Bachelor's thesis

Degree Programme in Nursing

Nursing

2014

Juan Luis Cobo Carretero and Erja Kuosa

MULTI-AGENCY COOPERATION AND MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN RESIDENTIAL CARE

– A systematic literature review &

Qualitative focus group content analysis

TURUN AMMATTIKORKEAKOULU

TURKU UNIVERSITY OF APPLIED SCIENCES

BACHELOR'S THESIS | ABSTRACT

TURKU UNIVERSITY OF APPLIED SCIENCES

Degree programme in Nursing| Nursing

2014 | 120 + 3

Tarja Bergfors and Heikki Ellilä

Juan Luis Cobo Carretero and Erja Kuosa

MULTI-AGENCY COOPERATION AND MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN RESIDENTIAL CARE

The total of minors placed in substitute care in Finland in 2011 was of 17409, many of them exhibiting behavioral and mental health problems in different degree. Child welfare and mental health services often must work in parallel to address the needs of those minors in residential care. As a consequence, a number of problems arise when both services have to coordinate their work, which often results in neglecting children and adolescents' needs and in a loss of effectiveness in addressing their problems.

The studies presented in this paper have been produced under the European initiative RESME, which addresses the issue of mental health problems of minors in residential care settings and collaboration between child welfare and mental health services. The first one, a systematic literature review which tries to find in precedent literature good practices in addressing residential care users' needs referred to mental and behavioral problems. The second study, a focus group content analysis examines the content of an interview to four mental health professionals, their views about the problems associated to collaboration of mental health and child welfare services, and their suggestions to improve actual practices.

As a result of both works, different problematic aspects of residential care and collaboration between services were identified, as well as a number of practices oriented to address such problems, and recommendations are made by the authors based on the findings.

KEYWORDS:

Mental Health; Children and Adolescent; Child Protection; Multiagency Cooperation

OPINNÄYTETYÖ (AMK) | TIIVISTELMÄ

TURUN AMMATTIKORKEAKOULU

Hoitotyön koulutusohjelma | Sairaanhoitaja

2014 | 120 + 3

Tarja Bergfors ja Heikki Ellilä

Juan Luis Cobo Carretero and Erja Kuosa

MONIAMMATILLINEN YHTEISTYÖ JA MIELENTERVEYSHOITOTYÖN KÄYTÄNNÖT LASTENSUOJELULAITOKSISSA

Vuonna 2011 kaikkiaan 17409 lasta ja nuorta oli sijoitettuna muualle kuin omaan kotiinsa ja monella heistä ilmeni eriasteisia mielenterveydellisiä ongelmia sekä ongelmakäyttäytymistä. Usein lastensuojelun ja mielenterveyspalvelujen tulee tehdä yhteistyötä, jotta sijoitettujen lasten tarpeet tulevat huomioiduiksi. Tämän seurauksena syntyy monenlaisia ongelmia, kun erillään olevat laitokset organisoivat toimintaansa molemmat omilla tahoillaan. Monesti tämä johtaa lasten ja nuorten tarpeiden laiminlyöntiin sekä tehottomuuteen heidän ongelmiensa esille tuomisessa.

Tämän opinnäytetyön kaksi tutkimusta ovat tehty RESME- projektille, joka on Euroopan Unionin rahoittama kansainvälinen projekti, jonka tarkoituksena on kehittää eurooppalaista lastenkotityön ammatillista osaamista kasvatus- ja mielenterveystyön rajapinnoilla. Ensimmäinen tutkimus on systemaattinen kirjallisuuskatsaus, joka pyrkii löytämään jo käytössä olevia hyviä toimintamalleja laitoksissa asuvien lasten mielenterveydellisten ongelmien kohtaamiseen. Toinen tutkimus on laadullinen ryhmähaastattelun analyysi, jossa psykiatrisen hoitohenkilökunnan haastattelussa (neljä haastateltavaa) selvitetään heidän kokemuksiaan yhteistyöstä lastensuojelulaitosten kanssa sekä heidän ehdotuksiaan yhteistyön parantamiseksi.

Tutkimustuloksista on löydettävissä sekä erilaisia ongelmakohtia niin lastensuojelulaitoksien sisällä kuin eri laitosten välisessä kanssakäymisessäkin, mutta myös useita jo käytössä olevia toimintatapoja sekä uusia ehdotuksia, jotka tähtäävät näiden ongelmien esiin saattamiseen ja korjaamiseen.

ASIASANAT:

Mielenterveys; lapset ja nuoret; lastensuojelu; moniammatillinen yhteistyö

CONTENT

LIST OF ABBREVIATIONS (OR) SYMBOLS 7

1 INTRODUCTION 8

2 RESME-PROJECT 10

3 BACKGROUND 11

3.1 Taking children into out of home care in Finland 11

3.2 Characteristics of child welfare institutions in Finland 14

3.3 Mental health problems among minors in residential care settings 16

3.4 Findings in the background literature 18

3.4.1 Modeling alternatives and opportunity-led work 19

3.4.2 Planned help: individualized support with daily living 20

3.4.3 Inclusion of a psychiatric nurse, or other professional with a mental health education background, into the team of caregivers 21

3.4.4 Continuity in child protection and mental health services cooperation 21

3.4.5 Family implication 22

4 AIM AND PURPOSE 23

5 SYSTEMATIC LITERATURE REVIEW 24

5.1 Research rational 24

5.2 Research design 24

5.2.1 Selection of databases and journals 25

5.2.2 Selection of articles 27

6 RESULTS OF THE LITERATURE REVIEW 30

6.1 Building resilience in a children's home: results from an action research project 31

6.2 Innovations in implementation of trauma-informed care practices in youth residential treatment: a curriculum for organizational change. 34

6.3 Modernizing residential treatment centers for children and youth — An informed approach to improve long-term outcomes: the Damar pilot. 38

6.4 Reducing transfers of children in family foster care through onsite mental health interventions. 41

6.5 Appraisal process 44

6.6 Synthesis and analysis 46

7 QUALITATIVE FOCUS GROUP CONTENT ANALYSIS 52
7.1 Research design of the focus group content analysis 52
7.1.1 Focus group interview 52
7.1.2 Content analysis 53
7.2 Sample 55
7.3 Data collection and analysis 55
7.3.1 Interview 55
7.3.2 Data analysis 56

8 RESULTS OF THE FOUCUS GROUP INTERVIEW 61
8.1 The structure of the current good cooperation 62
8.1.1 Current good cooperation 63
8.1.2 Elements for successful cooperation / result 65
8.1.3 Evaluation criteria 68
8.2 What is bad or problematic in current cooperation? 69
8.2.1 Systems & structures 69
8.2.2 Influencing factors 74
8.2.3 Obscurities 75
8.2.4 Not recommended current practices 79
8.3 Arising theme about seeking advice 83
8.4 Ideas for the development of the current cooperation 85
8.4.1 Why the change and development is needed? 85
8.4.2 What could be done? – Organisational & professional reformation 88
8.4.3 What could be done? – Personal & professional development 93

9 RELIABILITY, VALIDITY AND ETHICS 97
9.1 Systematic literature review 97
9.2 Qualitative focus group content analysis 99

10 DISCUSSION 101
10.1 The systematic literature review 101
10.2 Qualitative focus group content analysis 110
10.3 Correlation between findings 111
10.4 Conclusion 117

REFERENCES 118

APPENDICES

Appendix 1. Approval for interviews
Appendix 2. Used transcription characters.
Appendix 3. Results for the qualitative focus group content analysis.

FIGURES

Figure 1. Interaction between different co-operative factors. 61
Figure 2. Results for current good in cooperation 63
Figure 3. Results for current bad or problematic in cooperation. 70
Figure 4. Main elements in the problem of seeking and giving help and advice. 84
Figure 5. Results for ideas for development of the current cooperation. 86

TABLES

Table 1. Journal search. 26
Table 2. Selection. 28
Table 3. Selected articles. 30
Table 4. Appraisal results. 45
Table 5. Findings. 48
Table 6. Coded interventions. 50
Table 7. Categorising and condensation of the material. 57
Table 8. Translation. 58
Table 9. Creating sub-categories. 58
Table 10. Creating code categories. 59

LIST OF ABBREVIATIONS (OR) SYMBOLS

M1	M1 is an abbreviation about a referral to psychiatric examination when the patient is not voluntary willing to undergo the examination (Suomalainen Lääkäriseura Duodecim 2009).
Valvira	National Supervisory Authority for Welfare and Health (Valvira 2013).

1 INTRODUCTION

In 2011, a total of 17409 minors were placed into substitute care in Finland (National Institute for Health and Welfare. Official Statistics of Finland. 2012, 37), many of them with severe behavioral, emotional, or other types of mental health problems.

Literature is very scarce in research about practices and collaboration between child welfare and mental health institutions. Pitkänen (2009) directly addresses this topic in her bachelor thesis, and some of the findings of her study are included in this paper. No other studies were found that directly addressed issues concerning collaboration between children and adolescents residential care and mental health institutions collaboration.

Residential care workers show themselves insecure about the subject of mental health, about how to identify those cases in urgent need of help, and how to provide help for them once the need is identified. The situation is especially problematic with those adolescents who show behavior disorders with a high component of aggressiveness.

