targets set together. Therefore knowing one's own professional field is not enough for working together as fellow colleagues. Child welfare personnel desire more *knowledge* about psychiatry and its treatment practices and models and vice versa, psychiatric workers want more knowledge about procedures in child protection and educating practices as well as facilities in children's homes.

- A good practice for consulting and delivering professional knowledge between these two systems is *a social worker in the psychiatric ward treatment team* with doctors, nurses and other personnel.

- One good practice is that psychiatric workers work closely and involve in the care planning the *key worker of the child* when the child is accommodated in an institution. This has some crucial advantages because the key worker knows the child and his/her everyday life situation best and has valuable knowledge when planning the care order. When the key-worker is more involved, the transition back to normal routines after treatment goes more smoothly.

DISCUSSION

In Finland separate structures between child welfare and health care are strongly questioned. Experts from both child protection and mental health care and psychiatry share the concern that services should be better unified in order to provide clear procedures, good cooperation and adequate care for mutual child clients. However, some efforts have already been made. Revised child welfare legislation, where the procedures and practices for foster care are regulated in detail and multiprofessional practices are described, has been provided. The fact, however, is that to some extent the lack of qualified social workers in Finland is a burden when putting the updated regulations into practice. But even if qualified social workers make decisions for all child welfare and health care services for the child in borderline work, they have no means or possibilities for forcing health care to cooperate. There is a good level of training among professionals, but the question still remains: how to incorporate both sides' competencies and expertise for better collaboration? The promising practices presented here are a good start for supporting collaboration and developing the practices further. Mutual training for the personnel of child welfare institutions and psychiatric workers could offer a forum for exploring and exchanging and thus dispel the structural separations and encourage working together.

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BOUNDARY WORK – GOOD COLLABORATIVE PRACTICES BETWEEN MENTAL HEALTH SERVICES AND RESIDENTIAL CHILD CARE IN GERMANY

Astrid Jörns-Presentati & Gunter Groen

ABSTRACT

The majority of children and young people currently living in residential institutions in Germany have experienced traumatic events such as dysfunctional families, neglect, and/or sexual or physical abuse, often over a prolonged period of time. As a result, more than 60% are diagnosed with a mental health disorder and require psychiatric or psychotherapeutic care. For this reason, it is especially important that this population receives appropriate child and adolescent mental health services, as well as on-going welfare interventions. Unfortunately, cooperation on the borderline between residential care and mental health services in Germany poses a continuing challenge for members of both systems. This article gives a general overview of borderline work on a national level, based partially on results of a qualitative interview study with German residential care workers and mental health professionals, conducted in the context of the EU-project RESME (*On the Borderline between Residential Child Care and Mental Health Services*). The findings resonate with current literature, suggesting that there is a great need for more joint service responses to children and young people with complex needs. Good and promising examples of collaborative practice in Germany, such as liaison psychiatric services, joint case management, cooperation agreements, as well as inter-professional exchange are presented. The importance of developing innovative health and welfare interventions in order to overcome the inherent fragmentation of the system is discussed.

INTRODUCTION

Despite several positive developments in Germany in recent years, there are still challenges posed by the collaboration of child and youth welfare services and the mental health sector. The need for improved inter-professional collaboration remains a shared agenda of politicians and practitioners alike (e.g. Gahleitner & Homfeldt & Fegert 2012b; AG Psychiatrie der AOLG 2007; BT-Drs. 16/12860 2009). The 13th national Child and Youth Report (BT-Drs. 16/12860 2009, 103) points out that children and young people with complex needs living in residential care are particularly reliant on effective collaborative practice across all services, and they suffer most if the cooperation between health and youth welfare system fails. The EU-project RESME explores the interface between child and adolescent psychiatry, as well as psychotherapy and residential care. For RESME, we interviewed 19 professionals from a variety of relevant disciplines (social work/social pedagogy, psychiatry, psychology and psychotherapy) about their experience of collaborative practice in Germany (Groen & Jörns-Presentati 2014). The interviews enquired into challenges, good practice examples, and meaningful practice-based themes relevant for improving boundary work. The focus was to better understand the logic of conflicts arising in inter-professional working relationships, and to open up possibilities for inter-professional learning that builds upon practitioners' knowledge, their communication skills, and their ethics and values. One of the outcomes of RESME was a joint continuing educational course for practitioners working in both fields, with the goal to initiate a mutual exchange of knowledge and everyday practice in order to further positive change (Groen & Jörns-Presentati 2014).

PREVALENCE OF MENTAL DISORDERS IN GERMANY

Approximately 10 to 20 % of all children and young people[1] in Germany suffer from a mental health disorder (AG Psychiatrie der AOLG 2007). This is equivalent to the prevalence of mental health problems found in other western industrialized nations (Fuchs et al. 2013). In the *German National Health Interview and Examination Survey of Children and Young People* (KiGGS), undertaken between the years 2003 and 2006, 18.5% of the 3 to 17 year olds were categorized as "borderline or abnormal" in the total difficulties score for mental health problems. The study also revealed a clear gender

divide: boys rather displayed externalizing problems (e.g. conduct problems, hyperactivity-inattention) as well as higher scores for total difficulties, whereas girls exhibited more emotional problems[2]. Furthermore, low socio-economic status was shown to be related to higher scores for total difficulties, and all subscales (Hoelling et al. 2008). Within the KiGGS design, an additional study (BELLA) assessed the mental health of 2863 children and adolescents between the ages of 7 and 17 years, and found 21.9 % experienced some form of mental health problem (Ravens-Sieberer et al. 2007). 14.5% of the children and adolescents fulfilled the criteria for at least one specific mental health disorder associated with impairment, or had an overall mental health problem plus present impairment (Ravens-Sieberer et al. 2008). Just 40% of the children affected were reported as receiving treatment.

Children and young people who are taken into care by child and youth welfare services, are at a high-risk of psychiatric disorders, in comparison to the normal population, as they often have been exposed to multiple life stressors from an early age. In 2012, an overall 517.000 children and young people received child care services in Germany, of which 66.711 were placed in residential group homes or quasi-independent living arrangements and 64.852 with foster parents (Statistisches Bundesamt 2013). The majority of these children and young people has experienced psychosocial and biological risk factors as well as socio-structural disadvantages, for example: broken homes, neglect, loss of supportive relationships, death of a parent, a mentally ill parent, complex trauma (including sexual and physical abuse, violence, forced migration), poverty, discrimination, or social exclusion. Studies show that 60-80% have experienced at least one traumatic event or have been exposed to adverse life events for a prolonged amount of time (e.g. Schmid 2010). Adverse life events are well-documented risk factors of psychopathology and epidemiological studies show that more than 60% of children and young people in residential institutions receive at least one

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1. Epidemiological studies suffer from different methodological problems (diagnostic criteria, assessment, etc.), as a consequence results cover a wide range (Doepfner, 2008).

2. Data on mental health for 14.478 children and adolescents from 167 representative sample points all over Germany was collected. Mental health problems were determined using the Strengths and Difficulties Questionnaire (SDQ).

psychiatric diagnosis (e.g. Schmidt 2007; Schmidt et al. 2008). The largest epidemiological study in Europe to date, conducted in Switzerland, with a sample of 592 adolescents and young adults in residential care, of which 429 lived in the German-speaking part of Switzerland, showed that 74% fulfilled the DSM-IV-TR or ICD-10 criteria for at least one specific mental health diagnosis, 44% fulfilled the criteria for two or more disorders. Almost 80% had experienced multiple traumatic events, more than one third of the sample reported to have experienced more than three (Schmid et al. 2011). A variety of mental disorders are prevalent in the residential care population, such as conduct disorders, ADHD, depression, substance abuse, or self-harm. Disruptive behaviours pose the main problem in residential care institutions. Externalizing disorders are seen predominately in male adolescents, however, a disproportionally high number of female adolescents were found to be suffering from internalizing disorders (Schmid 2008).

THE MENTAL HEALTH SYSTEM IN GERMANY

The healthcare system in Germany is based on governmental and non-governmental institutions of the federal and state governments. A distinguishing feature of the healthcare system is its organization into public and private health insurances. Child and youth psychiatric services are mainly divided into inpatient and outpatient treatment, generally covered by insurance as part of public healthcare. Child and adolescent psychiatrists, paediatricians, psychologists, or pedagogues with a license to offer psychotherapy generally provide outpatient services for children and adolescents. All provide diagnostics and treatment, however only psychiatrists are eligible to offer pharmacotherapy. Outpatient treatment is generally offered in private practices covered by a public health insurance plan. Child and adolescent psychiatric hospitals offer limited ambulatory services, usually under the guidance of psychiatrists and psychotherapists. Some paediatricians also offer services for children and adolescents with mental health problems, and multiprofessional mental health teams treat patients in social psychiatric practices and social paediatric practices. Inpatient mental health treatment for children and adolescents is usually provided by child and adolescent psychiatric hospitals managed by local authorities, university hospitals, or hospitals run by non-profit welfare organizations. Private hospitals delivering mental health care for children and adolescents are still rare. Professionals working in inpatient

services are generally child psychiatrists or paediatricians, child psychologists, psychotherapists, pedagogues with further training, nurses, social workers, teachers and child care workers.

Over the past decades, outpatient and inpatient mental health services for children and adolescents in Germany have improved. However, lengthy waiting times for a first assessment are still common and can last anywhere between a few weeks and several months. In rural areas, mental health service provision remains especially scarce (BT-Drs. 16/12860 2009). In 2007, one child and adolescent psychiatrist served on average 11.263 patients under 18 years old, in the capital city of each state. Child and adolescent psychotherapists served on average 2840 children and young people per capital city across each state. 900 children and young people used ambulatory services offered by child and adolescent psychiatric hospitals in 2007. Between 2002 and 2007, there was a 12,5% increase in beds for inpatient treatment. Services offered in day hospitals also increased by 54%. In 2011, a total of 140 child and adolescent psychiatric hospitals offered 5647 beds overall. One bed in a psychiatric ward was offered on average to 2.933 children and young people across all states in 2007 (AG Psychiatrie der AOLG 2007). In acute cases, 24-hour emergency services are available at public child psychiatric clinics. Immediate admission is offered to patients in severe crisis (e.g. risk of harm to self and others). Compulsory inpatient treatment can be carried out against the will of a young patient, according to the evaluation of a child psychiatrist, and if a court order has been passed.

Although children and young people in residential care suffer more frequently and more severely from mental disorders, service provision for this population remains problematic. Children and adolescents from a residential context are generally underserved by mental health services. Although many may come in contact with the child and adolescent psychiatric system, treatment is often discontinued or does not adequately address their complex needs (Schmid 2007). Many treatment options, such as evidence-based talking therapies or pharmacotherapy, are not taken advantage of because the residential care staff has limited time to invest in escorting the child or young person, or because of the stigma associated with seeking mental health care (Besier & Fegert & Goldbeck 2009). Unfortunately, delaying treatment has particularly serious repercussions for this vulnerable group, such as avoidable psychiatric hospitalization due to escalating distress and increased rates of suicidality, comorbidity and chronicity. Furthermore, it has been suggested that

traditional forms of psychotherapeutic treatment and counselling offered in a setting where patients are expected to seek out the service (in the form of scheduled appointments) do not match the needs of this hard-to-reach population (Schmid et al. 2010b).

RESIDENTIAL CHILD CARE IN GERMANY

Germany falls within the broad model of conservative welfare regimes, according to the welfare typology suggested by Esping-Andersen (1999). Conservative welfare regimes utilize a welfare policy that prioritizes employment and mandates compulsory social insurance in order to safeguard individuals and their families from risk. Social assistance is reserved for those who are not protected through employment or through family members. Welfare service provision is extensive, with the state playing a pivotal role. Private market provision is minimal. The most important institutions in the youth welfare system are the municipal youth welfare offices, which are part of the municipal administration. There are 590 municipal youth welfare offices across Germany, each responsible for the provision of local youth welfare services, including residential child care (BT-Drs. 17/12200 2013). The majority of residential care institutions are supplied by the non-profit sector, including church-related organisations (Petrie et al. 2007). 67% of all residential group homes, which amounts to 61% of all children and young people residing in residential care, are non-profit welfare organizations, whereas only 1,5% are privately run non-profit organizations. Residential care is generally financed through local public budgets, but parents have to partially contribute to the costs. In 2011 public costs for care in residential homes and other forms of supported housing amounted to 2,87 Billion Euros (BT-Drs. 17/12200 2013).

Residential care workers in Germany must receive qualifications in institutions of either further or higher education. The lowest level of training is a three-year vocational apprenticeship, which leads to a qualification as a state approved child care worker. The majority of residential care workers, though, are educated at Universities of Applied Sciences, which offer four-year degree programmes in social work. Universities of Applied Sciences are institutes of higher education that provide undergraduate and postgraduate education, focusing on vocational degrees such as engineering, social work and business

management. These institutions are only authorized to award doctoral degrees in collaboration with a University. Residential child care workers trained at university level, e.g. in social pedagogy, education, or psychology, remain the exception, and are likely to occupy more managerial positions. Pivotal to working in residential care in Germany is using the social pedagogic approach, which can be summarized as having "a focus on the whole child and support for the child's overall development and the engagement of the practitioner as a person, in relationship with the child, and bringing emotional, reflective, and practical dimensions to the work" (Petrie et al. 2007, 35). Pedagogical competences therefore entail providing assistance in daily living, emotional support, group work and counselling, and have a special focus on the individual needs of each child or young person.

Germany has seen a big overhaul of residential child care services due to a widespread general critique of institutionalized care in the 1960's and 1970's (e.g. Goffman 1961, 1963). Due to a social policy shift towards community care, residential institutions have been reformed, for instance group homes have become smaller and more person-centred (Petrie et al. 2007). On average, 2.6 residential care workers offer full time care in residential group homes to eight children or adolescents (Schmid et al. 2008). In 2013, youth welfare offices in Germany took 42.100 children and young people in care. This is an increase of 1.900 minors (+ 5 %) more than in 2012. Compared to 2008, when 32.300 children were taken into care, the number has increased by 31%. In 40% of these cases (16.900 children and young people) out of home placement was initiated because a parent or family lacked the overall resources to provide for their well-being. If the best interest or welfare of a child is severely endangered, parents do not have to give their consent. However, a child or young person may also be taken into residential care upon request. There was also a sharp increase of unaccompanied minor refugees. In 2013 a total of around 6.600 children and adolescents arrived in Germany unaccompanied by an adult person and were as a result placed under custody. This was six times more than in 2008 (1.100 minors). Approximately 5.900 of these young people (89 %) were male, whereas only 700 unaccompanied girls crossed the border into Germany. Almost 4.600 (69%) of the minors were 16 or 17 years old. Child protection has become a priority for the German federal government, which has led to an increased focus on strengthening preventative services that support children and their families or carers before they reach crisis point. Overall, it can be said that the demographics of the

residential care population in Germany have changed considerably, as more tailored services to a variety of needs are provided. Residential care increasingly offers services to a larger number of severely traumatized children and young people (Schmid, Fegert & Schmeck 2012).