Moreover, very often caregivers do not even see mental health problems as part of their work, and place the entire responsibility of addressing those problems onto mental health professionals. It even occurs that some residential care workers do not have a clear idea of who to contact or what kind of services are available when this kind of problems arise. This situation calls for an attempt to reinforce a smoother and more effective communication and cooperation between the two, child protection and mental health services – which often is not the case –, and for making staff psycho-educational training and implementation of effective interventions to address such problems an integral part of residential care

Although safety and permanency in placement have been traditionally the goals on which to base substitute care, current literature introduce a third concept, that of child well-being, which has arisen to the center together – or including –

the two previous ones (Webb & Harden 2003, 49; Samuels 2011, 19). Child well-being comprehends both physical and mental well-being which includes the necessity to address all those problems that cause any special distress, and to attend to the especial needs of the person under care.

The present work is composed of two well differentiated parts, a systematic literature review and a focus group content analysis. The systematic literature review identifies a number of interventions and approaches that are used in residential care settings to address the especial needs of its client population, related to the high incidence of mental and behavioral problems among it. The articles that present these interventions are appraised with the hope that professionals in the field can benefit from them and farther research those that they think useful and can be implemented within their respective units. The focus group content analysis examines the content of an interview to four mental health professionals, their views about the problems of collaboration of mental health and child welfare services, and their suggestions to improve actual practices. It is the idea of the authors that both studies complement each other, and that together they can through some light into the actual problems and possible trends to follow in addressing mental health problems of children and adolescents in residential care.

2 RESME-PROJECT

The present work, composed of two different studies – a systematic literature review and a focus group content analysis – is part of a bigger initiative known by the name of RESME. RESME is a comparative study of the cross disciplinary cooperation and communication between mental health systems and the welfare systems in five EU countries, especially concerning children and youth from residential homes who needs help from both systems.

By researching and describing the challenges of cooperation between the two sectors or systems in five EU countries RESME aims to create a better understanding of the deeper logic in these challenges – and to drive change through educational programs and conferences that will focus on the challenges an present 'best practice' between the participating five EU countries.

The countries participating in the project are Lithuania, Germany, Spain, Scotland, Finland and Denmark.

Originally, four thesis works – consisting of two systematic literature reviews and two qualitative focus group analyses -- were to be presented together under the general cover of RESME, so their results would complement each other; because of differences in compliance with deadlines only two of those four theses are presented simultaneously in this work.

3 BACKGROUND

3.1 Taking children into out of home care in Finland

The Finnish Child Welfare Act 417/2007 safeguards the right of children to grow in a safe environment, to enjoy a balanced and well-rounded development, and to especial protection.

It places the primary responsibility for a child's wellbeing on the child's parents and other custodians, although under certain conditions, a child may be placed away from home or other measures may be taken to arrange care for and custody of the child.

Three different possibilities are contemplated in the text, in its sections 37, 38 and 40, when placing children into substitute care:

Section 37 Placement as support in open care. This modality includes 2 cases:

(1) Family or institutional care may be arranged as support in open care for a child together with a parent, custodian or other person responsible for the child's care and upbringing, in the manner referred to in the client plan and in the form of care in which the need for support is assessed or in the form of rehabilitative care.

(2) Placement as support in open care may also be arranged on a short-term basis for the child alone. Such placement requires the consent of the child's custodian and, if the child is twelve years of age or more, the consent of the child. The preconditions for the placement are that it is necessary for: 1) assessing the child's need for support; 2) rehabilitating the child; or 3) arranging care for the child temporarily on account of the custodian or other person in charge.

Section 38: Emergency placement of a child.

If a child is in immediate danger for a reason referred to in section 40 below, or is otherwise in need of urgent placement and substitute care, the child may be placed with urgency in family care or institutional care, or the care and custody the child requires may be arranged in some other way.

Section 40: Duty to take a child into care and provide substitute care.

1) If their health or development is seriously endangered by lack of care or other circumstances in which they are being brought up, or

2) They seriously endanger their health or development by abuse of intoxicants, by committing an illegal act other than minor offence or by any other comparable behavior.

In a survey taken place in Turku, Finland (Hukkanen 1999, 270), the main reason for the placement of children into substitute care was serious abuse of alcohol of the parent/parents –60%–, with domestic violence being the second reason, present in 24% of the cases.

Nevertheless, taking a child into care and provision of substitute care will only be resorted to if the measures referred to in chapter 7 of the act – open care – would not be suitable or possible for providing care in the interests of the child concerned or if the measures have proved to be insufficient, and if substitute care is estimated to be in the child's interests.

Among the different modalities of substitute care for minors, there are two which demand especial attention for the purpose of this study, namely, those of residential care and foster care. Residential care institutions features are described in section 2.2 of this text. Foster care is a family-centered system of substitute care in which the child is placed in the temporary care of a family other than his own, sometimes with relatives or other kin; this last figure – kinship foster care with relatives – seems to represent a relatively small group in Finland, where nearly half of the children taken into care in 2011 were placed in families, but only about 9% of those in foster care were placed under the custody of their

own relatives (National Institute for Health and Welfare. Official Statistics of Finland. (2012, 37). Children in kinship foster care use to present less behavioral and other mental problems, use to see their biological parents more often than those in other forms of placement, and are more often fostered within their local community (Holtan et al. 2005, 202), all of which contributes to their well-being. Nevertheless discussion is going on within the research arena about the adequacy of kinship over non-kinship foster care, for literature also reveals that “kin caregivers are likely to be older, less educated, and have access to fewer resources than traditional foster parents including minimal training on caring for children”, and that “there is evidence that both kinship families and the children in their care are less likely to be offered, or to request, supportive services, including mental health and substance abuse services, during the child’s placement” (U.S. DHHS, Children’s Bureau 1998) (see Webb and Harden 2003, 54).

In contrast to those in foster care, children in residential care have fewer opportunities to develop close relationships with a significant individual who can take the role of an attachment figure, which may result in further disorders – attachment disorders or another type –, especially in young children. Additionally, it has the disadvantage of dividing the time and the attention of the care worker between several children, in many cases with several of them showing especial needs to be attended by a limited and overloaded staff. The influence of those individuals with behavioral problems on their peers needs also to be taken into account, especially in the case of younger children who are easily influenced and ready to copy the often negative behavior of their older mates (Barth 2002, 7).

Foster families are currently given preference over children’s homes in the placement of children in Finland, especially in the case of young children (Törrönen 2006, 129). Foster care has the advantage, in addition to avoid or reduce the risk associated to the points mentioned above, that the costs involved are reduced by several times, as it is up to 6,6 times more expensive to keep a child in residential care compared to foster care (Barth 2002, 20-21). Without evidence that this higher expenditure results in any better outcomes,

foster care supposes a considerable saving of financial resources that can be used to provide better service – for instance, when it comes to treatment by mental health professionals –, or to provide better accommodation, or increase the number of staff for those in residential care.

Nevertheless, residential care might be a better model of care for those children minors with severe mental problems and aggressive or self-destructive behavior, and the number of families available in foster care is still a factor that irremediably limits, and will continue to limit the options available for minors in substitute care in the near future (Barth 2002, 25).

The Finnish Child Welfare Act 417/2007 also considers in its section 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 behavior otherwise seriously endangers their lives, health or development". This is done by a multidisciplinary care team in a child welfare institution, with the possibility of restricting the child's freedom of movement during the provision of special care. Not all residential care homes are prepared to provide this kind of care, though, as they need adequate installations plus enough and adequately trained personnel, not always available.

3.2 Characteristics of child welfare institutions in Finland

The Finnish Child Welfare Act 417/2007 states that children in child welfare institutions must be brought up so their privacy is respected, that institutions must have adequate and appropriate facilities and operating equipment, and that in case that an institution has one or more residential units, those units may also operate separately from each other (section 58).

Children's homes in Finland have also changed over the past years, becoming more 'home-like' and reducing their number of residents (Törrönen 2006. 129).

In relation to the number of minors to be cared for together, the Child Welfare Act establishes that a maximum number of seven minors may be cared for in a

residential unit, and a maximum of 24 minors may be placed in one building, where several units are located. In the case that institutional care is arranged for a child together with a parent, custodian or other person responsible for the child's care and upbringing, more children may be cared for together. Temporary exceptions are possible in case of urgency (section 59).

A minimum of seven employees in care and upbringing work must work in a residential unit, or in the case that there is more than one residential unit in the same building, a minimum of six employees per residential unit. If an employee in care and upbringing work lives together with the minors to be cared for, exceptions can be made concerning the said numbers of personnel (section 59).

The number of professional social welfare and other personnel in child welfare institutions must be sufficient with regard to the care and upbringing required by the minors, and the special needs of the clientele and the nature of operations in the operating unit must be taken into account in the qualifications for personnel in care and upbringing work (section 60). Shealy (1995) thinks that care workers in residential settings are neither parents nor therapists, but that should partially perform both of these roles as "therapeutics parents" (see Barth 2002, 5), including into their daily relationship with those cared for characteristics typical of a therapeutic relationship, such as unconditional positive regard, empathic understanding, etc., and avoiding negative behaviors associated with psychopathology – e.g. hostility, criticism, mixed messages, or the absence of clear boundaries, among others –, often present in the family setting, and which may be responsible for the development of trauma and emotional and behavioral problems. This would no doubt ensure a better response to the special needs of minors cared for in residential institutions.

This view is supported by other professionals; in an interview – part of Pitkänen's (2009, 38) bachelor thesis – of a psychiatrist who works with children in residential care in Southern Finland, he expressed his opinion that most of adolescents taken into custody were not able to deal with their issues in separate and individual visits in psychiatric care, and so there should be more cooperation and mental health counseling for those who are most in contact with

them – i.e. residential care workers. Also Hukkanen (1999, 273) comments: “Psychotherapy could be provided for a group of these youngsters but its availability is limited and not all children with difficulties can regularly attend or benefit from psychotherapy. Different kinds of approaches to help these children need to be developed.

3.3 Mental health problems among minors in residential care settings

It is an indisputable fact, repeatedly present in literature about minors in out-of-home care, that this group presents a higher incidence and severity, or is at higher risk to develop mental health problems, compared to other children and adolescents not placed in any form of institutional care (Ward 2006, Meltzer et al 2002, Sourander et al. 1997, Hukkanen 1999).

Many of these minors are likely to have experienced seriously traumatizing situations, such as abuse (physical or sexual), neglect, exposure to parental substance abuse, neighborhood violence, and other trauma, as well as the effects of distorted family relationships (Berridge & Brodie 1998; Edleson 1999) (See Ward 2006, 337 & Hummer et al. 2010, 80). In addition to this, children in out of home care are also exposed to stressful and emotionally overwhelming experiences, such as multiple placements and frequent changes in care workers or in schools (Ryan et al. 2006; Ko et al. 2008) (see Hummer et al. 2010, 80).

In 2002, a UK Government review found that young people looked after in residential care reported much higher incidence of emotional, conduct, and hyperkinetic disorders, compared to the general population, conduct disorders being the most prevalent – 60% –, and resulting in most of the children – 72% – presenting at least one mental disorder (Meltzer et al. 2002, 20-28). These numbers are consistent with those of Hukkanen et al. (1999, 272), who assures that about 55-80% – depending on the instrument used for the assessment – of children in residential care settings in a study carried out in Turku, Finland, presented some psychiatric disorder. Many young people in residential care have troubles with the police, especially those with conduct disorders; also difficulties

among children in residential care in reading, math and spelling are more prevalent than in any other placement (Meltzer et al. 2002, 81).

Looked after children are also thought to be at much greater risk than other children of having an attachment disorder. These attachment disorders can be differentiated in two types: 1) inhibited attachment disorders, characterized by marked difficulties with social interactions that are usually attributed to early and severe abuse from ‘attachment figures’ such as parents, and 2) disinhibited attachment disorders, characterized by diffuse attachments, as shown by indiscriminate sociability without the usual selectivity in choice of attachment figures, which is often attributed to frequent changes of caregiver in the early years (Meltzer et al. 2002, 138-140).

As put forward by Berridge (2002) (see Ward 2006, 337), for many of these young people their mental health problems are neither recognized nor actively treated. Petrenko et al. (2011, 1911-1912) speak of the existence of a “significant gap between those who need services [mental health] and those who receive them”. Ward (2006, 337) argues that the lack of training of staff working in this setting lead to a situation where the especial needs of this group are neglected in favor of what he calls the normalized model of everyday life. This model of practice emphasizes the need of children and adolescents of ordinary life dynamics, in the hope that even those who have had more difficult and traumatizing experiences and present actual traits of mental disorder will benefit from being subject to normal expectations, and from making their everyday experience as similar as possible to that of others living in normal, non-problematic family settings. This view is corroborated by a series of interviews carried out by Pitkänen (2009, 38-39) in her bachelor thesis in which residential care staff claims that they do not follow any especial working methods to address the mental health needs of those under their care: “We don’t have any magic tricks here. We go with supporting in everyday life”.

Ward (2006, 338) is more inclined to think that the experience of normality, which provides positive feelings of comfort and safety for individuals in different settings, may be perceived by those in residential care as a very problematic

reality, or that the achievement of normality may be related to subjective experience and meaning-making, rather than an external imposition of rules and arrangements. People in residential care settings, very likely with one or more mental disorder, will thus find much difficulty in achieving this sense of healthy normality until their especial needs are properly addressed, through interventions that go beyond those of normalization and ordinary life experiences, since often their own experiences of what is normal are very different from ordinary ones.

In a previous bachelor thesis (Pitkänen 2009, 21-22), in which a psychiatrist and 7 care workers of 2 different residential homes in Southern Finland were interviewed, the psychiatrist claimed that the biggest group among his clients was constituted of adolescents with conduct disorder, which were at the same time the most challenging to work with. Typical traits of these adolescents include aggressiveness, impulsive behavior, emotional instability, running-away from group care homes, and substance abuse.

When adolescents with behavioral problems, especially those who show an aggressive behavior, live along with younger children, they may terrorize the little ones, who are also at risk of copying their behavior (Pitkänen 2009, 34-35).

3.4 Findings in the background literature

A number of practices and approaches were found while reviewing background literature. The section 3.4 contains some of those practices and findings that could not be appraised in the systematic literature review, but nevertheless are considered of relevance by the author.

Adrian Ward (2006) in his paper: “Models of ordinary and special daily living: matching residential care to the mental-health needs of looked after children”, presents a number of models of special care which can be useful either in prevention, or addressing existing problems within the framework of children and adolescents with especial mental health needs in residential settings. These models are complementary, rather than mutually exclusionary, as they are also

complementary with the above mentioned model of ordinary everyday life, which can be kept as the ultimate goal to attain, but not as the only mean of care for the population of reference. From the 4 models proposed I have summarized 3 of them, which I believe to be especially relevant, and which I describe in the points 2.4.1 and 2.4.2 respectively. It is Ward's recommendation to use as many of them as thought that can be beneficial in a given setting.

3.4.1 Modeling alternatives and opportunity-led work

Children learn by observing and modeling in their social environment, and caregivers may be a model for them by showing them how to respond to habitual or exceptional problems in their environment in a positive and constructive way, in contrast to the patterns that children and adolescents may have learned at home, or may have developed in response to difficult family settings, e.g. by attacking others, or by developing aversive or addictive patterns. Workers in residential settings can act as attachment figures for them, and teach them by doing; for instance, by remaining calm, and showing empathy and understanding in the face of provocation. The final goal is to replace negative behavior and thought patterns with more positive and productive ones. Modeling alternatives is consistent with other behavioral models.

This model, based on social learning theory and attachment theory, is more a guideline for care personnel than a particular intervention to address specific problems and it counts with the disadvantage that for individuals with attachment or other severe disorders, the efficacy of this model may be seriously compromised. Nevertheless, staff must be aware that their own behavior may be a referent and a way to teach appropriate behavior and coping strategies to those placed under their care.

In addition to creating models of behavior for those in residential care, everyday incidents and interactions may provide care staff with plenty of opportunities to start an immediate, non-planned dialogue, promoting reflection and insight, with the aim of helping children and adolescents to reframe their assumptions and

learn new ways of interpreting and reacting, and sometimes turning into a therapeutic communication.

3.4.2 Planned help: individualized support with daily living

Minors with especially high stress or anxiety levels consequence of mental health problems may need to know that they will get support in coping with daily living in moments of crisis, not only at planned times. If their needs are not attended to within a reasonably short time-frame after request, they might recur to less healthy ways of coping with their problems, and outbursts of violence or other harmful behavior may take place.

Based on Dockar-Drysdale (1990) model for providing adaptations for young people in residential treatment, Ward (2006, 343-344) argues that children who feel that their personal care is handled with attention to their special needs, and that their caregivers are ready to engage with them in a personal and individual relation, will eventually learn to contain their distress rather than letting it overtake other aspects of their lives. Quick availability of staff members to attend individual demands on moments of crisis is very important to create a sense of safety and trust among individuals in residential care, as well as adequate training of the staff in providing support, and recognizing crisis. This concept if individualized help is consistent with other models found in literature, e.g., Hummer et al. (2010, 92) present the following point: “Each youth has a safety or crisis management plan with individualized choices for calming, de-escalation, and avoidance of seclusion and restraint”, as one of the practices conductive to effective trauma-informed care – trauma-informed care is described within section 5.1.2., where the article of Hummer et al. is summarized.

Nevertheless, this model has the inconvenient that enough staff must be usually available to attend the special needs of minors, which may not always be possible in terms of financial or human resources.

3.4.3 Inclusion of a psychiatric nurse, or other professional with a mental health education background, into the team of caregivers

Given the lack of training and information about mental health problems in residential settings, one practice suggested by a care worker in an interview commented in Pitkänen's (2009, 46) bachelor thesis was to include a psychiatric nurse in the team of caregivers, so this person could identify symptoms of mental problems or escalating episodes, and initiate action, either by providing adequate intervention, or by contacting mental health services, or both. This suggestion should be considered, as it would be very beneficial to have a member of the personnel trained in mental health issues who spends at least one or more days a week in close contact with service clients, allowing her to evaluate the mental status of children and adolescents under care without the necessity of especial arrangements, like individualized sessions or assessments with a psychiatrist or therapist, and with the advantage of providing a more natural environment for observation as it is the daily life dynamics of people in residential care.

On the other hand availability of qualified personnel might be a problem, and even if qualified personnel could work as normal caregivers one or more shifts a week in a given residential home, that would not solve the problem of rapid escalating episodes of violence or other problems which take place in a shift when the professional is not working, and whose signs has not been able to foresee and prevent.