CHALLENGES IN INTER-PROFESSIONAL COLLABORATION

Generally speaking, children and young people in a residential context are prone to being moved around between services. They show an increased dropout rate, and welfare interventions are discontinued more frequently (Nützel et al. 2005). Delivering adequate services to this population is complicated, and proves to be a challenge for professionals from both systems. This is especially true in times of crisis, when a child or young person exhibits externalizing problems as manifested by defiant, aggressive, rule-breaking and impulsive behaviour (Schmid, 2010). The results of our qualitative study were consistent with issues discussed in the literature regarding inter-professional collaboration for children and young people with complex needs (e.g. Gahleitner & Homfeldt 2012). The different theoretical perspectives and concepts underpinning the professional identities and approaches of the two systems play an important role in the working together between residential child care and the mental health system. Child and adolescent psychiatry often espouse a more medical model of disease, according to which mental disorders are classifiable entities to be diagnosed in a uniform, objective, and operationalized language. Their emphasis is on curing and rehabilitating the individual, taking psychosocial and contextual factors into consideration as focal points for a successful treatment plan. In residential child care, practitioners are guided by the social pedagogical approach, according to which reflexivity and attachment is key to enhancing children's well-being (Gahleitner 2011). Behavioural problems are interpreted as ways of coping with adverse life events as part of an educational and developmental process (Böhnisch 2005).

Although the approaches used to work with this high-risk population in residential care and in the mental health system have considerable overlap, our qualitative interview data suggests that, to some extent, challenges in collaboration stem from mutual misconceptions about roles and responsibilities assigned to the other profession. Especially when disruptive

behaviours lead to psychiatric inpatient treatment episodes, the residential child care workers we interviewed did not always feel their competences, such as the ability to assess the severity of a crisis, were taken seriously in a mental health context. At the same time, there was a sense that the mental health profession delegated major responsibilities to residential care workers (e.g. prevention of self-harm). On the other hand, we found that residential care staff were sometimes perceived by mental health professionals as having unrealistic expectations regarding the outcomes of mental health treatment. However, a residential care worker's comprehensive understanding of a young person's problems and resources plays a significant role in the clinical diagnostic process. In the interviews, mental health professionals stressed the importance of receiving information from residential care about a child or young person's care and treatment history, school records, and other relevant documentation. Generally, supportive relationships in residential group homes were seen to be paramount for stabilizing the psychological state of a child or young person, especially during times of transition (e.g. discharge after inpatient treatment, or a change of residential setting).

GOOD PRACTICE EXAMPLES FROM GERMANY

All of our interviewees emphasized the importance of inter-professional cooperation as a means to providing services suited to the physical, psychological and social needs of children and young people in residential care. It was thought that developing good practice models of integrated care allowed professionals to approach issues regarding a child's mental health (e.g. trauma, pro-social behaviour, impulse control, and emotion regulation) and their daily life (e.g. school, housing, finances, hobbies) holistically. Overall, we identified four categories, which appear to be crucial for successful collaboration between mental health services and residential child care: knowledge and competence, individual attitudes and values, personal contact, communication and relationships, as well as organisational and structural frameworks (Groen & Jörns-Presentati 2014). We found that it was crucial that practitioners were aware of organizational processes and resource constraints in each sector, in order to avoid excessive expectations and disappointment. Moreover, it seemed pivotal that cooperation was prioritized in their daily practice. Keeping a positive attitude towards working together appeared to be another factor that benefited good collaborative practice. Examples of successful inter-

professional cooperation were also characterized for many of the respondents by openness, face-to-face contact and personal relationships. Generally, inter-professional collaboration is reliant on institutional support on a macro level, as well as active networking across work relationships on a micro level. The goal should be to foster a culture of cooperation across systems and services. In the following, a number of good and promising practices in boundary work between residential child care and mental health treatment in Germany are described in more detail:

- psychiatric liaison services

- joint case management

- cooperation agreements

- interprofessional exchange

Psychiatric liaison services

Psychiatric liaison services provide routine assessment, diagnostics and treatment within the child welfare system, either on the premises of a residential institution, or in special care settings. Screening for mental disorders in children and young people coming into residential care institutions has been suggested in order to address poor mental health through preventive action, and introduce mental health services to a child or young person before an acute crisis occurs (e.g. Schmid et al. 2008). Furthermore, routine developmental and mental health assessment in residential care homes can help build a better understanding of a child or young person's history of mental health problems in order to respond more appropriately to mental health needs in the future, help a child or young person to avoid crises altogether or reduce, if necessary, the length of inpatient treatment.. Generally, offering mental health treatment to children and young people in the context of their residential group home has shown to lower perceived stigma associated with seeking mental health care; it intensifies the therapeutic alliance, and increases motivation for therapy (e.g. Schmid et al. 2010b).

Besier & Fegert & Goldbeck (2009) investigated the effects of a child psychiatric liaison service that offered an intensive, multimodal outpatient treatment program and crisis management program in 11 residential

institutions. Mental health professionals provided regular outpatient treatment at the group home and involved residential child care workers. The authors found that, compared to a control group that was treated in the usual form (n = 336), a reduction of inpatient days was found in the intervention group (n = 288). Although inpatient treatment could not be avoided completely, less termination of supportive relationships during psychiatric hospitalization and higher continuity of care provided by residential care workers was achieved. Our interview data suggests, however, that limited staff and time resources in the residential group home, and long waiting times for appointments at the hospital can pose a difficulty for establishing routine mental health assessments. Furthermore, installing liaison psychiatric services within residential institutions requires additional financial compensation for mental health staff. One psychiatrist we interviewed offered a regular psychiatric consultation service in residential group homes, where children and young people were able to discuss acute or on-going mental health issues. However, the costs for his services were only covered by a special public health insurance plan in the context of a special arrangement.

Many severely traumatized children and young people living in residential care vacillate between changing residential institutions and recurring psychiatric hospitalization, often without access to adequate psychotherapeutic treatment (Schmid 2010). A psychiatric liaison service in residential care, that aims to provide trauma-sensitive psychosocial interventions, is traumapedagogy: a fusion of psychotraumology, pedagogy, attachment theory and mindfulness skills (e.g. Schmid 2010b; Schmid et al. 2010, Gahleitner 2011). A psychiatric liaison service informed by traumapedagogy actively engages the residential group home as "therapeutic milieu" in the therapeutic process. Gahleitner & Krause-Lanius (2012c) conducted one of the few comparative effectiveness-studies looking at the benefits of a "therapeutic milieu" in therapeutic group homes for adolescents in Berlin. The authors analysed 237 case histories and 20 interviews with young people as well as residential care workers. They found that supportive relationships between a young person and residential care worker as well as group dynamics with peers played a focal role in the effectiveness of the therapeutic group homes. Daily life in residential care was seen to offer opportunities for children to overcome dysfunctional relationship patterns, work through their traumatic experiences, and gain self-efficacy and life skills. A traumapedagogical approach has been described as "dialogical" in that residential care workers' own experience of self-efficacy in dealing

with crisis in the group home is taken into account. As they employ a self-awareness of their own emotional reactivity to challenging behaviours, and engage in self-care during times of stress, they model alternative behavioural responses for children and young people in distress (Gahleitner 2011).

"Clearing houses" are an alternate model of psychiatric liaison services that offer short-term intensive multi-professional inpatient treatment and care for children with severe difficulties. Their conceptual foundations and organizational structures vary with each institution that has been established so far in Germany. In Bavaria, the term "clearing house" refers to a secure and closed type of residential institution, whose purpose lies in clarifying steps for further interventions. The Children's Centre St. Vincent, run by a Catholic child and youth care organisation in Regensburg, for example, offers three to four places for children and young people who present massively antisocial and delinquent behaviours, and who are in acute crisis situations. They are allowed to stay up to a period of three months and are served every fortnight by a psychiatric liaison team, working at the outpatient clinic of the local Child and Adolescent Psychiatric Hospital in Regensburg. A first evaluation of this particular psychiatric liaison service arrangement showed a high prevalence of mental disorders in children and young people coming into the clearing house (Rexroth 2008). A follow up evaluation two years later showed a significant improvement in regard to the assessment and treatment of mental health problems (Rexroth 2010). Furthermore, as inter-professional cooperation between outpatient clinic and the clearing house had been intensified in the meantime, psychiatric liaison services also provided formal and informal inter-professional learning opportunities.

Joint case management

Different knowledge sets and ways to place that knowledge into practice pose a specific challenge for successful cooperation in boundary work between residential care and mental health services (Gahleitner et al. 2013). Assessing the needs of a child or a young person in distress can lead to different outcomes regarding the severity of the problem and subsequently the course of action (e.g. in the case of emergency hospital admission) depending on the professional background of the individual providing the assessment. Working on acquiring a shared knowledge and understanding of different parameters (e.g. diagnostics, contextual factors) which play a role in assessing the needs of a

child or young person, and finding agreeable and adequate ways of responding to these needs is crucial for promoting cooperation between residential care and mental health treatment (Gahleitner & Homfeldt 2012). Psychosocial diagnostic instruments are increasingly embraced in child and youth welfare services and represent a shared language with which an inter-professional understanding of a child's complex needs can be furthered (e.g. Gahleitner 2013c). In 2015, an innovative pilot project in Hamburg and Schleswig-Holstein will begin, with the goal of developing an innovative concept for case management conferences, where representatives of a local child and adolescent psychiatric hospital, two youth welfare offices, and residential care institutions discuss children that present with high levels of developmental, emotional, and behavioural problems. The focus lies on sharing experiences, exchanging information, and developing strategies for both systems to operate together. The pilot project is going to be coordinated and evaluated by Prof. Dr. Gunter Groen at the HAW Hamburg. Of special interest will be the extent to which decisions made during joint case management constitute effective joint health and welfare care planning.

Cooperation Guidelines

Cooperation guidelines serve the purpose of helping to implement collaboration on a practical level, in order to promote effective and creative working relationships. They also encourage an on-going dialogue between child and youth welfare and mental health services. In the following regional areas of Germany, cooperation guidelines have been implemented: the Rhineland, Mecklenburg-Vorpommern, Berlin, Hamburg and the Saarland. Created in a collaborative process, in which professional autonomy for each system is recognized, guidelines should offer shared values and clear definitions of professional roles and responsibilities. It is essential that guidelines serve professionals as a viable source of orientation for complex working processes. For instance, when out of home placement or a transfer between residential care facilities occurs for the first time, binding agreements often facilitate a child or young person's acceptance of the new living situation, as service provision works more efficiently and waiting times are reduced. Furthermore, cooperation agreements can offer guiding principles for working with challenging behaviours (e.g. self-harm), serve as a practical tool for documenting working procedures, or as a framework for conflict resolution. Guidelines also outline quality standards for collaborative practices,

to be implemented across the individual and the organizational level. The implementation of guidelines should be evaluated, including the perspectives of all professional groups involved, as well as the child or young person, and their legal guardian. Cooperation agreements should not complicate working processes by introducing too many additional regulations, but rather serve as an incentive for both systems to streamline services and efforts in order to increase the overall quality of health and welfare service provision.

Interprofessional Exchange

Many of the participants in our interviews stressed the general importance of creating opportunities for inter-professional exchange. Bringing professionals together in an informal context, such as open door events, was thought to strengthen relationships, build trust and had resolved conflict in the past. Joint training workshops and inter-professional further education, focusing on in-depth study of practice-based case studies relevant to both professional groups (e.g. transition processes between systems), provides an inter-professional learning experience. Some of the interviewees had experienced joint training workshops and found that they facilitated knowledge transfer and networking. However, to promote inter-professional learning a number of resources are required: adequate educational learning material, moderating staff, an appropriate location and a high level of motivation and willingness for all professionals involved are crucial. Furthermore, it was thought that round tables and joint case conferences, if done with an appreciative and constructive atmosphere, helped practitioners deal with work related stress, promoted greater job satisfaction and installed a sense of achievement.

DISCUSSION

Working with very difficult cases of severe distress or antisocial behaviour on a regular basis is experienced as both emotionally and professionally challenging, by practitioners in the mental health sector, and in residential care institutions. This often leads to less effective health and welfare interventions, characterized by frequent transitions between residential institutions and psychiatric hospitals, as well as dropouts or discontinuation of care plans. A specific challenge for successful collaboration between residential care and mental health services therefore appears to lie in developing a knowledge base

that professionals in both systems can draw on, and from which effective joint psychosocial interventions can be derived. A collaborative practice, that unites psychotherapeutic and pedagogical approaches, such as traumapedagogy, appears to be particularly promising. Traumapedagogy specifically addresses the importance of the "safe place" (Gahleitner & Katz-Bernstein & Pröll-List, 2013b) that residential group homes represent for the therapeutic process, and offers evidence-based practices that help navigate the close relationships that residential care workers foster with children and young people.

The majority of participants in the German sample of the RESME interview study agreed that a successful collaboration between residential care and the mental health sector was beneficial first and foremost for the well-being of children and young people. If there was a diffusion of responsibility in boundary work, a child or young person's complex needs were often not met sufficiently by any service provider as they were passed back and forth between the two systems. The general consensus between practitioners was that, in order to provide innovative services, resources were needed in terms of financing, conceptualizing and organizing service provision (Groen & Jörns-Presentati 2014). In conclusion, the importance of good practice at the boundary between residential child care and mental health services in Germany needs to be reflected in social policy, as well as occupying a central place in the common ground between the professionals involved in boundary work.

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BORDERLINES BETWEEN CHILDREN CARE IN FOSTER HOMES AND MENTAL HEALTH SERVICES IN LITHUANIA

Alina Petrauskiene & Jolanta Pivoriene

ABSTRACT

The goal of the article is to outline inter – professional and inter – institutional co-operation between mental health and social services in residential child care in Lithuania. The first part of the article describes the, child care and mental health services based on a literature review and analysis of legal documents. Good practice examples from an SOS Village project is presented. In the second part, qualitative research data is discussed. Data analysis revealed that cooperation between mental health and child welfare service providers is controversial. Inter-professional cooperation between practitioners from mental health and child care organizations is described differently by both sides. Informants understand the importance of inter-professional cooperation between organizations but most often blame each other for not taking the initiative. Lack of communication, organizational restrictions, imperfection in the health care system and personal factors were mentioned as the main obstacles for a good practice.

INTRODUCTION

The impact of the loss of parental care as a risk factor for child's mental health is more significant in Lithuania than in other European Union countries because of the dominance of residential care as a policy response. Children experience psychological crisis when they lose parental care and are placed in

residential care homes. This situation can cause traumas for a large number of children and can affect their mental health, leading to adaptation difficulties, emotional and behavior problems (Pūras, Šumskienė, Veniūtė at al. 2013; Browne, 2009; Žukauskienė, Leiputė, 2002). State Child Rights Protection and Adoption Service states (2012) that at the end of 2011, 4119 children lived in residential care institutions (for 1335 of them temporary and for 2784 of them – permanent care was determined, and that is 38,1 % of all children who lost parental care). The Service highlights that children who live in residential care houses need mental health care. The lack of community mental health services, psychological help for children with behavior and emotion disorders becomes one of the main problems (Pūras, Šumskienė, Veniūtė at al. 2013).

Social workers are the main representatives of children living in residential care settings; they are obliged to ensure a child's well-being and mediate in satisfying their mental health needs (General state and local child care regulations, 2005).

LEGAL FRAMEWORK OF MENTAL HEALTH SYSTEM

Lithuania's legislation generally on health care and specifically on mental health care is based on various laws, acts, decrees, and regulations. There are several general laws, which regulate issues related to children and young people mental health care. The most important laws are in: the *Law on Public Health* (2002), where the focus of attention is to child development in teaching how to live healthy, in ensuring their medical and psychological assistance, protecting children and young people from the physical and mental health effects of of harm; the *Law on Health System* (1994/1998), where the main focus is children's and young people's personal health care, its supervision and provision of social services in health care; the *Law on Mental Health Care* (1995/2001/2005) pays attention to mental patients' rights and limitations. The Republic of Lithuania *Act Regarding Children's Health Promotion in year 2008-2012* states that the greatest attention should be paid to children and young people's lifestyle and social environment, which affects their behaviour in a negative way, i.e. alcohol, drugs consumption, smoking, physical inactivity, bullying and violence.

MENTAL HEALTH SERVICES FOR CHILDREN AND YOUNG PEOPLE

Mental health services in Lithuania are provided by four sectors: residential psychiatric hospitals, mental health services (which are self-employed or in primary personal health care settings), non-governmental organizations and the private sector. A person can apply to the mental health service according to his/her residence or may be referred from a family physician. According to Optimization Study of Mental Health Services (2007), Lithuania's mental health services include four main types, which combine individual and public mental health aspects:

- Prevention of mental disorders through training, counselling, where the target groups is the wider community with a focus on prevention.

- Early diagnosis of mental disorders through training, counselling where the target groups are the community, family doctors, employers, and other persons.

- Mental health diagnosis and treatment through diagnosis, counselling/analysis, where the target group is psychiatric patients.

- Psychiatric rehabilitation, medical, psychosocial, vocational rehabilitation through briefing, counselling, medical assistance, support at home, employment, housing programs, and so on where the target groups are psychiatric patients after hospital and patients' family members.

PROCESS OF INTERVENTION

State Programme on the Prevention of Mental Disorders (2012) states that it is important "to bring mental health care closer to communities through the establishment of mental health care centres within municipalities and to create an effective community-level network of social psychiatric structures by including NGOs in service provision". The Lithuanian Republic Minister of Health published the act "*Psychiatry and psychotherapy services organization, description and provision of requirements for children and adolescent*" (2000)

which stated that mental health services are to be provided to children and adolescents (aged 3-18) with mental and behavioral disorders, or risk factors for the disorder to occur. According to the Act, most commonly non-medical treatment instruments/methods are used. Treatment and psychosocial rehabilitation methods are used not only for children, but also for the family members, other people like teachers, caregivers, etc. A Child psychiatrist during the consultation can give an individual or group psychotherapy training, individual or family counselling. The Mental health professional team consists of psychiatrist, clinical psychologist, social worker and mental health nurse. Its goal is to clarify mental and behavioral disorders, organize and implement effective prevention, treatment and psychosocial rehabilitation, direct to other health care institutions in collaboration with general practitioners, pediatric services, education, social care, child protection, police and other authorities.

MENTAL HEALTH SERVICES FOR CHILDREN IN CARE

There is a lack of statistics about how many children in care are receiving mental health services in Lithuania. Compared to the general population, the prevalence of children with mental and behavioural disorders is high and ranges from 10 to 20 percent of all children.

Lithuanian Law on Fundamentals of Protection of the Rights of the Child (1996) defines the organization, control and supervision of child rights enforcement and the power of competent authorities. The institutions legally representing the child according to the law, promote inter – institutional cooperation between separate municipal administration bodies and social partners in organizing support for social risk families and children. In *Child Welfare Policy Conception* (2003) inter – institutional activity is highlighted when different institutions and agencies coordinate their activity creating and implementing a common strategic child welfare policy.

LEGAL FRAMEWORK OF CHILD CARE SYSTEM

In 1996 (last amendment, 2006) the *Law on Fundamentals of Protection of the Rights of the Child* came into force. The main institution is the State Child Rights Protection and Adoption Service under the Ministry of Social Security

and Labour the activity of which is regulated by *Resolution on the approval of regulations of the state child rights protection and adoption service under the Ministry of Social Security and Labour* (2005).

According to the Lithuanian legislation alternative care of a child may be:

- **temporary/permanent guardianship** in: a foster family, social family or child care institution;

- **temporary guardianship under the request of parents**;

- **adoption** (national or international).

Guardianship is established for children under the age of 14; curatorship is established for children older than 14. **Temporary child guardianship/ curatorship** means care for and upbringing of a child temporarily deprived of parental care and the representation and protection of the child's legitimate interests in the family, social family or institution. The Article 3.250 of the *Civil Code of the Republic of Lithuania* establishes that the State institution for the protection of the child's rights shall be responsible for the determination of children in need of guardianship and their registration. The Institution shall place a child under temporary guardianship within three days of the receipt of information about the child's need of guardianship. Temporal guardianship/ curatorship may be established when:

- parents or single parent are missing and attempts are made to trace them (pending the court judgement declaring them missing or dead),

- parents or single parent are temporarily incapable of taking care of the child because of the parents' (the father's or the mother's) illness, arrest, imposed sentence, or due to other compelling reasons,

- parents or single parent do not take care of the child, neglect him, do not look after him, do not bring him up properly, use physical or psychological violence thereby endangering the child's physical, mental, spiritual or moral development and safety (pending the court order separating the child from the parents).

The purpose of temporary child guardianship/curatorship is to return the child to their natural family. A child is placed under temporary guardianship by the decision of the Director of the Administration of the Municipality under the recommendation of the regional Child Rights Protection Institution.

Permanent child guardianship shall be established for children deprived of parental care who, under existing conditions, are unable to return to their natural family, and their care, upbringing, representation and protection of their rights and legitimate interests are entrusted to another family, social family or guardianship/curatorship institution. Permanent guardianship may be established when: both parents or single parent of the child are dead, both parents of the child or his single parent have been declared missing or dead by a court judgement, the child has been separated from the parents in accordance with the procedure established by law, the child's parents or close relatives are not identified within a 3-month period after the child's birth, both parents or the single parent of the child are declared legally incapable in accordance with the procedure established by law.

A child is placed under permanent guardianship by the decision of the court under the application of the regional Child Rights Protection Institution. The organization of care of a child is regulated by *Resolution of the Government of the Republic of Lithuania of 2002*. Temporary care of a child is regulated by *Order of the Minister of Social Security and Labor of the Republic of Lithuania* (2007).

RESPONSIBILITIES OF ADMINISTRATIONS TO LOOK AFTER CHILDREN

In implementing the Concept of Decentralization and Deconcentration of Certain Functions Fulfilled by Central Governance Institutions, approved by *Resolution of the Government of the Republic of Lithuania* (2006), the *Plan of Transfer of the Functions of the Founder of State Child Care Institutions to Municipalities* was approved by Order of the Minister of Social Security and Labour of the Republic of Lithuania (2007) and the *Plan of the Optimization of the Network of Child Care Institutions* was approved by Order of the Minister of Social Security and Labour of the Republic of Lithuania (Official Gazette *Valstybes žinios*, 2007, No. 107-4385). The Plan of the Optimization of the Network of Child Care Institutions establishes two stages of optimization:

the first stage in 2008–2010 for transferring functions of the provision of state child care institutions to municipalities; the second stage in 2011–2015 is a reduction of the number of places in child care institutions and optimization of the organization of the activities of child care. It was stated that from 2010 the number of places in child care institutions should not exceed 60; the provider of child care institutions should be municipalities or non-governmental organizations; and work with children in these institutions should be organized on a family basis. Thus the rights of ownership of 25 state child care homes have been transferred to municipalities and the rights of ownership of 7 child care homes have been transferred to the Ministry of Social Security and Labour.

As of 2015, the number of children in social families of child care institutions should not exceed 8, with a view to integrating a child at social risk or under guardianship (foster care) into society. Long-term social care could be organized in a social family of the child care institution living in separate premises. According to the new model of child care homes, one social pedagogue or social worker of a social family will take care of three to four children and deal with their families. The workload of social pedagogues or social workers of social families of child care institutions per week will distribute as follows: 70 per cent of time – direct work with children in a social family (including night-time), and 30 per cent of time – individual work with children and their families.

In implementing the Strategy on the Reorganization of the Child Guardianship (Foster Care) System, the following preventive measures, aimed at helping families to address the problems and creating the conditions for children to grow in their families, were implemented: development of day social care services in day centres; organization of the provision of complex services for a child and mother (father) in a critical situation; improvement of legal regulation of the system of the organization of child guardianship (foster care); training and assessment of potential guardians according to the PRIDE what is this? programme; optimization of the network of child care institutions; improvement of the conditions of social integration of children deprived of parental care; upgrading qualifications of specialists; organization of monitoring of the application of social care standards concerning children under guardianship (foster care); dissemination of information concerning the organization of child guardianship (foster care) (Trends of child guardianship (foster care) and analysis of the situation of 2009).

The good practice example we highlight in implementing the Plan of the Optimization of the Network of Child Care Institutions and Strategy on the Reorganization of the Child Guardianship (Foster Care) System 2007–2012 is the case of SOS children villages in Lithuania. Social workers work as SOS parents / foster – parents / guardians and develop positive assistance contacts with their foster children, organize special help of educators, speech specialists, individual psychological consultations, and apply an analysis of the relationship with a child, methods of monitoring and video feedback. Workers of SOS children village organize activities for children with behavior and emotion disorders. Children have opportunities to attend sport, dancing, acting, computer, English, Russian additional classes, and they receive a speech specialist's consultation. Meetings with teachers, school social educators are organized by the initiative of SOS children village workers to understand the causes of children's emotional and behavioral disorders. SOS children village workers are developing collaborative links with the school, specialists from health care and psychological services when they solve conflict / hard / sensitive situations constructively taking into account children's needs. This overall experience helps to share information in a more qualified way and make joint decisions concerning children's mental health (behavior and emotions) and education questions. Successful co-operation is continued with "Children Support Centre", "Family House", "Vilnius Family Psychology Centre" concerning psychological and psychotherapeutic help for children, consulting workers about child emotions and behavior disorders (http://www.sos-vaikukaimai.lt/klubas).

COOPERATION OF MENTAL HEALTH AND CHILD CARE SYSTEMS

In the description of children from birth to compulsory schooling and educational life of the improvement model (2009) it is noted that in order to insure effective complex support for children and their parents, it is necessary to promote inter- institutional and inter- professional cooperation. *In Lithuanian Law on Education* (2011) support for a child is differentiated according to special, pedagogical, psychological and social needs. In Lithuania social workers at child care homes are the initiators who provide support for a child and who cooperate with various institutions and professionals: municipality social worker, community child protection representative, police officer, etc.

General state and local child care regulations (2005) regulate foster home activities. One of the main tasks for foster homes is co-operation with state and local institutions and organizations. Social workers, social educators, psychologists, health care and other specialists work directly with the child. State or local governments establish budget and public social care and mental health services for children's institutions, which are obliged to investigate complex child care and health care service needs, plan the provision of services (including the initiatives of individual non – governmental organizations), follow the inter-institutional and inter-professional co-operation principles.

PROFESSIONALS' POINT OF VIEW ON MENTAL HEALTH SERVICES AT TERTIARY LEVEL FOR CHILDREN FROM CHILD CARE HOMES

In order to collect professional knowledge and experience in mental health and child care services, five individual interviews were carried out with professionals working at mental and child care organizations. Two professionals: a social worker and a psychologist work at a psychiatric hospital and represent child mental health services, three professionals: a social worker, a psychologist and SOS mother work at (different) child care organizations and represent child care in foster homes. All participants are women, have university education and professional experience in the field. Confidentiality was ensured during the research. For data analysis qualitative content analysis was done. Data is presented by two subheadings:

- inter-professional collaboration and main obstacles working in child protection and mental health services;

- other issues: need for training and for the best interests of a child.

INTER-PROFESSIONAL COLLABORATION INSIDE AND OUTSIDE ORGANIZATIONS

When mental health services are provided for a child in residential care two types of cooperation are important. First of all, both in mental health and child welfare organization work multi-professional teams which are responsible for services provision. When a child receives treatment at tertiary level mental health organization cooperation between mental health and child welfare organizations adds.

Inter-professional collaboration inside organizations was described by all interviewed professionals. Activities vary from informal to formal ones and are similar in mental health and child care institutions.

In mental health settings inter-professional collaboration is based around the daily routine. In specific cases additional efforts are put and initiation of it reflects the hierarchical structure of the organization. In child care settings inter-professional collaboration is also structured, also reflecting hierarchy. At both types of organizations it is the formal leader's responsibility to initiate and monitor inter-professional collaboration. Inter-professional collaboration outside organization differs in mental health and child care settings. Research data is controversial from mental health and child care service providers.

While a child is in a mental health setting, this organization leads cooperation and the two parties participate in it. Usually they have two meetings with professionals from the child care institution, at the beginning when they bring a child, and at the end. But what they really lack is a meeting in the middle. If the social worker at the hospital tries to initiate such meetings, s/ he usually faces resistance from child care organization. The same situation from child care organization point of view looks different. According to them, if someone from the mental health institution phones, it is usually only to tell child care institution that it is time to take a child home. They do not phone to invite for a conversation.

In the transition from mental health services back to the everyday environment a psychologist prepares recommendations. If a child is in care, often these recommendations substitute for the final meeting and that means that mental health and child care professionals do not have any direct personal contact. They do not write recommendations in all cases, but if a child is from a child

care institution, recommendation are in writing as they do not know who will come to take a child, if this person knows or does not know a child, will understand or not, what is told.

Professionals in child care services face challenges concerning recommendations and extracts from the health history. Written recommendations are very short, only a few sentences. If the child care institution wants more detailed information they have to ask for it and to tell where to send it. Health care institutions send information only to a family doctor at primary level or child psychiatrist at secondary level, or psychologist, but not to a child care institution. Information is sent only form professional to professional. Research data shows that inter-professional cooperation is better inside then outside mental health and child care organizations.

MAIN OBSTACLES FOR MENTAL HEALTH SERVICES PROVISION.

According to informants the main obstacle in providing services is the lack of communication between institutions. Professionals in mental health settings blame those working in child care institutions and vice versa. From the point of view of social workers working at mental health institutions child care workers do pay not enough attention to a child who is in mental health setting. Very often a child is brought to the mental care institution only by a driver, who does not know a child at all and cannot provide any information about him/ her. There is a staff person who is responsible for children's health, so it would be his/ her responsibility, but in reality it depends. Sometimes s/he is very busy, then a group teacher goes or anyone who is free at that moment. If group teacher takes a child, it means that s/ he leaves all other children without supervision.

From a mental health point of view, child care institutions have unrealistic expectations and don't recognize their own responsibilities. They expect that child will come back totally recovered, normal, to behave like angel. Professionals in child care institution think that they do not need to invest in a child's treatment, so very often it is not the child's problem, but of his/her environment.

The organizational structure of the institution can also cause obstacles. For example, hospital is a very big organization, there are a lot of levels, sometimes it is difficult to cooperate with other institutions because of that. On the other hand, child care institutions are not able to implement recommendations received from hospital, as it is impossible to give a child so many personal attentions or change other children around him/ her. Another big obstacle is a big workload and time limits.

Imperfections of health care systems were mentioned as another obstacle. There is no appropriate institution for such children. They cannot be in regular hospital but the psychiatric hospital is too extreme for them. Personal attitude was also mentioned as an important factor for cooperation.

To conclude, lack of communication, organizational restrictions, imperfection of health care systems and personal factors were mentioned as the main obstacles for a good practice.