3.4.4 Continuity in child protection and mental health services cooperation

One suggestion made by residential care workers in Pitkänen's (2009, 46) work is that when feasible, only one psychiatrist or other mental health professional should be in contact with, and give advice, information, and counseling to caregivers, so that they get familiar with each other, and with the resources available on each side. This idea was also supported by the psychiatrist, in addition to

being consistent with the theory of therapeutic relationship, in which continuity of professional – patient relation is a cornerstone, so why should it not be so in a professional – professional relationship.

3.4.5 Family implication

There is evidence that family implication in treatment models for minors in residential care, as partners in decision-making, as well as teaching skills to parents, all have a remarkable positive effect on those children (Landsman et al. 2001) (see Barth 2002, 15). Minors will most likely trust more those caring for them if they perceive that parents and caregivers cooperate openly and friendly in partnership, instead of seeing care workers as competitors or rivals for their parents, and residential care as a form of imposed separation from their parents and homes. Family involvement may so help to reduce issues with behavioral problems, and significantly ease the child/youth-caregiver relationship (Barth 2002, 24-25). This view is consistent with a previous bachelor thesis by Pitkänen (2009, 39). She states that "it was emphasized that when the adolescent knows that the workers from the children's home are co-operating with his/her parents and they accept each other, this information helps the adolescent".

4 AIM AND PURPOSE

The purpose of the present bachelor thesis work is to explore the actual situation concerning minors' mental health issues in residential care settings, to identify good practices to address the special needs of that population, and to improve the cooperation between Social (Child Protection) and Mental Health (Psychiatry) Services in order for children and youth requesting help from service systems to benefit.

The questions that the research tries to answer shall be:

- What are the good practices to address mental health problems among minors in residential care?
- What does psychiatric personnel experiences as *good* in current cooperation between child protection and psychiatric services?
- What do the psychiatric personnel view as *bad* or *problematic* in the cooperation?
- What *ideas* they have for the development of the current cooperation?

5 SYSTEMATIC LITERATURE REVIEW

5.1 Research rational

There is plenty of research about the high incidence of mental health problems among children and youth in substitute care settings, and the need of this population of special care and interventions, either performed by mental health professionals, by caregivers, or by them both in collaboration. Nevertheless not much research exists about how to address such needs within the mentioned settings, especially when it comes to collaboration between the two institutions of child welfare and psychiatric services and their respective professionals.

By performing a systematic literature review on the actual phenomena of mental health problems among children and youth in residential care, as well as the interventions and practices in use, it is hoped to provide some insight into the problematic and flaws of the actual system of out-of-home-care, but specially into the current good practices in addressing those problems, so professionals in the field may find new and more efficient and beneficial ways of providing care. This research is funded by the RESME Project, an international project, which accommodates many independent studies under its umbrella, and which focuses on the cross disciplinary cooperation and communication between mental health and child welfare systems in five EU countries.

5.2 Research design

A systematic literature review was conducted with the aim to gather all possible information about the topic which complied with a minimum standard of quality. This standard comprises three basic points: 1) the material used must consist of research articles published in a scientific journal, 2) all articles must be peer reviewed, and 3) the information must not be obsolete; to comply with the third requirement a time-frame from publication of 10 years was decided, so the search was confined to articles published since 1.1.2003 to the present day.

After a first preview of some databases – namely CINAHL, Cochrane Library and Elsevier: Science Direct –, and a pre-search with different key-words – child*, adolescent*, youth, mental health, psychiatric services –, the search was decided to be organized by journals focused on children and youth issues, in order to optimize the finding of information relevant to the content of this research.

5.2.1 Selection of databases and journals

A pre-search of journals related to the topic was used to look for key words that could be used to systematically identify a number of scientific journals used in the final search. The pre-search was effectuated using the portal of the University of Applied Sciences of Turku, Nelliportaali.fi, on the 29th and 30th March 2013. The words Child, children, adolescent, and youth were used and the results presented were screened to find key words to be used later in a second search. The words finally selected to be used were a combination of “child” and any of the following: “services”, “welfare”, “social work”, “psychiatry”, “mental health”, and “abuse”. See the table 1.

Six searches were effectuated, and a total of 15 results were obtained, from which one (*) was repeated in two different searches: “child AND psychiatry”, and “child AND mental health” respectively. Thus, a total of 14 journals were identified in this first phase of the search. Two of them (**) were left out because they were not peer reviewed, and one of them (***), “Children & libraries”, was omitted because its tittle made it clear that it was not related to the topic, leaving a total of 11 journals that could be used in the systematic literature review. Two databases were identified to carry out the search: CINAHL, and Elsevier: Science Direct, because of the familiarity of the researcher with them and because they presented a major number of relevant results during the first screening than Cochrane Library. In those databases, 6 journals from the remaining 11 of the list were identified, namely: “*Children and youth services review*” and “*Child abuse & neglect*” in Elsevier: Direct Science, and "*Child welfare*", "*Child & family*

social work", "*European child & adolescent psychiatry*", and "*Child abuse review*" in CINAHL. The 5 remaining journals (****) were not accessible in those databases, and consequently were not used in this research.

Table 1. Journal search.

SEARCH	JOURNAL	ISSN	PEER REV.
Child* AND service*	Children and youth services review	0190-7409	Y
	Children & libraries***	1542-9806	Y
Child* AND welfare	Child welfare	0009-4021	Y
Child* AND social work	Child & adolescent social work journal****	0738-0151	Y
	Child & family social work	1356-7500	Y
Child* AND psychiatry	The Canadian child and adolescent psychiatry review**	1716-9119	N
	Child and adolescent psychiatry and mental health****	1753-2000	Y
	European child & adolescent psychiatry	1018-8827	Y
	European child & adolescent psychiatry**	1433-5719	N
	Journal of the Canadian Academy of Child and Adolescent Psychiatry****	1719-8429	Y
Child* AND mental health	Child and adolescent psychiatry and mental health*	1753-2000	Y
	Journal of child and adolescent psychiatric and mental health nursing****	0897-9685	Y
	Journal of Indian Association for Child and Adolescent Mental Health****	0973-1342	Y
Child* AND abuse	Child abuse & neglect	0145-2134	Y
	Child abuse review	0952-9136	Y

5.2.2 Selection of articles

Using the 6 articles mentioned above, a search was conducted in CINAHL and Elsevier: Science Direct databases. The search terms were linked to the institutions object of this study as they were identified in the literature – namely residential care OR foster care OR out-of-home-care OR substitute care on the one hand, and psychiatric services OR mental health on the other. As the search was confined to journals addressing children's and youth's issues, there was no need to farther restrict the search to fit this particular population.

Alternative key words were considered, as for instance: collaboration, collaborative, best practice, or good practice, but they resulted in a very limited number of results, even effecting the search through the whole scope of the database instead of limiting the search to certain journals, and given the scarcity of research on the concrete topic of this review, they had to be discarded for otherwise they would pose a risk to omit some valuable articles.

The search criteria were as follows:

> Full Text; Published Date from: 2003.01.01; IS [0190-7409 OR 0009-4021 OR 0738-0151 OR 1356-7500 OR 1753-2000 OR 1018-8827 OR 1719-8429 OR 0897-9685 OR 0973-1342 OR 0145-2134 OR 0952-9136] AND [psychiatric services OR mental health] AND [residential care OR foster care OR out-of-home-care OR substitute care]

In addition, because only peer reviewed journals were used, all returned articles were also peer reviewed. The search was undertaken with the same parameters in both databases. They returned a number of 103 and 104 results in CINAHL and Elsevier: Science Direct respectively. Further screening of the articles was undertaken firstly by selecting them by their title, and from these, in a second stage, by selecting among the remaining articles by their abstract. In CINAHL, from the first 103 articles, 46 articles were selected by their title and 30 by their abstract. In Elsevier: Science Direct, from the original 104 articles, 28 were selected by their title, and finally 13 were selected by their abstract.

That threw a total of 43 articles to be ultimately examined in more detail to see if they accommodate to the aim of the study.

Table 2. Selection.

Database	Results	Selected by title	Selected by abstract
CINAHL	103	46	30
Elsevier: Direct Science	104	28	13

An in depth reading of the content of the articles served to classify them according to different criteria, namely:

1. Does the article provide evidence-based models of good practices to address mental health problems of children and adolescents in substitute care* settings?
2. Is the article original research – in opposition to literature review or other types of documents, e.g. general guidelines?

* Substitute comprises for the purpose of the study 2 main modalities, residential care and foster care. The focus of the present review is on residential care, although literature about foster care was also collected, for both systems are close in aims and clientele; therefore possibility exists to extrapolate – with due precaution – findings from one to another, and both are interconnected in practice by an incessant movement of clients from one to another – in both directions, from residential to foster care, and vice versa.

When the answer to the first criteria – addressing mental health problems in substitute care settings – was yes, a new classification was made according to whether the specific setting was residential or foster care. The second and last criteria served to differentiate between original research and other forms of research or papers. Original research was preferred over literature reviews, for it is easier to appraise, and more complex forms of research may exceed the capacity of the researcher; similarly guidelines, although may contain very rele-

vant information, offer little possibility to appraise their quality with the limitations of time, knowledge and means available for the present bachelor thesis work.

27 articles were considered not to provide evidence-based good practices, and so were directly omitted. From the ones that did provide good practices, 9 belonged to foster care settings, and 7 to residential care settings. From those 7, three were discarded for being literature reviews themselves – although one of them (Ward 2006) has been used in the background –, and 1 article was a guideline, and therefore did not meet the specified criteria of the search. That left a number of 3 evidence based articles which provide evidence-based good practices to address mental health problems in residential settings. When reviewing the literature that meets the same criteria in foster care settings, 1 article was selected because of its focus on institutional collaboration, given that no article that addresses a similar topic in residential care setting could be identified during the present systematic literature review.