DISCUSSION OF THE RESULTS

As already mentioned, interconnection among different professionals (psychiatrists, psychologists and social workers) are found and these interconnections reflect not only different professional identities but hierarchical relations as well. The superiority of doctors in health care settings was documented in many researches (including in Lithuania, e.g. Petrauskienė (2007) and isn't surprising, however, in this case it shapes cooperation in general. Berzin et al (2011) studied the frequency of collaboration with different professionals on different occasions inside organizations and defined four types of relations: non-collaborator, system level specialist, consultant and well balanced collaborator. Research data suggests that in providing mental health services for children from residential care relations between system level specialists dominate inside both types of organizations and that influences services for a child.

Research data shows that inter-professional cooperation is better inside then outside mental health and child care organizations. Research (Baia at al., 2009; Ward, 2006) shows that cooperation among these two systems can improve children's mental health. Darlington and Feeney (2008) add that both sides - services providers and clients - benefit from such cooperation. Different authors defines different barriers for cooperation, e.g. Darlington and Feeney (2008)

named inadequate resources, lack of confidentiality between professionals, gaps in cooperation in interagency process, unrealistic expectations between disciplines, discrepancy between professional knowledge domains and professional boundaries. In the Lithuanian research, a lack of communication, organizational restrictions, imperfection of the health care system and personal factors were mentioned as the main obstacles for a good practice. Darlington and Feeney (2008) also acknowledge that communication along with professional knowledge and skills as well as adequate resources are important for good cooperation. Davidson et al. (2012) found that inadequate resources and unclear structure in the systems hinder good cooperation.

Both sides, mental health and child care in foster homes services providers, experience the problems concerning communication, interconnection and continuation of services. Janssens et al. (2010) emphasize that good partnership can develop only in an atmosphere of mutual respect and with intention to provide the best care for the child. Data form Lithuania shows that the child is very rare in the attention of mental health and social welfare practitioners and a child mostly is remembered in the case of contradictions among the services providers but not in discussions about their own best interests.

Data reflects not only the problems of inter-professional cooperation between mental health and child care organizations but also the poor regulation of information flow between professionals, as information could be provided only from the same professional to the same professional. It is not clear in the child care system how other professionals like social workers, group teachers -supervisors could receive this information. Usually it varies from case to case and depends on the regulations of specific child care organization or the personal interest of particular professionals. This example shows irregular, case-varied activities, which according to Janssens at al. (2010) could not lead to true cooperation.

CONCLUDING REMARKS

The mental health care of children living in residential care institutions in Lithuania is related to solving questions of child rights protection and their representation, as well as the needs of inter- professional and inter-institutional co-operation. Residential child care, physical health care and protection of child rights is regulated by miscellaneous legal provision, therefore practical

implementation is complicated as inter-professional co-operation inside and outside institutions, constant activity combination and effort of specialists (doctors, psychologists, child's rights protection specialists, social workers) and shared responsibility to ensure child's well-being is needed. Social workers are the main representatives of a child living in residential care institutions that deal with a child's mental health care issues. They experience obstacles to co-operation closely related to hierarchical traditions of doctors' behavior, undervalued social worker's status in child care houses, their questionable contribution, the lack of resources needed in their profession (competence, long-term professional targeted assistance, supervision, material and staff resources). Effective co-operation between social workers from residential child care institutions and mental health care specialists is related to the worker's constructive attitude, informal relations and personal responsibility, individual initiatives ensuring child health care and solution to treatment questions.

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WORKING ON THE BORDERS BETWEEN RESIDENTIAL CHILD CARE AND MENTAL HEALTH: THE SCOTTISH SITUATION

Mark Smith & Denise Carroll

ABSTRACT

The Scottish partners in the RESME project were Kibble Education and Care Centre, the largest provider of residential care services in Scotland and the University of Edinburgh. This report is based upon a study of the historical and policy contexts of both residential child care and child and adolescent mental health services in Scotland and interviews with respondents in both sectors in order to determine some of the facilitators and barriers to effective joint working.

INTRODUCTION

The 2011 census gives the population of Scotland as 5,295,000 – the highest ever and a rise of around 200,000 over the past ten years. There are 293,000 children aged under 5, an increase of 6 percent from 2001. However, the number of children aged 5 to 14 has seen a decrease of 69,000 (11 percent). The number of children under 16 (the age at which population estimates cut off) has similarly decreased in the last 10 years and currently stands at around 900,000.

Social work and social care and health services are devolved functions of the Scottish Parliament. While policy decisions are devolved, budgetary allocation remains with the UK Government in London. Day to day responsibility for

social work and social care functions are located with local authorities. There are currently 32 local authorities, although there is ongoing debate as to whether having so many units of government allows for strategic decisions to be taken. It also creates some difficulty in the provision of resources. Small local authorities, for instance, are unlikely to need or to be able to afford more specialist provision. As a result, there are still some "national" resources of which secure accommodation would be the most obvious example, but some schools for blind, deaf or other special categories of children continue to receive some national funding. Fourteen Health Boards across Scotland provide health services, including child and adolescent mental health.

THE CHILD CARE SYSTEM

Historically, there has been a reluctance to use residential child care in Scotland and a preference for fostering and increasingly, kinship care. The Kilbrandon Report of 1964 is a watershed in Scottish social welfare philosophy. Lord Kilbrandon was given a remit "to consider the provisions of the law of Scotland relating to the treatment of juvenile delinquents and juveniles in need of care or protection or beyond parental control". His Committee concluded that similarities in the underlying situation of juvenile offenders and children in need of care and protection "far outweigh the differences" and that "the true distinguishing factor" is their need for special measures of education and training, the normal up-bringing processes having, for whatever reason, fallen short" (para. 15). The concern was to try to meet children's needs through a welfare model rather than address their deeds through a criminal/juvenile justice one. In reaching these conclusions the Committee looked to Europe and primarily Scandinavia rather than America or England for its ideas.

Kilbrandon's recommendations were basically socio-educational. His remedy for those occasions when children's upbringing process had fallen short was additional measures of education for the child, and where appropriate for their parents. In the sense that there is a strong socio-educational underpinning to thinking about social welfare, Scotland might be thought to be closer to European models of social pedagogy than England (Smith and Whyte, 2008). However, recent policy direction has mirrored an Anglo Saxon model and in particular in relation to the dominance of a very legalistic and procedural understanding of child protection.

Many of the principles and provisions of the Social Work (Scotland) Act (1968), Scottish social work's foundational legislation, stem from the Kilbrandon Report. The 1968 Act placed a broad duty on local authorities to promote social welfare, which remains in place today. Social work services were brought together in new generic Social Work Departments. One of the innovative changes to flow from the 1968 Act was the creation of a system of children's hearings to address the problems faced by children who offend and those deemed to be in need of care and protection, the underlying needs of both groups being considered largely similar.

The key player in the children's hearings system is the Reporter to the Children's Panel or Children's Reporter. The Reporter may come from a variety of professional backgrounds (although mostly and increasingly, law) and her/his role is both as the initial gatekeeper to the system and the person who ensures its proceedings comply with the law. Children and young people can be referred to the Reporter from a number of sources, including police, social work, education and health. They are referred because some aspect of their life is giving cause for concern. The legal grounds of referral incorporate offending and care and protection concerns, both of which might reflect the presence of mental health issues.

The Reporter's primary role is to take a decision as to whether a child may require compulsory measures of care. To assist her/him in this decision they may ask for a social work report. If, following receipt of this report, a decision is taken that a child may require compulsory measures of care, then the child (and her/his parents) are required to attend a children's hearing. A hearing consists of three lay panel members who are part-time volunteers, thus emphasising a community responsibility for children in trouble. Panels receive background reports prepared by social workers but the child and her/his family are included as key participants in the decision-making process. Following a full discussion of the circumstances of a case, panel members can decide to take no further action, suggest voluntary measures of support or impose a supervision requirement, which may involve a child remaining at home subject to social work supervision or could include particular conditions, such as the requirement to live in a foster home or residential care. Decisions are intended to be made "in the best interests of the child rather than on the basis of abstract legal principles".

The Children (Scotland) Act (1995) replaced the child care provisions of the Social Work (Scotland) Act (1968), taking into account the United Nations Convention on the Rights of the Child (UNCRC). It also, however, shifted

some of the welfare focus of the Hearings system, making it more legalistic. The Children's Hearings (Scotland) Act (2011) and the Rights of Children and Young People Bill (2011) have sought to update legislation, the latter Act putting the UNCRC on a statutory footing. This involves the introduction of a duty on the Scottish Ministers to have due regard to the UNCRC when exercising any of their functions across a range of policy contexts. Children who are deemed to be in need of compulsory measures of care can be "looked after" by local authorities (see below for further explanation) or "looked after and accommodated". Those in residential child care would come into the latter category.

The current overarching policy framework for children's services is *Getting it Right for Every Child* (GIRFEC), (2004). The thrust of GIRFEC is to provide adequate levels of support for all children and for considering the needs of children with additional support needs within a universal framework of children's needs. GIRFEC identifies a number of wellbeing indicators for children, specifying that they ought to be: Safe, Healthy, Active, Nurtured, Achieving, Respected and Responsible and Included. Health or mental health issues ought to be identified within the GIRFEC framework.

RESIDENTIAL CHILD CARE

Residential child care is provided, primarily, in children's homes, and residential schools. The trend over the past thirty years or so has been to move towards smaller children's homes, catering for, on average, around four or five children. Schools are larger (although smaller than they used to be) but, within these, children usually live in smaller, more homely accommodation.

The overall pattern in the use of residential child care is one of significant decline since a high point in the 1970s. On 31st July 2011 there were 16,171 children looked after by local authorities, an increase of 2 per cent since 31st July 2010. The overall number of children looked after has increased every year since 2001, and is at its highest since 1981. Thirty four per cent of children looked after were looked after at home with parents and 24 per cent were looked after by friends or relatives. Such kinship care arrangements have grown substantially over the past decade.

Nearly a quarter (24 per cent) of children looked after were with foster carers provided by the local authority, with a further 7 per cent looked after by foster carers purchased by the local authority (evidencing a rise in private or charitable foster care providers). The number of children looked after by foster carers or prospective adopters has increased every year since 1993.

The proportion of children looked after in residential care, however, is only nine per cent nationally, and is now at its lowest level since data has been available. The actual number of children in residential care has been fairly static between 2000 and 2007 but has started to show a decline since 2007. In 2011 the figure stood at 1475. This points to a very different balance of provision between Scotland and other partner countries in the RESME project where residential care is far more widely used.

Of the 1475 places in residential care, 87 of these were in secure accommodation across six units. The secure units vary in size from four beds to 21. Children are only placed in secure accommodation if they meet the following legal criteria:

1. they have a history of absconding and are likely to abscond from other types of accommodation and
2. if they abscond they are likely to suffer significant harm or are likely to injure themselves and/or others.

In every case it also has to be agreed that placement in secure accommodation is in a child's "best interests". Secure accommodation offers, primarily, a welfare rather than a justice response to children's needs. Many children placed in secure accommodation will have significant mental health needs although secure units do not operate within the sphere of mental health provision. One or two of the bigger units may employ some medical staff (usually a nurse and perhaps a psychologist) but mostly mental health services are accessed through community based mental health services.

For the second half of the 20th Century most children's homes operated under local authority management. Residential schools tended to be operated by a variety of voluntary/charitable bodies. Until the latter decades of the 20th century the Church of Scotland and the Catholic Church were significant providers. The past ten years has seen a significant growth in private provision. Relative numbers of public/private providers is hard to come by but the

balance is shifting steadily towards more private provision. Some long-established residential schools have closed or are on the brink of closure, in the past couple of years. Current austerity measures place further pressure on residential care services across the board.

One consequence of the reducing proportions of children in residential child care settings is that those placed there tend to be the more difficult to place children, often those who have experienced a number of previous placements in kinship care or foster care. Many of these will experience diagnosed or undiagnosed mental health difficulties.

A number of studies have identified that the mental health problems for looked after and accommodated children and young people are markedly greater than that of their peers in the community. Reasons include the child's experience in terms of poor parenting, trauma, bereavement or serious illness, including mental health difficulties in one or both parents, and the impact on the child of the environment such as poor neighbourhoods, deprivation, social exclusion and poverty.

Mental health was highlighted as a particular problem, with young people in care having significantly higher incidences of mental health issues than children cared for at home. One Scottish study concluded a prevalence of 52 percent of mental health disorders in children and young people in the care system compared to an estimated 8 percent in the general adolescent population. The disorders evident were conduct disorder, hyperactivity and emotional disorders of anxiety and depression (Meltzer et al, 2004). There is a high prevalence (13–23 percent) of anxiety and a similar trend for depression. Meltzer et al. (2000) reported that 2 percent of the general adolescent population has had an episode of major depression whereas Meltzer et al. (2004) reported that 5–6 percent of looked after children had a depressive disorder.

RESIDENTIAL CARE STAFF QUALIFICATIONS

Historically, many residential workers took up positions in residential child care with no academic qualifications, reflecting a view that the job was low level and consequently poor status.

Over the years a number of attempts have been made to improve qualification levels. With the professionalization of social work, following the 1968, Social Work (Scotland) Act, the intention was for residential care worker to become professionally qualified in social work. There have always been doubts raised as to whether social work was the most appropriate qualification for residential care workers. Despite a number of initiatives, the aspiration for workers to become qualified in social work was never realised and the residential child care workforce has remained under-qualified and undervalued. Social workers are the legally recognized case managers for children subject to a supervision order, even although the social work task has become a more administrative one in recent years and residential workers are likely to know children far better than social workers do.

To address difficulties in residential workers becoming professionally qualified, a competency-based approach to the assessment of practice, Scottish Vocational Qualifications, was introduced. Main grade workers now all will have at least a Higher National Certificate (HNC) and Scottish Vocational Qualification (SVQ) 3 qualifications with higher (SVQ Level 4) or other management qualifications required for managers.

A National Residential Child Care Initiative (NRCCI) (2009), initiated by the Scottish Government, recommended that a new Level 9 (Bachelor's degree) qualification specifically in residential child care should be introduced. Work is currently being undertaken to develop this qualification. Kibble Education and Care Centre is at the forefront of developments to bring qualification levels up to degree level and is working with a local university to develop a social pedagogy degree, which all staff will be required to gain.

THE MENTAL HEALTH SYSTEM

Mental health services, including child and adolescent services operate under the National Health Service, established following World War Two. This is now a devolved function of the Scottish Government. Ten percent of all young people in the UK are identified as requiring mental health support at some point in their lives (Public Health Institute Scotland, 2003). The past decade has seen greater attention being focused on children's mental health. The Scottish Needs Assessment Programme (SNAP) Report on Child and Adolescent Mental Health in 2003 (Public Health Institute Scotland, 2003)

emphasised that all agencies and organisations have a role in supporting the mental health of children and young people. It set out three core themes that have underpinned policy in Scotland ever since. These are: the right of children and young people to be heard, the importance of mainstreaming mental health and the integration of promotion, prevention and care. (White et al, 2012). This led to the establishment of Child and Adolescent Mental Health Services (CAMHS) for children who experience mental health problems.

CAMHS comprise of multidisciplinary teams with expertise in the assessment, care and treatment of children and young people experiencing mental health problems. Their main function is the diagnosis and treatment of children and adolescents who are experiencing the most serious mental health problems (White et al, 2012). Practitioners in CAMHS teams include: psychiatrists, psychologists, nurses, social workers, and others which may include psychotherapists (including child/analytical, systemic/family, cognitive behavioural), creative therapists (including art, music and drama), play therapists, liaison teachers, speech and language therapists, occupational therapists and dieticians (Scottish Executive, 2005).

CAMHS services are typically considered as a 4-tier service:

- Tier 1: is provided by non-specialist primary care workers such as teachers, social workers, school nurses and health visitors who, in the normal course of their professional roles, may encounter common problems of childhood such as sleeping difficulties or feeding problems.

- Tier 2: consists of specialised Primary Mental Health Workers offering support to other professionals around child development, assessment and treatment in primary care functions, such as family work, bereavement, parenting groups and Substance Misuse & Counselling Services.

- Tier 3: services are typically multidisciplinary in nature and the staff come from a range of professional backgrounds, based in local clinics. Problems attended to in this tier tend to be too complicated to be treated at tier 2, for example, assessment of development problems, autism, eating disorders, hyperactivity, depression, early onset psychosis.

- Tier 4: are highly specialist services for young people. These are typically inpatient units for young people who require admission into hospital. There may be a considerable overlap between the skills and competencies of staff working in the specialist services (NHS Health Advisory Service, 1995).

Access to the CAMHS is typically through General Practitioner (family doctor) referral. That is, the young person would attend the GP who would refer if a mental health issue was considered clinically indicated.

A further policy development, specifically for looked after and accommodated children is "Looked After Children and Young People: We can and must do better" (Scottish Executive, 2007). Action 15 of this Report recommended that:

> *Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to looked after and accommodated children and young people, and to those in the transition from care to independence.* (Scottish Executive, 2007, p.43).

Further provisions of the report seek to ensure that NHS Boards offers a mental health assessment to every Looked After Child or Young Person.

CURRENT ISSUES AND PROMISING PRACTICES

In this section we consider the current situation regarding mental health and residential child care services working together and offer some examples of good practice. We did not find any particular model of "best practice" but identified a number of principles that might support this interface but also some of the factors that get in the way of the two professional groupings working together.

As noted in the previous section CAMHS services are differently constituted across Scotland. For the research component of the RESME project we interviewed CAMHS staff in Edinburgh and Greater Glasgow and Clyde. In

the latter, which provides services for Kibble, the model was essentially one of clinical referral. In Edinburgh, the focus was more on consultancy and capacity building among residential care staff teams.

In Edinburgh, the CAMHS team providing a service to residential care homes was multi-disciplinary, consisting of those with occupational therapy with additional training in therapeutic skills with young people and in family therapy, clinical social work, nursing and psychology.

This team identified their role as providing regular, monthly consultation with residential home staff groups and providing consultation about specific young people. They also identified a training and development role.

CAMHS staff with a more obviously medical or clinical background were clearer about their role. Generally, they defined the characteristics of their profession in terms of diagnosing and side effects of medicines, and monitoring the progress of young people's mental health. However forensic CAMHS (FCAMHs) stated it was not as simple as this as mental health issues often overlapped with violence and inappropriate and sexualised behaviour.

The Paediatrician we spoke to described one of her main responsibilities as undertaking medical assessments in child protection investigations (child protection in the UK tends to be very investigative rather than welfare oriented). She considered her qualification to diagnosis autism and neurodevelopmental disorders as the unique characteristic of her profession.

The residential workers we spoke to predominately worked at Kibble. They had experience in relevant areas of practice such as care of vulnerable adults, working in addiction teams, and mental health nursing. In addition to this they have experience of working directly with LAAC in residential childcare ranging from eight to 26 years. In terms of their backgrounds and experience they are probably not representative of the residential workforce in Scotland more generally.

Residential staff described working directly with young people and ensuring their needs were met. For all residential staff, and specifically those in senior positions, their responsibilities included managing staff. Residential workers discussed the principles of Getting It Right For Every Child (GIRFEC) policy as providing a framework for their work. It is the profession that provides the social response to young people who are traumatised or may have been

considered troubled and troublesome. The characteristics of residential child care involve focusing on personal, family and community aspects of their care and also liaison with education and health. Staff described themselves as the "glue" in the middle of this whole system.

Respondents thought that residential child care was slowly becoming more recognised as a profession because staff must have some qualifications and must register with the Scottish Social Services Council (SSSC), the regulatory body for the social services workforce. Managers in Kibble Education all had or were working towards a Masters degree in management.

The respective roles of the mental health services and residential child care workers are summarised below:

Residential workers

- Work directly with the young people.

- Being the "glue" holding together all the other aspects of a young person's care

- To ensure the wellbeing and safety of young people.

- Ensuring care plans are implemented, and addressing the holistic needs of young people

Those staff in management or leadership positions also identified roles in

- Investigating complaints

- A leadership role for new staff, managing staff

- Implementing the strategic direction of the organisation

- Staff support and wellbeing

Mental health workers

- Assessment of young peoples' behaviours and making a diagnosis

- Supporting and directing care staff

- Weekly consultation at the secure units to give advice and guidance for specific young people.

- Consultation with other professionals and training.

Generally, the role of care workers is broader and less well-defined.

PRINCIPLES OF GOOD PRACTICE

While we found no one example of good or "best" practice between mental health and residential child care workers some of the general principles that would be associated with more effective practice in this area included:

Communication

There was a general consensus that "communication, every time" (FCAMHs worker) had a significant role in cooperation. Residential staff suggested the importance of the mental health professionals being easily contactable (for example by telephone with a duty system).

Cooperation was improved when CAMHs workers come into residential homes to explain and give advice on specific behaviours and conditions and were receptive to questions from residential workers.

Clear and specific guidance on how to work with particular children was welcomed, for example, explanation of the use of body language, maintaining eye contact and specific management of anxiety techniques. This was felt to increase residential workers' confidence in any support that was offered.

Common understandings

Good practice was possible when "everyone has a holistic and realistic understanding to the young person's presenting behaviours" and this was communicated to all staff (including for example domestic staff). Yet this common language could be difficult to find when different residential units operated to different understandings of key concepts such as, for instance, attachment.

Leadership

Much of the literature around residential child care identifies the importance of good leadership in homes and schools. This was confirmed in our interviews, in which CAMHS workers identified good leadership in residential units as "absolutely crucial" to determining how the staff worked with the CAMHS services and hence to successful joint working. The need for leaders to manage anxiety within staff groups was identified and, conversely, a failure to do so was implicated in more demands for crisis interventions from mental health staff. A sense of order within homes was also felt to be vital.

Ongoing relationships

The most successful collaboration happened in the context of ongoing relationships between mental health and residential care workers. In Edinburgh, the CAMHS team sought to maintain this contact, even where there may not have appeared to be any immediate issues to address. This was felt to work better than just waiting for the call in response to crises situations.

WHAT GETS IN THE WAY OF GOOD PRACTICE?

Communication

While good communication was felt to aid good practice it was not experienced as common. One residential manager stated "I would have to go back a number of years" to recall good communication. The good communication he had in mind was when a particular psychologist took a particular interest in a particular child and followed this through. But such personal commitment was rarely possible or apparent.

Time and resource pressures

Many of the obstacles to good practice were practical ones. It was felt that it would be helpful if people could work in the same building and departments, as working in different buildings and departments can make them unsure of each other and not relaxed in their discussions. Pressures of time, including thinking time and pressures on services, were also identified as getting in the

way. In general, Management practices such as not replacing staff when they are off sick, stretched resources and so reduced the ability to cooperate. Wider anxiety about the future of services, especially in times of austerity, was also experienced. Other practical things such as the availability of a car to take children to mental health appointments were also noted.

Lack of "social" information

It was felt that some mental health workers did not have sufficient understanding of the impact of social factors on behaviours. This could limit their understanding of the influences affecting the young person at that time and may have implications for their assessment and the advice they give and how relevant this is to both the young person and the staff caring for them. On the other hand CAMHS staff could feel that residential staff accompanying children to consultations did not always know them well enough to be able to pass on sufficient information for mental health staff to make an assessment. This could be made more difficult in situations where a young person had multiple placement moves and care histories were disjointed.

Different professional expectations

It is interesting that both services were critical of each other and there was a clear mismatch in expectations. The mental health professionals stated there was an unrealistic expectation on the mental health services, with residential staff not considering the external factors. They stated that they (residential staff)"want us to see the young person quickly, as in today or tomorrow, and they want timeous reports on what to do".

Residential staff, in turn, felt that the CAMHs services talk about how difficult it is to engage a young person, and when they (residential workers) have a young person in a position that they are willing to be referred, they then have a lengthy wait. Staff working with the young people felt frustrated by the lack of response, which could allow a young person to dismiss or minimise their problems.

Mental health staff experienced challenges in relation to confidentiality, both in terms of accessing and sharing information, reflecting different professional codes of ethics. Generally, there was felt to be an unequal balance of power

between the two services. At CAMHs consultations (where care staff attend to present their concerns about a young person) it is CAMHs who lead and decide if they will provide a service and be involved in the young person's care.

In Edinburgh, the CAMHS workers said that they tried not to be seen as the "experts" on a case but that when residential staff felt under stress they could look to them to take on such a role and expect them to provide answers.

Cooperation can be difficult when mental health professionals come into the units and do not understand the practicalities of what they are asking to be implemented. Some residential staff raised concerns that there is a lack of honesty and a willingness to be open where they felt CAMHs had pre-empted the young person's outcome.

Residential staff felt they did not get support in the really difficult cases often feeling as though they were left on their own working with some of the very complex issues that could arise with young people in their care.

Social versus medical models

There were often divergent understandings of the source of behavioural problems; residential staff might feel that there must be mental health concern behind particular behaviours but CAMHs may put it back and say it's an environmental/ behavioural issue.

Language

Staff on both sides could feel that there were particular ways of presenting a problem that might or might not lead to a response from mental health services. Residential staff, for instance, may know something is not right with the young person but may not use the right mental health terminology to articulate this and thus the young person is less likely to access the service.

DISCUSSION AND CONCLUSIONS

All the participants thought cooperation between professional groupings to be beneficial for organisations, staff and young people. Like any service, there are practical benefits to this in that it cuts down time spent trying to contact the right person and establishing a relationship and some credibility with them. This would allow more effective use of resources and the staff caring for the young person would have a better understanding of their behaviours.

It was also felt that better cooperation would improve the outcomes for the young people with more successful assessment and treatment plans initiated. It was assumed that benefits would be evident in a reduction in restraints, absconding and in young people having a sense of greater direction in their lives. Instances were cited where effective cooperation prevented young people from going into secure care.

It was clear from our study, though, that while there may be pockets of effective practice on a local scale, there is no definitive model of "best practice" in inter-professional working between mental health and residential care workers. There are a number of structural and cultural barriers to such an approach, which make it difficult to identify particular ways of working that might be "rolled out" more widely.

What was clear from all participants was that when good cooperation is achieved it is the personal relationships that are vital to this: "being a familiar face, it's the face-to-face stuff, relationship building and trust so people relax around each other". This would suggest the need for opportunities for the different groups to engage with one another in more naturalistic, non-formal ways. Within formal relationships, where residential workers merely transport children to psychiatric appointments, for instance, the status differential between the two professions is likely to get in the way of effective cooperation. There needs to be opportunities for both groups and indeed individuals from the different professions to build up a common understanding of the strengths but also the limitations of their respective roles and to realize that there are no easy answers in working with children whose behaviour throws up all sorts of challenges to the adults around them.

One possibility to consider further might be around just how realistic it is to expect two professions, which come from very different epistemological positions to find it easy to work together. Mental health professionals draw

upon a generally positivist "scientific" knowledge whereas residential workers might be thought of as "experts in the everyday", generalists rather than specialists. This distinction between the generalist and the specialist is a real and a deep one that cannot be got over through better procedures or greater exhortations to work more effectively together. It is evident in differences in knowledge bases, professional ethics and in status.

So, where might all this leave us? It may be with the suggestion that effective boundary work is most likely to happen in localized contexts where workers from the different disciplines can build up mutually respectful personal relationships and that efforts to improve current working practices should be targeted at this level of encouraging personal contacts and the opportunity to establish mutual respect.

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DEBATES AND SOME GOOD PRACTICES FOR ADDRESSING THE MENTAL HEALTH NEEDS OF CHILDREN IN RESIDENTIAL CARE IN SPAIN

Amaia Bravo & Jorge F. Del Valle

ABSTRACT

Our Spanish section describes both mental health and child care systems in Spain (particularly residential child care). Typologies of residential facilities and staff requirements are analysed as the role and qualification of social educators in Spain is a very important factor in understanding the application of the social pedagogy model. Compared to other European countries, Spain has a high percentage of children in residential care and the question of emotional and behavioural disorders, particularly in adolescents, is a significant issue in children's homes. This paper reviews data about children in residential care who receive mental health services, as well as raising some important points such as the high percentage of those children with intellectual disabilities, an aspect that has little visibility in international child care research. Finally, we discuss results from our empirical national research with key professionals from both systems, as well as good practice in the country.

THE CONTEXT OF CHILD PROTECTION IN SPAIN

According to the last census (2011) Spain has over 46.8 million inhabitants, of whom 8.3 million (17.8%) are aged under 18. It has one of the lowest birth rates (1.36) but also has an important problem of an ageing population, as 8.1 million people are older than 65, which makes it one of the oldest populations in Europe.

During the Franco era, which effectively lasted from the end of the Spanish Civil War (1936–1939) until the Constitution in 1978 (three years after Franco's death), child social welfare was based on the charity model. It was usually provided by the Catholic Church and based on large residential institutions. In the 1970s, child care in Spain still consisted of an extensive network of large institutions for orphans, abandoned children and children in poverty. Institutionalisation was the only answer for children in need of care, whether as a consequence of mistreatment, families with large numbers of children, parental alcohol abuse, prostitution, or other factors.

The development of the personal social services system in Spain over the last two decades would have been very difficult without political decentralisation, which created the "State of the Autonomous Communities". Spain was divided into 17 Autonomous Communities, some with a strong tradition of autonomy, such as Catalonia or the Basque Country, and all with their own parliaments and governments, as well as responsibility for providing education, health, social services and so on. During the 1980s, the Autonomous Communities began drafting their own social services legislation, with support from central government for both financial and technical aspects, so there was some degree of harmony across the different communities.

During the last 20 years, the child care system has been developed in Spain on the general social services model of the welfare state, in an effort to replace the old charitable and institutionalising model from the dictatorship era.

Child care figures

There is a significant problem in monitoring child protection statistics in Spain, as it is the responsibility of the autonomous communities, so there are 17 administrations, each managing their own data. Although the state government publishes a national statistical bulletin each year (Observatorio

de la Infancia, 2012), the system is largely dependant on the way information is recorded in each community and there are significant gaps in the final product, as will be seen later.

Looking at the data from 2011 (latest published data) across Spain, 35,505 children were found to be in out-of-home care (the data refers to December 31st of that year), this represents a ratio of 45.7 per 10,000 minors in the population. Of those, 60.4% were found to be in foster care, and the remaining 39.6% in residential care.

These data seem to indicate a slight predominance of family over residential programmes. Nonetheless, it is important to bear in mind that foster care includes both kinship care and non-kinship care. A study carried out some years ago showed for the first time that the large majority of cases (80%) are kinship care (Del Valle, López, Montserrat & Bravo, 2003) and taking the national statistics from 2011 from those communities which do provide this differentiation, the percentage is still 75% today.

Consequently, one of the major challenges for child protection in Spain is to increase foster care (with people from outside the family) compared to residential care, the use of which remains very common. One example of this anachronism in protection measures and of the imbalance of priorities outlined in the law, is the existence of residential care for children under 3 in all autonomous communities. The new national law, currently being drafted, is expected to state that children under 3 years old cannot be placed in residential care, as a way of implementing obligatory family placement for the youngest children.