6 RESULTS OF THE LITERATURE REVIEW

Four articles were selected according to the criteria described in the section 4. The table number 3 below presents information of reference for those articles, and table 5 in section 5.3 presents a summary of interventions and procedures that were identified in their texts. A summary of the content of the articles is provided in sections 5.1.1 to 5.1.4.

Table 3. Selected articles.

Author/Year	Method	Name of the article	Journal	Research question
Houston, S. 2010	Qualitative Descriptive Case study	Building resilience in a children's home: results from an action research project.	Child & Family Social Work	1) what approaches are helpful in building resilience? 2) what are the background factors that enable and constrain the social workers' interventions?
Hummer, V. L. et al. 2010	Qualitative Descriptive Case study	Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change.	Child Welfare	What are the organizational factors related to successful implementation of trauma-informed care?
Holstead, J. 2010	Mixed Descriptive Control Case study	Modernizing residential treatment centers for children and youth – an informed approach to improve long-term outcomes: the Damar pilot.	Child Welfare	Do nontraditional, research-informed, community-based residential treatment services produce more positive outcomes when compared to traditional campus-based services?
Collado, C. & Levine, P. 2007	Mixed Descriptive Case study	Reducing Transfers of Children in Family Foster Care Through Onsite Mental Health Interventions.	Child Welfare	Do onsite mental health interventions help to reduce transfers of children in family foster care?

6.1 Building resilience in a children's home: results from an action research project

Houston (2010) conducts an action research project in a residential home in Northern Ireland with a cohort of eight professional staff and five young people. The research tries to answer 2 questions: (a) what approaches are helpful in building resilience?; and (b) what are the background factors that enabled and constrained the social workers' interventions? For that purpose, the researcher conducts an in-depth, qualitative study of the participants' reflections and their actions.

THE PROJECT: The model described "provides a theory and practice template designed to enhance resilience across six key domains of experience , namely: (a) secure base; (b) education; (c) friendships; (d) talents and interests; (e) positive values; and (f) social competencies" (Houston 2010, 358).

Strength-based approach, relationship-building work and opportunity-led work are essential concepts to this model of working with youth in a residential setting, and to building resilience.

The participants in the research met formally with Houston once every 2 weeks to implement the following stages of the action research: "1) assessing the young people's needs; 2) identifying concrete, specific goals for each of the young people; these goals were also formulated to apply, more widely, to the group context and the culture within the home; 3) devising an action plan to implement the goals; 4) implementing the plan; 5) evaluating whether the plan had met its goals, and, as part of this process, identifying helping interventions and enabling and constraining factors; and 6) initiating another action research cycle" (Houston 2010, 359).

The Daniel and Wassell (2002) model was used in the implementation of each of the six stages, and provided the 6 domains through which resilience was built. In the assessment stage, a checklist was used to appraise the young people's needs under each of the domains.

One therapeutic intervention that is highlighted in the article is that of motivational interviewing with the young people, a general orientation that tries to identify strengths and to build resilience on them – and also helps in building relationships between youth and care personnel. Another important intervention identified in the study is opportunity-led practice, previously described in the section 2.4.1 of this work.

The importance of the cognitive-behavioral approach in building resilience is underlined by the researcher, who writes “The participants were convinced that positive thought schemes including optimism led to a better mastery of the social world and the regulation of troubling emotions” (Houston 2010, 361).

Identified risk factors included fear of social groups and lack of motivation to engage in activities. One of the interventions introduced was “having a weekly planner for each of the young people . . . looking at the week ahead . . . for some young people there is very little in that week . . . if they are not in education, they might need to go to the job market, join the gym” (Houston 2010, 362). This weekly plan was part of the personal file of the young person. Each resident had a file containing the following sections:

Section A – Contains the young person’s weekly plan explained above.

Section B – “This section outlined a list of the Daniel and Wassell’s (2002) domains and examples of activities connected with each one of them” (Houston 2010, 363) which was meant to help to plan interventions with the young person.

Section C – consisted of a completed Assessment and Intervention Chart that “focused on: target areas within each of the domains, suggestions for how they would be met, who would be responsible for meeting them and how progress would be measured” (Houston 2010, 363).

Section D – “This section collated work session records focusing on how the Daniel and Wassell categories had been implemented in daily practice with the

young person. Here, critical incidents were recorded, contacts summarized and aspects of social work process addressed" (Houston 2010, 363).

FINDINGS: The study identified two dimensions within which participants operated: "the sphere of the system and that of the life-world of the young people" (Houston 2010, 365-366).

For young people "enhancing resilience meant being there, being with, conveying presence, showing care and providing a secure base from which the young people could launch themselves into the outer world" (Houston 2010, 366). This means also to establish personal relationships between the care personnel and the young people under care. The care personnel present opportunistic work – i.e. opportunity-led work – as an essential form of accomplishing the above mentioned goals. The researcher also claims that opportunity-led work offers the possibility for residential care personnel to be in time, "in a way that fostered attunement through seizing the moment, if it were late at night when the young person returned to the home or after a fraught contact visit" (Houston 2010, 366-367).

A problem-solving tool known as the *force-field analysis* (Lewin 1951) is presented by the residential care workers as effective and congruent with the action research process. Such tool focuses on the helping and hindering factors that affect change towards a desired end. Rewards for positive behavior are presented as an example of an important helping factor. The use of schematic aide memoires was reported to be also a useful instrument, as it was the action research process itself.

Additionally, Houston describes those factors that participants believed were constraining the labor of social workers, namely: lack of resources/time; challenge of applying therapeutic care; risk averse culture; performance culture; organizational requirements; care vs. control tension; change at all levels; bureaucratic parenting; formal approach to young people; vagaries of mood and emotion linked to self-concept; lack of motivation; negative influence from family and peers; and lack of daily structure.

The described action research project, based on Daniel and Wassell's model (2002), gave the possibility to residential care personnel to develop a model of care which allow them to periodically undertake the stages of assessment, planning, intervention and evaluation which are the very core of evidence-based practice.

RELIABILITY: the researcher mentions a number of measures used during the research process to ensure trustworthiness of the findings. Those measures include: "(a) respondent validation of the interpretations drawn from the data; (b) researcher reflexivity (reflecting on spontaneous memos in a written diary); (c) phenomenological bracketing (holding the researcher's premises in check when generating the themes); (d) consultation with a reference group; (e) method triangulation; and (f) maintaining a clear and transparent audit trail linking the participants' verbal comments to the enumerated themes" (Houston 2010).

LIMITATIONS: the study validity is limited by two issues; first, the views of the young people were not gained directly by the researcher, which decreases trustworthiness. Second, there is no measure of the effectiveness of the interventions by measuring resilience before and after them, which could have provided a more objective measure than the opinions of the staff, or could have complemented those opinions.

6.2 Innovations in implementation of trauma-informed care practices in youth residential treatment: a curriculum for organizational change.

Trauma-informed care differs from trauma-specific interventions, for while the latter intends to address directly trauma and complex trauma through individual or group therapy – e.g. cognitive-behavioral therapy, psychotropic medication, etc. – especially focusing on trauma recovery, the former approach focuses on avoiding inadvertently retraumatizing the individuals under care when agencies are providing such care. Staff working in settings that use a trauma-informed approach should be trained to recognize and respond effectively to manifestations of trauma that their clients or patients may present. Trauma-specific prac-

tices are integrated within a broader trauma-informed organizational culture (Jennings, 2004, p. 68) (see Hummer et al. 2010, 82).

Hummer et al. (2010) describe whether and how organizational culture in three different agencies located in Florida – three statewide inpatient psychiatric program, two therapeutic group care, and two therapeutic foster care programs – supported trauma-informed practice. Results were obtained though 75 interviews, 33 clinical record reviews, 12 treatment team observations, and reviews of policy and procedure manuals at 8 sites nominated by peers as using trauma-informed care practices.

FINDINGS: The researchers identified what were the organizational factors present in those agencies that conducted to successful implementation of trauma-informed care. Organizational self-assessment was identified as one key element of trauma-informed practice. Organizational factors were identified and classified in different categories:

Program procedures and settings:

1) Physical and Emotional Safety issues were addressed through, e.g. "systematic debriefings of seclusion and restraint, documentation of de-escalation attempts prior to a seclusion or restraint episode, youth debriefing with staff, and staff debriefing on the event and what might have prevented it" (Hummer et al. 2010, 84)

2) Trustworthiness. Children and youth were informed of the role of each staff member and knew program expectations. Maintenance of physical and emotional boundaries was included in the agenda of all programs visited.

3) Child and Youth Choice and Control. Three programs actively encouraged child and youth choice – e.g. clothing, food, what members of staff helped in moments of crisis, etc... Youth were encouraged to participate in treatment teams, and to invite others to attend.

4) Collaboration, Power Sharing, and Empowerment. Related to the previous point, three programs gave the opportunity to youth to participate in house council activities, in which they could be an active part and gain control over their environment and activities. Nevertheless, power was generally associated to staff members rather than youth.

5) Caregiver Involvement. Biological or foster families were invited to participate in planning processes and therapeutic interventions. Family engagement remains a challenge.