Typologies of residential care

In order to serve the needs of different care plans (the term used to denote the individual care intervention plan for a child and their family, which includes goals, the ultimate objective, resources to be used, etc.), the residential care network is made up of the following alternatives (Bravo & Del Valle, 2009):

a) Care homes for children aged 0-3. It is common to find institutions specialising in the care of babies and very small children. The needs involved in this type of care are clearly different from other types, and it is one of the most characteristic specialised resources provided by local

authorities, although this is currently decreasing, with the prioritisation of foster care for the youngest children. Nevertheless, given insufficient foster care resources in Spain, institutional care for this sector of the child population, anachronistic though it may be, remains a distinct reality.

b) Emergency shelter homes. These are institutions for the reception of urgent cases, when it is necessary to separate the child from the family and temporarily place them in a protected environment. The purpose of such facilities is to provide the child's most urgent needs and to make an assessment of the case in order to implement a longer-term measure as soon as reasonably possible.

c) Children's homes. This is the term we use to refer to different types of facility that provide care based on the idea of children of different ages living together, basically in an attempt to create a family-style, protective environment for as long as the minor needs to be in residential care.

d) Supervised homes for adolescents. These are facilities, usually in the form of an apartment within the community, in which a small group of adolescents prepare for the transition to independent life. These are cases in which it is impossible or inadvisable to return to the family, and, given the proximity of adulthood the choice is to give these young people support in developing the skills necessary for starting life on their own. The adolescents live together in these homes, taking responsibility for domestic organisation and cohabitation with peers, with only basic contact and support from child protection personnel.

e) Homes and units for adolescents with emotional or behavioural problems. Specialised institutions have been introduced in response to an increase in cases of adolescents who, in addition to being in situations of neglect or abuse, have severe problems living with others, and especially where they pose a serious risk to themselves or others. These are normally residential facilities situated in more open environments or small, independent houses, some with farms, workshops or other resources for various activities, housing a small number of adolescents and boasting considerably more professional staff and psychotherapeutic

support than other facilities. There are various terms for this type of facility, such as socialisation homes or special regime facilities. Some regional authorities also run so-called therapeutic centres, which work with young people with serious mental health disorders.

f) Residential homes for unaccompanied asylum-seeking children: designed to cater for minors who arrive in Spain from other countries – principally North Africa – without family. Their growing presence has led to the creation of specific resources, with staff who are familiar with their language and customs.

Qualification of residential care staff

At the beginning of the 1990s a new university degree called "Social Education" was approved by the Ministry of Education. Like Nursery studies or Primary Education this degree consisted of three years of university studies, although recently, in accordance with the Bologna system implementation, it became a four-year degree. Since then, residential workers have had to have this qualification to get a job as an "educador social". It is not unusual to find graduates of other subjects working as social educators (psychologists, pedagogues, social workers, etc.) who started some years ago due to the scarcity of qualified, graduate social educators.

The team of social educators receives support (particularly in the case of the biggest organisations) from a multidisciplinary team usually made up of psychologists, educators and social workers.

In the case of residential facilities for young people with severe emotional or behavioural problems some clinical psychologists and psychiatrists become part of the staff.

THE MENTAL HEALTH SYSTEM

The Spanish mental health system was significantly reformed in 1983. Until that time, during Franco's dictatorship, and similar to the social services system, severe mental health problems had been dealt with by means of institutionalisation in large facilities that had been roundly criticized since

the 70s. In 1983 a Commission for Psychiatric Reform was launched and a Document of Recommendations was published in 1985. Most of those recommendations were included in new health legislation the following year.

A key element of the reform was the acknowledgement of the civil rights of people with mental health issues and their inclusion in the general system of health. Principles included in that Law with respect to people with mental health disorders were:

a) Mental health problems should be dealt with in the community, emphasising outpatient resources, partial hospitalisation and home care. Special attention should be paid to children and elderly people.

b) Patient hospitalisation should be in psychiatric units of general hospitals.

c) Services for rehabilitation and social reinsertion should be developed in order to achieve integrated care, including the necessary coordination with social services.

c) Mental health services should, along with social services departments, address aspects of primary prevention and psychosocial problems usually correlated with mental diseases.

In 2006 national legislation was introduced which regulated the services portfolio in the mental health system to include diagnosis and clinical follow-up of mental health diseases, pharmacological therapy, individual psychotherapy, group and family therapy (excluding psychoanalysis and hypnosis) and hospitalisation. Specific services were to be:

a) Prevention programmes and mental health promotion along with other health and non-health services.

b) Diagnosis and treatment of acute mental health diseases and acute phases of chronic diseases, including outpatient treatment, individual or family interventions, and hospitalisation when necessary.

c) Diagnosis and treatment of chronic mental health diseases, including integrated treatment of schizophrenia by means of outpatient care as well as individual and family treatment and rehabilitation.

d) Diagnosis and treatment of addictive behaviour, including alcoholism and compulsive gambling.

e) Diagnosis and treatment of psychopathological disorders in children and adolescents, including treatment of psychosis, autism, and behavioural disorders in general, as well as eating disorders (anorexia/bulimia) by means of outpatient treatment, psychotherapy intervention in day care hospital, and hospitalisation when necessary and reinforcement of healthy behaviour.

f) Treatment of mental health disorders due to risk and social inclusion.

g) Information and counselling for people supporting patients, particularly the main carers.

h) Rehabilitation.

Due to the organisation of the Spanish Administration, the Autonomous Communities had to develop those principles. Most have developed their own programmes and strategic plans.

The range of services in most Autonomous Communities to address those principles is the following:

a) Community mental health centres

b) Day care hospitals

c) Units of child and youth psychiatry

d) Therapeutic communities (for addiction disorders)

e) Community rehabilitation units

f) Hospital psychiatric units

Within this framework, children and young people must be treated in specialized mental health units (community units). The problem is that there are very few of them (for example in Andalusia, one of the biggest Autonomous Communities, there are 70 Centres for adults and 17 for children). There

is a high demand for these services and the type of service is very limited. Consultations are once every one or two months, mostly by psychiatrists using psychotropic medication, and very few children are able to receive more intensive psychological treatment. Hence, it is really common for children and adolescents under 18 to use private mental health services, particularly clinical psychologists, when they need a more intensive or lengthy treatment.

Unfortunately, there are no available registers about the use of mental health services. As a consequence, we do not know the prevalence of mental health disorders referred to those services.

When it comes to the hospitalisation of children due to severe mental health diseases, they are usually placed in hospitals in the general public health system. Children under 14 years old are hospitalised in paediatric hospitals, which must have special units properly conditioned for those cases. Adolescents over 14 are hospitalised in acute crisis units in general hospitals. However, some autonomous communities have created specific hospitals for children and young people in order to treat severe diseases intensively (1 month maximum). Spanish legislation requires that non-voluntary hospitalisation of minors must be approved by the courts.

Detection of mental health disorders is an important objective for community paediatric services (up to 14 years old) and family medicine services. In case of detection they should refer the child to specialised child and youth mental health services.

EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN IN RESIDENTIAL CARE

There is little research describing the prevalence of emotional and behavioural disorders among children in residential care in Spain, although these problems are among the most serious challenges for workers (social educators) in residential programmes.

In recent years we have been carrying out longitudinal research into these problems in a sample of six autonomous communities and SOS Villages programmes including a sample of 1,230 children and young people between 6 and 18 years old (Del Valle et al., 2014). We have collected data about

referrals to mental health services, family background, types of treatment received and other variables related to emotional and behavioural problems. This research also included the use of screening tools such as CBCL and YSR (Achenbach & Rescorla, 2001) and a three-year follow up in order to evaluate treatment outcomes.

Preliminary results show that 49% of the total sample was already receiving some kind of mental health therapy (24% psychological treatment; 16% psychological and psychiatric and 6% psychiatric only). In terms of pharmacological treatment, 21% of the total sample and 43% of children in treatment were being treated with some form of medication.

Data from CBCL shows 51% of the total sample in the clinical range in the externalising broadband scale and 31% in the internalising broadband scale. Therefore, there seems to be a very high percentage of cases within the clinical ranges, particularly in the externalising scales. An important question is how to use an objective system for early detection of cases needing referral to mental health services (Burns et al., 2004).

This research concludes by showing the high impact of emotional and behavioural disorders among children in residential care in Spain and the need to develop excellent cooperation between both child care and mental health systems.

One important data point is that 16% of the total sample had a diagnosis of intellectual disability (mental retardation in terms of the DSM system). An extremely high percentage of them (72%) were receiving some mental health treatment due to additional disorders. This group of children in residential care shows specific needs and characteristics that make them particularly vulnerable. However, research on this group in residential care is scarce (Trout et al., 2009).

In one of those rare pieces of research Sainero, Del Valle, López & Bravo (2013) concluded that this vulnerable group manifests many problems related to social relationships in children's homes, as well as serious behavioural problems that are difficult for social educators to manage:

> *In short, children with intellectual disability present major differences with respect to their peers in residential care, not only in terms of the severity of the family history of alcohol problems, mental health and mothers with*

disability, as well as having suffered a higher probability of physical abuse, but also in presenting additional complications in their physical and mental health. These latter complications mainly refer to thought problems, which may be indicating strange ideas and behaviors that might entail particular severity, and social problems that have to do with their own immaturity but also with rejection by their peers in the children's homes. This rejection, which arises in day-to-day co-existence with a large number of peers, who in turn are presenting major emotional and behavioral problems, and over long periods of time, may be turning into a serious problem for their development and might easily lead to situations of bullying. All of this would more than justify that this group should cease to remain in the invisibility of statistics and scientific research, especially so that their specific needs can be better understood and programmes and interventions more suited to them designed. (Sainero, Del Valle, López y Bravo, 2013, p. 1398)

INTERACTION BETWEEN BOTH SYSTEMS

The procedure for referrals to mental health services usually consists of decisions made by social educators who raise the need for those services with the approval of the children's home director and the local authority (which usually pays for all treatments). There are large differences between autonomous communities in Spain regarding the types of services available. Some use exclusively public services (treatment usually given by psychiatrists), others have some agreements with private services (mostly psychologists) to treat children in care and there are also some specific programmes created for children in care. In addition, some specific residential programmes such as therapeutic residential care have their own therapeutic services included in the staff.

The conclusions of some studies in Spain (Sainero, Del Valle & Bravo, 2014) demand more active methods of detection, assessment and criteria for referral to mental health services. The percentage of children with emotional and behavioural disorder is extremely high and child care services do not have clear, written systems to provide the specific treatment and procedures that are needed.

As a part of our study in the region of Extremadura, a process for the detection of mental health disorders was created, including early detection, follow up assessment and final evaluation (Del Valle, Sainero & Bravo, 2011).

The key social educator responsible for the children is the person who usually accompanies children to therapeutic services and establishes regular contact to follow up the process. The way they interact is one of the main problems, as the expectations of both parties are frequently very different.

As a result of our empirical research, by means of interviews with professionals from both systems, we have found some interesting perceptions and mutual attitudes.

Both systems agree about the need for more mutual knowledge and this must be the way to overcome the relevant differences in expectations and attitudes. Mental health staff need to know more about the role of children's homes both in terms of the legal framework and the role of social educators, as they are not parents but have parental responsibility. In addition, social educators in Spain are qualified to degree level so they must be seen as professionals who are able to contribute and be involved in the therapeutic intervention. Residential child care staff need to know more about mental health issues and be more realistic about the possibilities of therapeutic interventions and the time needed to achieve results in some cases.

The mental health perspective is that child protection cases have a serious problem of lack of information about historical background (family, school, health, etc.) and changes in staff accompanying children to sessions makes it even more difficult. Additionally they perceive social educators as very keen to demand specific interventions such as medication and quick solutions ("asking for a miracle"), particularly in cases of severe disruptive behaviour. Some criticism also emerged when talking about hospitalisation in mental health units because sometimes social educators don't follow up cases, acting as if they were the sole responsibility of the mental health system. A more sound criticism by therapists (even in specific programmes for child care) is the lack of stable adult references for children, adults who would be able to follow and support the therapy intervention. Changes in placements and staff in children's homes don't make this easy to achieve.

The child residential care perspective is that mental health services are very passive, not really aware of the complexity of child care cases. Due to the lack of knowledge about child residential care services they don't recognise the role of social educators and the need to share the intervention. Moreover, responses are too limited in terms frequency, length of sessions and the type of therapy (mostly medication). Social educators need advice on how to treat children in homes and concrete patterns and guidance, but they feel that psychiatrists make only very general and useless comments.

It is interesting to note that when interviewees were professionals in mental health services in specific programmes devoted to children in care (see section about good practices) their perception, knowledge and attitudes were much more positive and comprehensive.

SPECIAL GROUPS AND THERAPEUTIC RESIDENTIAL CARE

Young people seeking asylum have become a serious problem for the child care system in Spain. During the period 2000-2012 thousands of adolescents, mostly from Morocco and North Africa arrived in Spain and were placed in residential care. All of the autonomous communities had to launch new services for them with the serious challenge of addressing a very particular type of needs.

However, from the point of view of mental health needs they have fewer problems than local children in care. One of the problems some of them present in a very acute way is inhalant abuse, mostly in adolescents from African cities who were living on the street. However, most of asylum seekers come from rural areas presenting a profile of healthy development without significant psychological problems.

Adolescents with other problems such as substance abuse are usually referred to specific treatment centres for these kinds of problems but it is also a scarce resource in some autonomous communities.

The main problem during the 90s, however, was the increasing number of adolescents with serious disruptive and aggressive disorders who made children's homes a place where safety and control was almost impossible to maintain. As a consequence, most autonomous communities started to

formulate some kind of response, although with very different names and approaches. Thus, the first "socialisation" residential programmes appeared in some communities towards the end of the 1990s (80% of this type of resource available today began after the year 2000). In other regions various terms were in use such as special regime, high intensity education, attention to youths in social difficulties or social conflict etc. The term therapeutic began to be used later (in very few communities) and was defined as measures directed towards adolescents with serious mental health diagnoses (autism, psychosis, antisocial disorder, etc.) who, in addition, had significant behavioural issues. However, in the majority of autonomous communities, the idea of a therapeutic centre was confused with the idea of centres dealing with serious behavioural problems, so an early conclusion we can make is that there is a lack of clarity in these concepts (Del Valle, Sainero y Bravo, 2014).

Once established, the enormous demand for these types of programmes, thanks to the significant increase in cases, led to the increase in private non-profit organisations (there are hardly any for-profit organisations in this sector in Spain) who offered to provide these resources, since the cost is somewhere between double and triple the cost of a normal place. In this way, the most specialised care fell into the hands of the private sector, which in large part, was without previous experience in such demanding programmes and which had very different working methods and approaches in different communities. This gave rise, as evidenced in the Ombudsman's report (Defensor del Pueblo, 2009) to practices which failed to respect the basic rights of children, in which control and coercion were the primary psychological treatments. The report shed light on some administrations' lack of control over the development of these programmes, on which they had spent large amounts of money. Nowadays, an intensive debate about the characteristics and procedures of those specialized programmes for highly demanding adolescents continues and international discussions and revisions are taking place (for example: Whittaker, Del Valle & Holmes, 2014).

GOOD PRACTICES IN SPAIN

Through our specific empirical research for the RESME project, including 8 interviews with professionals from both systems, we were able to find some interesting good practices.