6) Preparation for Placement Transition. Most programs prepared children and youth for transitions, but uncertainties about available post-discharge placements made it difficult and not always possible to plan adequate discharge.

Formal service policies

All programs had developed policies and procedures concerning recovery from trauma, de-escalation, seclusion and restraint, confidentiality and children and youth rights – e.g. how to contact the state abuse registry. This way, staff could consult personal preferences of children and youth in moments of need, and so provide personalized care in accordance with the needs and preferences of each individual, for instance by allowing that member of the staff the child feels more comfortable with, to participate in the process of de-escalation or debriefing, or by undertaking the process of debriefing after a crisis at that moment in time when the child feels it is better for him or her.

Trauma screening, assessment, and service planning

Assessment for trauma at entrance was common practice, with especial focus on physical and sexual abuse; other trauma exposure, e.g. exposure to natural disaster, was not always included in the screening process. Trauma related issues were addressed in later planning therapeutic and care services, taking into account children and youth preferences – e.g. by allowing the child or ado-

lescent to specify the gender of the person that will work with him or her in moments of crisis.

Staff trauma training and education

Staff cross-training, open forums in which to share knowledge and experience, problem solving, and developing policies and procedures were useful in gaining knowledge and insight about trauma related issues, and in developing a culture of openness, learning, and teamwork. On the other hand high levels of staff turnover was reported to hinder the maintenance of adequately trained working personnel.

IMPLEMENTATION OF TRAUMA-INFORMED CARE:

Based on the results of their study of the programs mentioned above, as well as a posterior literature review on the topic, the curriculum Creating Trauma-Informed Care Environments was developed, consistent of “a set of field-based standards for trauma-informed care developed for use in out-of-home care mental health treatment settings for children and youth” (Hummer et al. 2010, 87-93).

The mentioned curriculum included meetings and training of staff, as well as the use of self-assessment “to identify a trauma-informed practice to implement in one unit of their facility. The group then gathers information and data on the practice topic and identifies implementation strategies and potential barriers to implementation. These teams also identify or develop measures to assess progress toward implementation” (Hummer et al. 2010, 88).

A self-assessment tool was developed to help in the assessment process. Such tool allows a particular agency to measure its organizational readiness for change, competence of trauma-informed care practices at different levels, and the level of engagement of youth and their families in trauma-informed care practices.

RELIABILITY: Consensus among a team of three researchers was used to ensure reliability, and at least two reviewers were present at each site to record reviews, interviews, and other documents. Other measures to ensure reliability, like respondent validation, is not commented by the researchers.

LIMITATIONS: Measures to ensure reliability are not presented beyond the fact mentioned above of the cooperation between the team of researchers to analyze data and present results. The authors do not comment about possible limitations in their research.

6.3 Modernizing residential treatment centers for children and youth — An informed approach to improve long-term outcomes: the Damar pilot.

Holstead et al. (2010) carried out a control case study of a residential unit for behavioral and psychiatric challenging adolescents in Indianapolis. The characteristics of this particular residential program varies from other cases of out-of-home care, in that the text of the research seems to present as a reason for the placement the youth’s own behavioral problems rather than their parent's incapability to take care of, or their harmful influence on them. Such a fact makes it necessary to interpret the results in a slightly different light when trying to apply to other youth residential care settings. Nevertheless, it is believed by the researcher that, given the generalized occurrence of similar behavioral problems among the population in residential care settings, this particular study may contribute to the purpose of this bachelor thesis work.

THE PROJECT: 56 young people aged 13 to 17 participated in the study. Two groups were formed, an intervention and a control group, each consisting of 28 participants who matched their counterpart in terms of demography – e.g. age, gender, race –, diagnosis, length of stay in residential treatment, and family circumstances. The participants in the intervention group “were selected and approved by their guardians to move from a campus treatment unit to a more homelike community setting” (Holstead et al. 2010, 119).

Researchers utilized existing literature – identifying variables associated with positive outcomes and reduced recidivism – to plan treatment. Recidivism is defined in the context of this research as the placement of the adolescent within one year of transition in the same or a higher restriction level setting. Identified variables included: “family involvement/engagement, school attendance, pro-social peers, evaluation of outcomes and promotion of best practices, and generalization of interventions” (Holstead 2010, 120). Strategies were implemented within the pilot group to address each variable:

Family involvement and engagement: the families of the participants had full access to young people in residential treatment at any time of the day. Families were contacted whenever problems arose, their suggestions were heard by the staff, and they played an important role in the care team. Care staff also facilitated transition to the family home by taking responsibility for planning home visits and client communication with the family. Family members learned skills necessary for managing problematic behavior in their youth.

School attendance: was identified in the literature as having an influence in reducing recidivism (Hoagwood & Cunning ham, 1992) (see Holstead et al. 2010, 121). The researchers claim that “being present in a regular school promotes generalization of learned skills, regardless of achievement”.

Prosocial peers: contact with prosocial peers was identified as an important factor in reducing recidivism among youth in residential treatment (Burns et al., 1999). In the context of the study, “ prosocial peers were defined as those youth who did not have a history of psychological diagnosis or previous placements, were involved in at least two community activities, were engaged with and had a strong relationship with their caregivers, and did not have a history of legal problems” (Holstead 2010, 121-122).

In the Damar pilot project, each youth was required to participate in at least two community activities each week, which fomented interaction with pro-social peers. Attending public schools is also believed to promote youth interaction with positive peer models, and youth could invite friends home after school, so

they could practice their social skills and continue benefiting from the influence of positive relationships in the home setting.

Evaluation of outcomes and promotion of best practices: Results yielded by procedures were measured systematically, and that information was used to evaluate and revise treatment plans once a month. New evidence-based interventions that had been successfully used with children in similar circumstances were researched and implemented to replace those interventions that yielded poor or no results.

FINDINGS:

Data was collected in different forms and different markers were used to extract conclusions on the effectiveness of the Dama Pilot Project, e.g. restraint and incident reports, direct-care data reporting sheets, number of family contacts and visits, number of adoption placements post-discharge, contact with pro-social peers.

Results achieved in the pilot group were generally positive, with "no elopements, no self-injurious behaviors, no episodes of physical aggression, and only a single incident of property destruction" (Holstead et al. 2010, 125-126). Aggressive behaviors decreased by 73%, noncompliance decreased by 65%, and the number of restrictive interventions was reduced by 89%. Family involvement increased by 88%, and families were more involved in addressing behavioral problems than in the control group. Those in the treatment group were four times more likely to be adopted, and were three times more likely to have contact with pro-social peers than those in the comparison group. Finally, long-term post-discharge recidivism level were exceptionally low – 10%.

RELIABILITY: The utilization of a control group provides a particularly good model to compare outcomes, and it is the biggest strength of this research. Different markers were used to extract statistical, objective data, and evidence-based interventions were used to attain effective results.

LIMITATIONS: the small size of the sample limits the extent to which the findings of this study can be generalized, and although different factors were used to match participants in both, the intervention and the control group, it is assumed that the match was not a perfect one, considering the difficulty that is inherent to such a task in such a setting as the one of the present study.

6.4 Reducing transfers of children in family foster care through onsite mental health interventions.

Collado and Levine (2007) present a descriptive case study of successful collaboration between two foster care agencies, which integrated mental health services and foster care into their Foster Care Initiative (FCI) program in New York. FCI was conceived by the Jewish Board of Family and Children's Services (JBFCS), of which both Collado and Levine occupy directive positions. Both foster care sites served children aged between 5 and 12 years old, who shared profiles of “multiple past replacements, acting out in school, sexualized behavior, or family history of mental health problems or substance abuse”.

Although the project in question does not refer to residential care, the researcher decided to include it in this bachelor thesis, given the lack of research about that particular setting that addressed the problematic of inter-agency collaboration. The similarities between foster care and residential care make the outcomes of this study still valuable, and it is believed by the researcher that the findings of the paper of Collado and Levine can be extrapolated with the due precaution to residential care settings.

THE PROJECT: FCI is a multidimensional model, that comprises 3 different spheres or sub-models: 1) a clinical mental health model in which children, foster parents, and biological parents were provided with individual and family therapy; 2) an administrative model focused on relationship-building between agencies and 3) a structural model linking mental health and foster care agencies into one system of care.

Building trust: the process started with an initial preparation period of six months in which the terms of agreement between agencies were settled down in securing formal letters, FCI was introduced to agency staff, and guidelines and protocols were created for “1) mental health consultation, 2) creating mental health assessment instruments, and 3) setting criteria for what constitutes a child at high risk for referral to FCI” (Collado & Levine 2007, 139). Many meetings, interviews and ongoing discussions were necessary to build up trust between the agencies.

One person was designated to coordinate the project, and a psychotherapist was placed to work full-time at each foster care agency. Therapists provided training and consultation about mental health issues to caseworkers and foster parents for a 3 month period, and gradually increased the time dedicated to assessment and treatment of children.

The activity of therapists came to include among others, attendance at service plan reviews and observations at and interventions during family and sibling visits. Therapists were provided specific trauma training, and they in turn trained caseworkers and supervisors, forming a chain of education that reached every member of the staff. Besides providing consultation when needed, therapists participated in staff meetings every two weeks, and monthly in grand rounds. Counseling and family therapy were provided to foster and biological parents.