In Extremadura research on needs evaluation of mental health services for children in residential care was recently carried out (Del Valle, Sainero, & Bravo, 2011). A particularly interesting point in that study is that the mental health services were the promoters and financed the project, realizing the importance of developing prevention and early detection strategies for that high-risk, vulnerable group of children. The study produced a publication as a Guide for working with mental health problems in residential care.

In Guipúzcoa (Basque Country), the child protection services decided to create a list of available clinical psychologists, specialising in children and young people who social educators can consult for assessment, diagnosis and therapy; the service is paid for by the child protection department. The list of professionals was produced in cooperation with the Psychologist Association, a coordinator from this association is in charge of the project, following resources, results, etc. Child care services imposed a procedure that involves periodic reports (three months). The agreement allows a maximum of 48 sessions a year (weekly frequency) and covers all children who need attention without waiting lists.

Also in Guipúzcoa, following an agreement between both systems, the mental health department appointed a psychiatric nurse to be a coordinator in cases were children and young people in residential care are involved. The experience has been very effective and satisfactory for both sides.

In the Community of Murcia, the child protection department has obtained an agreement to finance a specific programme of clinical psychology for children in care (mostly residential care but also foster care). This programme is in the public hospital, in the department of child psychology, where the therapist (also a professor in the Faculty of Psychology) is a specialist in virtual therapy, which has been shown to be very engaging for children and very effective. Children in care, particularly those suffering severe mistreatment benefit from this programme.

DISCUSSION AND CONCLUSIONS

Residential child care is still a significant resource in the Spanish child care system despite the efforts made since the 80s to develop family foster care services capable of serving most children in out-of-home care. About 15,000 children and adolescents are looked after in residential care, 75% of them, over 12. As the data has shown, almost half of them are already receiving some kind of mental health service (mostly psychological support but 21% pharmacological treatment).

Externalizing disorders make the role of social educators extremely difficult in day to day life, considering that they have to deal with groups of 6-10 children and young people at children's homes with so many different needs and profiles. Disruptive and aggressive behaviour is the main reason for referring young people to mental health services. An exceptionally important problem is the frequency of children with intellectual disabilities in residential care, who are in a particularly vulnerable situation when living in groups in residential care. However, little research has been carried out about the special needs of this group in child care systems.

Fortunately, we were able to find some promising experiences of addressing children's mental health treatment in our empirical research. There are some autonomous communities which are trying to implement new programmes and investing money in new forms of therapy and making therapy easily available for children in residential care.

Professionals from both systems agree on the need to cooperate to better serve children and be more effective. However, differing and unrealistic expectations make it really difficult to achieve this collaboration. As in other situations where unfeasible expectations and even some prejudices exist, there is a need for better relationships, more contact and planned cooperation at the political and management level. The rationales for the RESME project related to a lack of mutual knowledge between mental health and child care systems are clearly visible in this empirical research. We hope that results of this RESME project can improve this key issue and facilitate better cooperation and better services for children in residential care.

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ON THE BORDERS BETWEEN RESIDENTIAL CHILD CARE AND MENTAL HEALTH CARE: EVALUATION OF THE RESME PILOT-COURSE

Gunter Groen & Astrid Jörns-Presentati

ABSTRACT

The main goal of the EU-Project RESME (On the Borders between Residential Child Care and Mental Health Care; 2012–2015) is to foster the inter-professional collaborative practices between residential child care and mental health. In the course of the project we developed an educational curriculum for professionals and evaluated the implementation of pilot courses in six European countries. In order to base the curriculum on the needs and challenges of collaborative practice, in each country mental health and residential child care professionals were interviewed about the cooperation of children and youth services and child and adolescent psychiatry. The results of this research formed the foundation of the developed curriculum, which aims to foster inter-disciplinary cooperation. Pilot courses were conducted in all of the participating countries, tailored to specific national topics and framework requirements. There were 157 participants in total. Evaluation data were collected from participants and tutors. Overall, the evaluation shows the potential of an inter-professional curriculum to enhance the collaborative practices on the borders between residential child care and mental health services.

INTRODUCTION

Children and young people that are recipients of child and youth welfare services and/or patients of child and adolescents psychiatric hospitals have often been exposed to an array of psychosocial stressors and problems. Their complex needs call for a joint and systematic response of helping professionals working in partnership (Baia, Wells & Hillemeier, 2009; Besier, Fegert & Goldbeck, 2009; Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk, 2004; Shin, 2005).

Children and young people living in residential care are likely to have been exposed to a number of risk factors to their development before they are taken into care. According to studies between 60 % (Schmid, Goldbeck, Nuetzel & Fegert, 2008) and 75% (Schmid, Koelch, Fegert &Schmeck, 2011) of the residential child care population suffer from a mental disorder, often experiencing comorbidity and very severe and complex mental health problems. It was shown that a variety of psychosocial and biological risk factors have a negative effect on the development of these children, such as: multiple traumatic life events (e.g. serious maltreatment, violence, abuse), mentally ill parents, loss of attachment figures, and poverty. Generally, this group is typified by a lack of accessible and effective care. Many vulnerable children and young people transition between services, or fall through cracks of the system (Nuetzel, Schmid, Goldbeck & Fegert, 2005). Studies also show that children and young people that receive inpatient treatment on a child and adolescent psychiatric ward are often also in need of child and youth welfare service interventions. Beck and Warnke (2009) found that 50% of a sample at a child and adolescent psychiatric day hospital also required social care services. For a third, out of home placement was suggested.

Inter-professional working between residential child care and child and adolescent psychiatry is known to be an essential component of effective service provision. Despite recent positive developments, improving the cooperation between both systems remains a very relevant topic for social policy makers, researchers, and professional's working in children's services alike (e.g. Fegert, Besier & Goldbeck, 2008; Gahleitner & Homfeldt, 2012; Gesundheitsministerkonferenz der Laender 2007; Schmid et al., 2012). A variety of factors that impact collaborative practice are being discussed, such as: professional roles and responsibilities (e.g. Ziegenhain et al., 2010), as well as structural and cultural components that guide professional discourse

and treatment decisions for children and young people (see Haselmann, 2010). Differing professional histories seem to play a role for the professional partnership as well as competing values and ethics, or unevenly distributed power and status (Schmid et al., 2011; Tetzer & Rensch, 2012; Buettner, Ruecker, Petermann & Petermann, 2011). Furthermore, existing social policy doesn't always clearly define roles and responsibilities for each discipline, and resources can be limited, with no additional reward set out for collaborative practice (see Fegert & Besier, 2008; Schmid et al., 2011).

Only few studies have examined interdisciplinary cooperation between residential child care and child and adolescent psychiatry (Besier et al., 2009; Freese, Holze & Adam, 2009; e.g. Cottrell, Lucey, Porter & Walker, 2000; Darlington & Feeney, 2008; Darlington, Feeney & Rixon, 2004, 2005a, b; Janssens, Peremans & Deboutte, 2010). The findings, however, suggest that cooperation is pivotal for providing effective and sustainable services for children with complex needs, as well as creating job satisfaction for the professionals engaging in this demanding field of work. Different ways of improving cooperation have been suggested in the literature. One promising way to enhance collaborative practice is by enabling opportunities for inter-professional learning, for example through continuing education courses where shared teaching of professionals from different disciplines occurs. However, there has been no systematic evaluation of interdisciplinary continuing education courses for staff members of residential child care and mental health services.

THE RESME PILOT COURSE – DEVELOPMENT AND CONCEPT OF THE EDUCATIONAL CURRICULUM

As part of curriculum planning, members of all partner countries in the RESME project conducted a qualitative interview study in which professionals working in both systems were asked to describe their experience of boundary work. As a result, each country produced a research report summarizing the results from the interviews with residential child care and mental health practitioners. The research showed that inter-professional working was generally considered an essential component of good service provision in all participating countries. Furthermore, the data showed that for each national context, specific topics were particularly relevant for exploration in a shared

learning environment. In all of the countries, participants voiced a keen interest in exchanging experiences with members of the other system, in order to improve collaborative practice through better understanding of the other's work processes.

Apart from meaningful practice-based themes (Groen & Jörns-Presentati, 2014), the curriculum is based on content that was generated by the international research group of the RESME project. A pilot course was conducted with professionals of residential child care and mental health services in all of the six member countries (Denmark, Finland, Germany, Lithuania, Scotland and Spain).

COURSE CONTENT AND GOALS

The aim of the pilot course was to promote inter-professional learning and collaboration between mental health professionals and residential child care professionals. The objectives of the pilot course were to allow each group of professionals to explore the common nature of the children and young people with whom they work and to provide opportunities to share knowledge about specific aspects of the lives of vulnerable children and young people with whom they work. The curriculum should provide practical experience of each other's working structures and environments, encourage reflection on the application of learning to practice across boundaries and provide opportunities to learn from each other's experiences. Furthermore a training needs analysis for guiding future learning and collaborative opportunities should be developed.

The course followed accepted adult professional learning principles. Adults learn best in an experiential way. The professionals involved will be encouraged to use their experience, acquire new information and skills and use critical reflection and appraisal to integrate new knowledge into practice. The course had three modules: Frameworks for borderline practice and international issues, Problems that practitioners face in everyday work and Inter-professional issues and collaboration. The complete, detailed course can be found in Appendix.

The content of the training course was mainly founded by the RESME research. RESME research results, ideas, expertise and facilities were transformed into study plans for piloting continuing training courses in partner countries.

Also themes from focus groups are reworked and implemented for group work themes in training course. One main idea in implementing the inter-professional training course is to explore and exchange, challenge both sector's attitudes and prejudices.

The curriculum was in parts tailored to specific national topics and framework requirements. Specific topics and issues in the curricula of the partners in the different countries were:

- Enabling dialogue between residential child care and child and adolescent psychiatry, child protection and child welfare - discipline and love in everyday work, therapeutic approaches to residential child care, myths and truth about laws/legislation, good and promising practices for working together (Finland)

- Child care and child welfare systems, interventions for children with complex needs, therapeutic approaches in residential child care, good and promising practices in collaborative practice, exchanging of experiences and case studies of dealing with obstacles in collaborative practice creating a therapeutic environment in residential child care (Spain),

- Challenges for collaborative practice, good practice examples of cooperation, group work around practice-based case studies, social and medical diagnostics, professional identities, different working conditions, dealing with crisis, interventions for children with complex needs, dialogue between the systems and concrete steps towards better collaboration (Germany),

- Legislation and comparison of systems, work in a complex and changing society, coherent action for the mentally ill, competence to engage in an interdisciplinary and trans-sectoral collaboration for the benefit of the mentally ill (Denmark),

- Sociological perspective to the health and inequalities, therapeutic residential child care, questions of diagnosis of mental health problems and interventions, working together, exchange of knowledge, social and medical modules, international perspectives (to both systems) (Scotland),

- Introduction and international perspectives on collaboration, psychological aspects on work with children and youth, ethics in child mental health care services, inter-professional practice, protecting children´s rights and providing adequate health care, biopsychosocial needs of children in residential care, rights and responsibilities of children and professionals, obstacles and opportunities for inter-professional collaboration (Lithuania).

LEARNING AND TEACHING TOOLS AND IMPLEMENTATION OF THE COURSE

The course uses a blended learning approach in order to encourage shared learning and collaboration in a range of ways: through acquisition of knowledge and skills, through opportunities for personal contact and exchange between practitioners and through practice-based case studies generated by the participants. Furthermore, inter-disciplinary practice placements and work shadowing, ranging from a few hours to a few days, are considered a central resource for inter-professional education. A range of learning approaches can be used in inter-professional teaching and learning in order to enable participants to gain knowledge, have new experiences and build competences. The following learning approaches were mainly used in the RESME pilot courses: Lectures, presentations, case work, group work and discussion, work shadowing, learning café, self study/e-learning and role play. The majority of these learning approaches were used across all partner countries, within specific national frameworks. Except for Denmark, work shadowing was planned and implemented.

In all countries, the courses were taught by a minimum of two tutors (members of the RESME research team) and additional external experts. The structure and length of each pilot course was contingent on the national context (e.g. concerning the delivery of adult education[1]) and on the professional framework of residential child care and mental health services (e.g. legal and financial issues) (see Table 1). The general themes are of central importance across all countries, however, each partner country chose specifically which topics were dealt with in more depth.

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1. For example in Germany, it would have been very difficult to find participants able to join a further education class over more than four days, with such short notice.

TABLE 1. *Course Structure and Participants in the National Pilot Courses.*

Partner-Country and Institution	Duration (face to face days)	Number of Participants	Profession of Participants
Finland, Turku TUAS	7 days/8 hours January-September 2014	13	1 psychologist, 1 psychiatrist, 4 mental health nurses, 7 social pedagogues
Spain, Oviedo UNIOVI	8 days/6 hours March-September 2014	25	13 mental health professionals: social workers, psychologists and psychiatrists and 12 managers of residential child care homes. Chief executives of the mental health and the social care department.
Germany, Hamburg HAW	4 days/4-8 hours (overall 24 h) May-June 2014	20 + 35	12 social workers and social pedagogues working in residential care, 2 social pedagogues working in the mental health system, 3 psychologist, 1 psychotherapists, 1 school counsellor and 1 psychiatrist; Additionally a seminar with 35 students (6th semester, BA Social Work) was conducted.

Denmark, Arhus VIA UC	10 days /4-5 hours per day, (January-May 2014)	37	Two parallel teams, "diploma" course (5 ECTS) and "academic" course (10 ECTS) with assistants in health care and residential child care as well as employees from private organizations;
Scotland, Edinburgh EDUNI KIBBLE	8 days/7 hours (April- August)	8	Only residential care workers
Lithuania, Vilna MRU	8 days/7 hours (February-May 2014)	19	2 managers working in residential child care, 10 social workers working in residential child care, 7 mental health nurses

EVALUATION OF THE PILOT-COURSES

The pilot courses were developed to promote inter-professional collaborative practices and are an important output of the RESME project. In order to appraise the quality of the courses and the learning progress of the participants, each pilot course was evaluated by collecting feedback from participants and tutors.

PARTICIPANT EVALUATION

Across all six partner countries, 157 participants took part in RESME pilot courses. The participant group mainly consisted of professionals, however, there was one class conducted with students (see Table 1). In most of the countries, the majority of participants evaluated the course by filling out standardized questionnaires that also included a number of open questions.

In the main results below, only evaluation data gathered from professionals is summed up. The data is based on 66 comparable questionnaires (which are not necessarily representative of the number of participants that took part in each country: Spain: 24, Lithuania: 16, Germany: 15, Scotland: 6, Finland: 5; the questionnaires use in Denmark were mostly not comparable).

Professional Background

Most of the participants fell in the age range of 36–45 (21%) and 46–55 (44%) years. The majority of participants (77%) were female. 59% were social educators, social workers, or pedagogues. 17% were nurses or psychiatric nurses, and 23% were psychologists, psychiatrists and/or psychotherapists. The latter professional group only took part in the pilot courses in Germany and Spain. Most of the participants had relevant professional experience, with 4–10 years (23%), 11–20 years (18%) or over 20 years (44%) of work experience. 65% of the participants worked in the mental health sector, whereas 32% worked in the child welfare/child protection system. Nearly half of the participants worked as a supervisor, in a managerial or executive position.