Part of FCI agenda was to change the perception of mental health services by caseworkers, supervisors, and foster parents from a crisis-oriented focus to a less stigmatized orientation which focuses more in everyday life issues and common foster care procedures, in which mental health is an integral part of care when attending the especial needs of children in foster care. Issues addressed to reach this goal were, for instance, defining reasons for referral, consultation, assessment and treatment. Communication issues among foster parents, caseworkers, and foster care supervisors were also addressed, and through foster parents education awareness was developed of their own role in the treatment process, and of the importance of keeping therapy appointments and of mental health interventions as a continuous process of care rather than

intermittent, isolated interventions to “fix” specific emotional/behavioral problems of children in moments of crisis. A protocol was introduced to share appointment times for therapy, so that information would be clear for every member of the staff, served to alleviate the problem of missed appointments.

OUTCOMES: placement disruption rates decreased in the intervention group to 1.9% and 4.6% while in NY City the Administration for Children's Services' rate was about 30% 2005 and 25% in 2004. It is argued by the researchers that therapists played a vital part by influencing, adapting, and coordinating the systems – e.g. former and new foster family, health care, and school – concerning the children, which in turn mitigated the disruption.

FCI served to outline the importance of “establishing collaborative relationships among mental health and foster care agencies”, as well as “providing mental health services on site at foster care agencies” (Collado & Levine 2007, 148).

Based on the conclusions extracted of the FCI project, the New York State Office of Mental Health developed guidelines to apply for onsite satellite mental health clinic licenses. Those guidelines included:

• “A managing coordinator / supervisor from the mental health agency, whose competencies include: consultation with senior foster care agency staff..., advocacy for improved psychosocial assessment for foster family selection and support, ongoing training – particularly on trauma and attachment – for caseworkers and foster and biological parents..., and advocacy for additional, innovative approaches to mental health education for foster parents” (Collado & Levine 2007, 148).

• Inclusion in best practices – in the context of foster agencies that already provide mental health services – of: “facilitation of communication between their foster care and mental health functions, and increase of overall agency understanding of the dynamics of foster families, biological families, and intra-agency services” (Collado & Levine 2007, 148-149).

• Mental health agencies should play a broader, systems-related role, rather than remain a separated, inflexible agency that delivers interventions only in very specific cases or settings.

• Work of mental health agencies should include among its goals, to provide evidence of the efficacy of their interventions.

RELIABILITY: The researchers do not comment on how they position as members of the Jewish Board of Family and Children's Services – the agency that conceived the Foster Care Initiative – influenced the process of research and the findings, how data was collected, or what are the limitations of the study. Even if the description of the collaboration process between agencies is detailed and clear, and most relevant to the field of child protection and out-of-home care, the lack of reflection on the mentioned issues rests reliability to this work. Despite the negative points formerly mentioned the presentation of statistical, objective results – placement disruption rates – adds some strength to its reliability.

LIMITATIONS: The above mentioned lack of reflection on the research process, and consequently, uncertainty about the reliability of the findings, added to the fact that both researchers were members of the directive board of the Jewish Board of Family and Children's Services, and had no external researchers to check for bias or consensus are serious limitations of this article. Therefore it is recommended that the conclusions withdrawn should be managed with precaution.

6.5 Appraisal process

The 4 articles examined in this paper are all case studies. Three of them describe evidence-based practices which can provide a model for institutions and workers in the field of children and youth residential care; the fourth one describes the process of collaboration between two foster care institutions and mental health services. Two of the articles – Holstead 2010 & Collado & Levine 2007 – offered quantitative data to validate their hypothesis, although the em-

phasis of the researches is on the descriptive part, while the other two articles – Houston 2010 & Hummer et al. 2010 – does not offer quantitative measurement to support its assumptions, but for that purpose it either relies on the opinions of the agency staff – Houston 2010 –, or it merely describes those factors present on the study case which had been previously identified in literature as related to successful implementation of trauma-informed care – Hummer et al.2010. The Critical Appraisal Skills Programme (CASP), developed in Oxford in 1993, has been used to appraise those articles. The table below summarizes the result of that appraisal.

Table 4. Appraisal results.

Question	**Houston, S. 2010**	**Hummer, V. L. et al. 2010**	**Holstead, J. 2010**	**Collado, C. & Levine, P. 2007**
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes
3. Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes
4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes
5. Were the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Can't tell
6. Has the relationship between researcher and participants been adequately considered?	Can't tell	Can't tell	Can’t tell	Can't tell
7. Have ethical issues been taken into consideration?	Can't tell	Can't tell	Can’t tell	Can't tell
8. Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Can't tell
9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes
10. How valuable is the research?	Valuable	Valuable	Valuable	Valuable

In the case of purely qualitative, descriptive studies, as the ones of Houston (2010) and Hummer et al. (2010), they are not intended to provide hard, objective, empirical evidence on the effectiveness of the interventions described, but they are a record of participant's opinions and perceptions, or a mere description of procedures already identified as effective in previous literature. In the

other 2 studies appraised, their hypothesis is sustained to some degree with empirical, statistical data; Holstead (2010) uses different measurements to support his conclusions, namely: registered number of incidents related to elopement, harmful, self-harmful, or other type of aggressive behavior, number of restrictive interventions, family involvement, and others. Collado and Levine (2007) measure the rate of placement disruption in the foster care program described in their article, and compare it with average rate in New York City, showing a marked reduction. Nevertheless, in this particular case, qualitative studies provide a mean to understand the procedures and practices considered to be effective in addressing mental health issues and behavioral problems in youth in out-of-home care, and the mechanisms by which those practices work effectively.

Some structural deficiencies were identified during the reading and following appraisal process. In all articles it was noted an absence of a clear statement considering the relation of the researchers with participants, how that relation could have induced bias, or how the researchers handled ethical issues. Collado and Levine (2007) fail to explain how they accessed the data to produce their descriptive study; the researcher assumes that as they were both employed in the agency that conceived the project, they were implicated during the process of the project planning, implementation and evaluation, and so they had first-hand knowledge of the structure, dynamics and procedures described.

6.6 Synthesis and analysis

Articles were read and summarized, focusing on practices that addressed mental health or behavioral problems, and evidence of their effectiveness – if there was such evidence. Two articles provided quantitative data to support their assumptions of effectiveness. Research question was identified and it is presented within table 3. The text of the articles was subjected to manifest content analysis, identifying visible, obvious components presented by the researchers. According to Graneheim and Lundman (2004) the unit of analysis can refer to a

great variety of objects of study, from a person to an organization, interviews, or organizational protocols. For the purpose of this research, the unit of analysis was defined as agency of children and youth residential care. Meaning units were identified – understanding by meaning unit in this case, any particular textual unit that refers to a practice or intervention thought to be effective in addressing the mental health or behavioral problems of the client population – and coded, sometimes shortening the expression used in the article, but preserving the original meaning and the keywords chosen by the authors to refer to a particular idea. A summary of such practices and other factors that promote addressing such especial needs is presented in table 4.

The next step in the analysis process was to farther code interventions identified in table 5, and produce a new list with no repeated meaning units. In order to do so, when an intervention was identified in more than one article and using different tittles, the one that was thought to better represent the essence of the intervention was selected, and the different tittles were now resumed under a single one.

For all the interventions categories and subcategories were established that grouped them according to 2 different classifications. Identified practices were grouped first according to the category of *target group*, that is, the group towards practices or interventions were directly addressed. 4 possible target groups were identified: 1) Inter-agency collaboration; 2) Intra-agency; 3) Family and other significant ones; and 4) Children and Youth.

Inter-agency collaboration refers to practices addressed to working personnel of different agencies with the purpose of ensure successful collaboration, communication and coordination of activities, so the client population does not suffer deficient or incomplete care because of a failure of agencies to work smoothly and effectively with each other.

Table 5. Findings.

Author/Year	Findings
Houston, S. 2010	**Approaches that are helpful in building resilience**: motivational interviewing with the young people; strength-based approach; person-centered approach; cognitive-behavioral approach (positive thinking); being present; building positive relationship; opportunity-led work; assessment-planning-implementation-evaluation process; force-field analysis; aide memories. **Background factors that enable the social workers' interventions**: flexible rules; staff support and recognition; culture of rewards; home providing secure base; homely environment; human agency/creativity; homely environment; use of relationship and care; therapeutic being/presence; normality/being natural; team communication and problem-solving; motivation (staff and young people)/ambition; positive family and peer influence; weekly activity planning for young people.
Hummer, V. L. et al. 2010	systematic debriefings of seclusion and restraint; maintenance of physical/emotional boundaries; Promoting choice and control; house council; family involvement; preparation for placement transition; policies and procedures documentation; trauma screening, assessment, and service planning; staff cross -raining; staff participation in open forums.
Holstead, J. 2010	Family involvement; family training; planning of placement transition; promoting school attendance; contact with pro-social peers; systematic implementation and evaluation of evidence-based practices.
Collado, C. & Levine, P. 2007	**Inter-agency collaboration**: 3 dimension structure, clinical mental health model, administrative model focused on relationship-building, and structural model linking mental health and foster care; inter-agency guidelines and protocols; building trust through continuous meetings and ongoing discussions. **Intra-agency interventions**: Psycho-education to foster and biological parents and caseworkers; individual and family therapy; permanent placement of psychotherapist onsite at foster care agency; therapist's interdisciplinary work; attendance of psychotherapists to routine procedures, staff meetings and home visits.

The intra-agency domain refers to care personnel and other agency staff, and it comprises those interventions that directly do not affect the agency's clients or people outside the agency.