Evaluation Results

At least 85% of the participants evaluated a number of components of the curriculum and learning approaches, common to all pilot courses as excellent or good: the learning principles, the teaching, the teaching staff, the possibility to actively participate, the balance of theory and practice, the atmosphere in the group, and the work shadowing. The latter two aspects were evaluated most positively by the largest number of participants (see Table 2).

TABLE 2. *Satisfaction of the participants (professionals) according to the evaluation questionnaire (in Percent; N = 66; for some questions 63, due to missing responses).*

How satisfied are you with (in %)	Excellent	Good	Fair	Poor
the learning principles, which underpin the course?	47	43	11	0

the teaching?	41	44	15	0
the teachers/ teaching staff?	55	37	8	0
the possibility to actively participate?	55	41	4	0
the balance of theory and practice?	38	48	12	2
the atmosphere in the group?	65	30	5	0
the work shadowing?	62	31	7	0

Participants also evaluated the adult education course based on the relevance to their daily work, specific learning objectives, and knowledge gain. Results were also generally very positive (see Table 3).

TABLE 3. *Evaluation of specific aspects of the curriculum by the participants (in Percent, N = 66).*

	Excellent	Good	Fair	Poor
How relevant was the course for your daily work?	46	42	11	1
How well have you been able to use the information from this course in your daily practice?	29	56	11	4
Has the course built upon your previous knowledge?	48	38	9	5
Did you gain knowledge on the European perspective in relation to mental health?	20	42	29	9
Did you gain knowledge on the European perspective in relation to residential care?	18	44	29	9
Have you gained knowledge on the service systems relating to residential child care (e.g. policy, legal)?	30	43	27	0
Have you gained knowledge on the service systems relating to mental health care (e.g. policy, legal)?	22	50	23	5

Has your understanding of social pedagogical work/residential child care work increased?	41	45	10	4
Have you increased your understanding of the development in child care/ child welfare in your country?	44	40	14	2
Have you gained an understanding of the specialist interventions in relation to the children in your care?	32	46	22	0
Did you gain any new methods/interventions/ tools to support your work with young people?	21	45	32	2
Did you gain any useful practice advice to support your daily work with young people?	25	43	27	5
Do you have a greater understanding of your professional role in working on the borderline?	33	53	11	3
Do you have a greater understanding of your own expertise in working with young people in your care?	20	55	23	2
Have you gained knowledge on how different codes of practice impact on working collaboratively?	35	45	18	2
Have you increased your knowledge of some of the common diagnosis in mental health services?	11	44	32	13

Open Ended Questions

The participants were given the opportunity to answer open-ended questions in order to comment on or critique the pilot course, and give recommendations for the future. The following shows a summary of the answers to the open questions, which generally reflect a very positive appraisal of the impact the pilot courses had upon participants' understanding of inter-professional collaboration.

When asked about which **features of the course were the most helpful**, many felt that working in partnership was an essential component of effective service provision. Hence, engaging in inter-professional learning was inherently useful. Learning together as a group, and from one another about different perspectives and professional approaches to working at the boundary was thought to be particularly helpful. Group discussions and

interdisciplinary pair work that dealt with practice-based case studies were thought to be appropriate and effective learning approaches. Many of the participants stressed the good working atmosphere and appreciated being given an opportunity to make personal contact with professionals from the other system. The pilot courses enabled an experience of "being in it together," and created an opportunity to ask questions and learn about the other system. Many participants particularly appreciated the practical aspects, such as being given the opportunity to work shadow. Also mentioned was the ability to acquire knowledge about complex theoretical issues. Specific issues dealt with in the pilot courses were, for instance: better understanding the lives of children and young people in residential child care, social diagnostics, guidelines for dealing with crisis, children's rights, and autism.

When asked to **evaluate the course with regard to its relevance for participants' daily practice**, many stressed that establishing new contacts within the group actively improved cooperation. For residential child care workers, it was particularly useful to be given an opportunity to network and even seek advice from other professionals without the apprehension of being judged. Others felt that learning about the realities of residential child care was particularly useful in order to assess children's needs more holistically. Practical skills to be taken away from the pilot courses were: learning about new collaborative practices between residential child care and psychiatry, about ways of integrating psychiatric treatment within residential child care (such as psychiatric consultation via phone), gaining a better understanding of child and adolescent psychiatry and of the potential and limitations of the other system in general, and acquiring knowledge about symptoms and diagnoses of children and young people with complex needs. Mental health professionals expressed that it was particularly interesting to learn about a range of issues related to residential child care, such as: the complexities of roles and responsibilities of social educators, different types of residential care, the importance of attachment between residential child care workers and children, and milieu therapeutic approaches to residential care.

When asked if the **pilot course helped strengthen participants' professional identity**, it was stated by some of the residential child workers that taking part in the pilot course helped them to gain more confidence in their professional role and made them more confident to challenge the mental health services, if necessary, in order to advocate for a child or young person's well-being. Participants of both professional groups experienced a better understanding of

"the other side" as a result of the pilot course. Some also stressed that they were more aware of their own resources and skills, suggesting that learning about work processes of the other system in boundary work can aid professionals in gaining a stronger sense of their professional identity.

A few participants named a number of individual, organizational, and circumstantial **barriers for personal learning**. Doing homework proved difficult for some, due to a lack of time, or simply because it had been a long time since they had to do homework, and they felt out of practice. However, most of the participants saw no barriers for their personal learning. Some participants thought that the course was sparse on detailed information about specific topics, while others bemoaned the lack of participants working in the other system, depending on the ratio of residential child care workers to mental health professionals in attendance. In some of the pilot courses, participants wished for the inclusion of perspectives of professionals involved in other fields related to boundary work, such as: administration, politics, police, the educational system, and the legal system. However, the majority of participants were generally satisfied with the course content.

When prompted for **further suggestions**, participants most often wished for a continuation of adult learning opportunities for professionals working at the boundary between residential child care and mental health services. For the development of the curriculum, participants suggested a range of things: more focus on discussing multi-professional case studies, the development of cooperation guidelines, and specific topics to be covered in class (e.g. evidence based mental health treatment, mental health diagnoses, a legal perspective on inter-professional cooperation, and best practice examples of collaborative practice). Some thought the participants' views on improving collaborative practice should have greater precedence in the course. Others favoured group discussion and lectures over writing exercises, and some thought the course should have been offered as an intensive training workshop lasting less study days.

The Danish partners conducted three qualitative interviews with participants in order to evaluate their national pilot course. They found that for their participants effective cooperation required an understanding of goals and good communication over roles and responsibilities. Participants stressed the importance of continuing education for professionals, as formal qualifications were associated with job security for them. However, they thought it was

nevertheless important that low-skilled staff was also familiar with working processes relevant for successful collaborative practice. Furthermore, documentation skills were thought to be particularly important for residential child care workers in order to gain more authority when working inter-professionally with mental health services.

TUTOR EVALUATION

Tutors from all pilot courses gave feedback through the use of standardized questionnaires, including open-ended questions. A summary of this self-evaluation data received from seven tutors, most of them members of the RESME research team, from four countries (Finland, Germany, Scotland and Spain), is given below:

- All seven tutors evaluated the **classroom atmosphere** in the groups as conducive to learning. Participants were thought to have brought a positive attitude towards inter-professional learning, as reflected by trust and willingness to share their experiences openly and discuss learning material freely. Generally, tutors perceived the majority of participants as very engaged and enthusiastic. Overall, the group dynamics were described as friendly, yet committed.

- The majority of tutors evaluated the **opportunities given for active participation** as excellent, and the **balance between theory and practice** as good.

- Almost all tutors evaluated the **work shadowing** as positive. It was thought to be an opportunity to have a unique learning experience about the "other system," which turned out to be eye-opening for some participants. In some countries the work shadowing did not take place due to organizational challenges, mostly a lack of time.

- All tutors thought the pilot course curriculum matched **expectations and needs** of the practitioners to a large degree. Accordingly, the majority of participants seemed to enjoy the variety of learning material. However, some reported that they thought the course was too short to cover the full spectrum of relevant issues surrounding collaborative practice. Tutors had the impression that residential

child care workers were particularly grateful for the opportunity to discuss their professional identity. Few participants wished for more detailed information about common mental health diagnoses. Some of the participants told tutors that, although they appreciated gaining an impression of a European perspective on collaborative practice, they felt that this component of the curriculum had the least relevance for their daily practice.

- Tutors did not see any major **barriers for the participants' personal learning** in the pilot courses. They identified a lack of time as the main constraint. However, they did acknowledge that knowledge transfer between residential child care workers and mental health professionals proved difficult at times. For some participants it posed a challenge to engage with more complex learning materials, such as research articles. This created a barrier for some participants to join more theoretical group discussions dealing with multi-professional perspectives and scientific literature.

- Most tutors did not detect any **differences between professionals/ disciplines regarding patterns of participation** in the pilot courses. A few tutors perceived mental health professionals as more confident in regard to their professional identity. Residential child care workers were perceived by some tutors as attributing more authority to mental health professionals than vice versa.

- Tutors evaluated the following **aspects of the course as particularly relevant** for the participants: discussions on collaborative practice based on practice-based case studies, networking, sharing personal experiences, learning about responsibilities and work processes in "the other system", acquiring relevant practical knowledge (e.g. diagnostic manuals or assessment tools), work shadowing, and developing a sense of solidarity.

- Tutors evaluated group work, case studies, work shadowing and lectures followed by group discussion as very **relevant didactic methods**.

- Tutors thought that **particularly important discussion topics** were cooperation and communication, lack of resources, different responsibilities and professional identities, pharmacology in residential child care, the meaning of "life world" in the context of residential care, professional assertiveness and confidence as well as examples of collaborative practice.

- From the perspective of tutors the following **aspects were missing** from the pilot courses. Some participants thought the work shadowing could have been prepared more thoroughly. Others felt that mental health practitioners could have been more involved, particularly in regard to sharing their knowledge about mental health diagnoses common for children and young people in residential child care, and their expectations for collaborative practices in general. For some, lectures on specific issues should have framed interdisciplinary discussion of case studies. A few residential child care workers felt their profession was not represented adequately.

- When asked about **proposals for the development of the curriculum**, tutors suggested to further develop the curriculum and to intensify links with the practice in both systems. It was thought that guidelines for collaborative practice should be developed and practitioners should be encouraged to meet regularly, for example on arranged contact days every three weeks. Furthermore, it was suggested that existing collaborative practices should be documented and presented by participants through presentations in the course.

Overall, tutors evaluated the pilot-courses as very successful. The majority thought it was most relevant that the courses gave an opportunity to have face to face contact between inter-disciplinary professionals, to further inter-professional learning, to work on multi-professional case studies and to work shadow in "the other system".

DISCUSSION

The experience gained from implementing the pilot courses and the results of the evaluation suggest that inter-professional continuing education for professionals working at the boundary between residential child care and mental health services holds a lot of potential. The feedback we received shows that the curriculum and the learning format matched the needs of practitioners. Participants and tutors were satisfied with the pilot courses, and appreciated shared learning and teaching. A range of aspects were thought to be particularly helpful, such as: being given an opportunity to network, to exchange experiences, to discuss case studies with an interdisciplinary perspective, to work shadow, and to engage with relevant research literature. It can be concluded, particularly between these two systems, that adult learning classes are a useful learning approach to improve skills and competences relevant for successful collaborative practice.

Further steps are to develop the application and implementation of the curriculum as a standardized adult education course, for instance through discrete modules. All of the partner countries intend to continue offering the course. At the University of Applied Sciences in Hamburg, for example, a regular class on collaborative practice for undergraduate students of the Bachelors of Social Work is going to be offered starting in the upcoming winter semester. Some components of the pilot course will be used in a curriculum for the training of future child and adolescent psychotherapists at a local, state-approved institution. At Kibble in Scotland, it is planned to have the pilot course be accredited within a new social pedagogy degree being developed at the University of Strathclyde.

The course should also be evaluated in regard to its outcomes at the individual and organisational level. One way to do this would be in a larger-scale, systematic and more standardized evaluation of the course with an even larger international sample. To ultimately assess the usefulness of the curriculum, it would also be important to collect follow-up data, in order to answer relevant questions such as: How possible was it for practitioners to implement input from the course into their daily practice? Has the collaborative practice really changed and improved as a result of the course? Did children and young people benefit from the inter-professional learning?

However, inter-professional training, like the one conducted and evaluated in the RESME project, seems to be a very good possibility to develop collaborative practices. In the future, inter-professional learning about cooperation could be offered also in an adult education setting for other professional groups, such as educators, members of the justice system, the police, as well as paediatricians. Academically and politically, the dissemination of the curriculum will continue to be important in order to drive change and improve collaborative practice. There needs to be a professional and public debate about the importance of working effectively and in partnership at the boundary between residential child care and mental health services. Furthermore, it needs to be ensured that good collaborative practice is promoted, rewarded, and addressed in social policy, so that people working with children and young people with such complex needs are valued, and trained adequately.

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CONCLUSION

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While residential child and youth care is under pressure because of the high number of users and because the outcomes of child protection systems seem to be relatively poor across the Europe, demands for better collaboration between child protection services and mental health services is understandable. Child well-being encompasses both physical and mental well-being and the necessity to address all those problems that cause special distress, and to attend to the special needs of the child taken into care. Mental health is a resource for coping in life and is thus to be promoted and protected. High quality residential child care work requires focused, qualified staff insisting that facilities and resources for inter-professional networking support the service system in the best interest of the child. Surprisingly, we discovered in the RESME partnership that there was no targeted inter-professional continuing training for the borderline work between residential child care and mental health treatment in a single partner country.

Results of the our international research indicate that there is a spectrum of services, expertise, programs and practices available in child protection and mental health systems across the partner countries. The diverse collection of national knowledge in this publication examines critically national practices and addresses the key question: How might we incorporate both side's competencies and expertise for better collaboration? Our suggestion in the RESME project is joint continuing education. Our course, "On the Borders between Residential Child Care and Mental Health Treatment", (15 ECTS) has been piloted now in every partner country in six languages (available at www.resme.eu). It is now a widely accepted principle across Europe that the transition from institutional care to family-based care is prioritised. We believe, however, that institutions are still required and residential care is the best option for the most challenging and demanding children. Moreover, we truly believe that it is possible to respond to children's best interests in institutions when there is a highly qualified staff and when alternative institutional facilities as well as integrated open care services are available. The

starting point for any improvement needs to take into account particular local contexts and to find spaces to promote dialogue and common and realistic understandings between the professional groupings.

We identify a possible tension that, in deploying ordinary discourse – parallel to what happens in a family context –, residential workers might be seen in a non-professional frame when collaborating with other professions. Residential child care work might, as a result, be conducted through a diagnosis and treatment model which does not necessarily reflect the educational and pedagogical expertise that exists in residential care work. Thus, residential care workers need to become more confident in their social pedagogical skills in dealing with behaviours they may not entirely understand. Traditionally in Germany and in Nordic countries, as well as currently in the UK, social pedagogy offers one paradigm for the professional knowledge of the residential care workers. The model of social pedagogy (with mental health approach) is a key piece in the RESME Project, as those professionals working in the context of daily living is regarded as the main resource to promote changes in children, through addressing behavioural and emotional problems.

The most important objective for us was to guarantee better mental health and well-being for those children who are taken into care and are living in institutions. The joint education course proved to increase the inter-professional collaboration between practitioners working on the borders of these systems. Hopefully in coming years an updated joint training will be available for all practitioners who are interested to develop their professional competencies and collaborative practice on the borders between residential child care and mental health treatment. We are happy to provide consultations for future training.

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