Family and other significant ones refers to interventions addressed to those who are expected to participate in the care of the agency's client, either at the moment of the stay or later, and so it mainly embraces, but it is not restricted, to

biological or foster parents. These interventions may have different goals, being the main ones to increase the knowledge and awareness about mental health issues, to implicate significant ones in the dynamics of the agency, to help to solve family dynamics that are detrimental to the mental wellbeing of the client, or to improve parental skills and addressing behavioral or mental problems of the parents that are hindering factors to the provision of care to the client. In a nutshell, they try to provide a safer family frame outside the agency that will better support the needs of the client.

Children's and youth's interventions are addressed to the client population, and are meant to have a more or less direct effect on their wellbeing, e.g. by building their resilience.

Once all the interventions were grouped in the 4 mentioned categories, new subcategories were created within each target group, attending to the purpose of the intervention, and that subcategory was named *rationale*. The rationale described for every intervention or group of interventions is not intended to exhaustively comprehend all possible purposes or benefits derived from them, but it rather presents the main goal or goals that staff tries to attain through their undertaking. Graneheim and Lundman (2004) claim that themes – or categories – do not need to be mutually exclusive and that a meaning unit – code – can fit into more than one theme. In the present case, the intervention called *Family therapy* falls under the umbrella of two different categories, *Family and other significant ones*, and *Children and Youth*, if it is understood as the child and his or her parent(s) receiving therapy together.

Table 6. Coded interventions.

Target	Practice / intervention	Rationale
Inter-agency collaboration	3 dimensional meta-model: clinical, administrative, structural	Creating an unified system of care
	Inter-agency guidelines and protocols	
	Inter-agency continuous contact through meetings and discussion	Creating understanding among agencies; increasing insight of mental health workers on common procedures that have an effect on the mental health condition of the client population
	Attendance of psychotherapists to routine procedures, e.g. staff meetings	
	Therapist's interdisciplinary work	
	Permanent placement of psychotherapist onsite	
Intra-agency	Use of evidence-based practices	Promoting best practices; providing feedback to assessment – planning – implementation process
	Systematic evaluation of interventions and practices	
	Force-field analysis	
	Systematic debriefings after incidents, e.g. seclusion and restraint	Promoting evaluation of practices, assessment of needs, and considering alternative practices
	Maintenance of physical/emotional boundaries	Avoiding favoritism and discrimination
	Staff cross-training	Increasing knowledge
	Staff participation in open forums.	
	Psychoeducation	
	Flexibility	Proportioning sense of control and home-like feeling
	Staff support and recognition	Motivating staff
	Documentation of policies and procedures	Promoting care continuity; providing reference for consultation to care staff
	Aide memories	

(continue)

Table 6 (continue)

Target	Practice / intervention	Rationale
Family and other significant ones	Psychoeducation to foster and biological parents	Increasing understanding of mental health problems
	Family involvement	Increasing the client overall wellbeing; increasing trust in residential workers
	Family therapy*	Helping to solve problems in family dynamics; Addressing parents' problems to improve their parental skills
Children and youth	individual therapy	Addressing mental problems through therapy
	Family therapy*	Helping to solve problems in family dynamics
	promoting school attendance	Providing a positive peer model; promoting practice of social skills
	contact with prosocial peers	
	Preparation for placement transition	Reducing negative feelings about transition, e.g. confusion, sense of powerlessness...
	Promoting choice and control, e.g. house council	Increasing sense of control; empowering client population;
	Motivational interviewing	
	Trauma screening and assessment	Providing information for planning therapeutic interventions
	Opportunity-led work	Providing therapeutic intervention; promoting social skills
	Team communication and problem-solving	
	Culture of rewards	Promoting positive behavior
	Therapeutic presence	Promoting positive client-staff relationship
	Weekly activity planning	Motivating and promoting activity engagement

*This intervention is present in two different target groups: Family and other significant ones, and Children and youth

7 QUALITATIVE FOCUS GROUP CONTENT ANALYSIS

7.1 Research design of the focus group content analysis

The research design of the study was qualitative and inductive content analysis of the semi-structured focus group interview.

7.1.1 Focus group interview

Focus group interview is a method to be used, when the research has got the aim e.g. here to find out current good practices and when is wanted quickly to gather information from many interviewees. The aim is told to the participants before the interview. The participants of the focus group are carefully selected according to chosen criteria. The criteria for participants of this study will be explained more in the paragraph 7.2.

Focus group is commonly used model, when seeking to develop new ideas. (Hirsjärvi and Hurme. 2009, 62-63.) Thus, use of focus group in this study is justified as it suits well for e.g. the study's aim to develop new ideas for cooperation between two services.

During the discussion, the interviewer pursues to create a relaxed rapport and atmosphere in order to participants to feel free to open up (Hirsjärvi and Hurme. 2009, 62). Thus, the person centred approach (Rogers 1995, 114- 117) was applied by interviewers as they used open ended questioning and endeavoured to understand participants through their frame of references. In addition, they tried to convey that understanding to participants by checking their comprehension and asking clarification by using focused questions.

In addition, the interview was semi-structured as non-structural and semi-structural methods were used. For instance, non-structural open questions were used and the interviewers with their responses took the answers deeper and let the answers (interviewees) to lead the interview forward. In addition, semi-

structural themes were used as it was decided beforehand, that good and bad experiences were explored together with the developmental ideas. Likewise, it was agreed also with the participants, the focus would be in good practices they had experienced. (Hirsjärvi and Hurme. 2009, 45-47; Elo and Kyngäs 2008, 107.)

7.1.2 Content analysis

Qualitative content analysis used in nursing research and education is one of the principal usages of the method of content analysis (Graneheim and Lundman 2004, 105). It also suits well with inductive approach applied in the research, as in inductive analysis, the studied material is the base for conclusions and it dictate the direction the research will take (Hirsjärvi and Hurme. 2009, 136). Furthermore, it is adequate here as inductive content analysis is appropriate in cases where there are no former studies dealing with the research matter or when the knowledge about it is fragmented (Elo and Kyngäs 2008, 107, 113.) which seems to be case here according to the literature review introduced earlier in this paper.

In addition, throughout the research, in the interview as well as in the analysing process, the person centred approach was applied in order to try to understand participants and not to twist what they had said. Therefore, although the analysis was made mainly focusing on the manifest content (see the explanations below) it was tried to be aware and understand the latent content as well.

Currently there exist various uses of concepts and terms within qualitative content analysing. Therefore, it was decided to follow methods and terms Graneheim and Lundman (2004, 105-112) suggest in their paper as they fitted well with the inductive approach and with the material collected from the interview.

Used terms in the analysis

Manifest content = the content of the text which is visible and obvious.

Latent content = underlying meaning of the text or the message conveyed through non-verbal communication e.g. the tone of the voice.

Meaning unit = a piece of text, varied in length, in which the words, sentences or paragraphs are related to each other by their content and context.

Condensed meaning unit = a meaning unit which is (possibly) reduced in length, but still persevere its core meaning. Likewise, sometimes other way round, the text becomes longer as the latent content of the material is written visible.

Doubly condensed meaning unit = the term created by the researcher herself due to demands of translation work. *Doubly condensed meaning unit* refers to an intermediate stage between a condensed meaning unit and a code.

Abstraction = the process of arranging the text material and creating themes, categories and codes.

Code = the classifying name to given for a meaning unit.

Category = a cluster of content sharing commonalities under the same heading.

Theme = links underlying meanings (latent content) together.

The process of content analysis the material is condensed in order to be able to handle it and to see or produce connections between different factors (Silius 2005, 3-4). Creating categories is an essential feature in content analysis (Graneheim and Lundman 2004, 107). It helps the researcher to interpret the material, create theories and to see arising themes. The analysis process is explored further in the part 7.4.2 and an example of arising theme in the part 8.3.

7.2 Sample

The research sample consisted of four participants; three men and one woman. The psychiatric services were invited to participate by six interviewees, but only four could be present at the time of the interview. The requirement in order to qualify to participate was having minimum of five years of work experience in the field of psychiatry.

Participants real work experience in psychiatry was between seven to 15 years and they had been working in both, in psychiatric out-patient services as well as in in-patient services too.

All participants had experiences about multidisciplinary cooperation with social services and child welfare institutions. Furthermore, one of the interviewees had had previous experience of working also in a child welfare institution.

7.3 Data collection and analysis

The material for the content analysis was gathered in one focus group interview and analysed from the written transcription of the recorded interview.

7.3.1 Interview

The interview was conducted on 26th February 2013 in a meeting room at the premises of the adolescent psychiatric services. There were four participants (out of invited six) present and it took one and half hours in all to run through.

In the beginning the participants were shortly told about the RESME by the member of the RESME-project and they were reminded about the voluntary nature of the participation as well as about strict confidentiality of the research. The interview started with everyone introducing themselves and that opened the conversation and relaxed the atmosphere as participants were encouraged freely to grasp on others ideas and thoughts and continue from there. However, most of the time participants preferred to answer the questions in the same or-

der they had introduced themselves. Still, it can be said, they were having a coherent discussion and dialogue together, as they complemented, supported, corrected and continued the conversation based on what the others had previously said. The overall impression was that the participants were prepared well and had thought about their views and experiences beforehand. Nevertheless, having the conversation together with the slight guidance by the interviewers about staying within agreed themes seemed to create wider understanding about their own feelings in the cooperation matters and about the factors affecting for it.

7.3.2 Data analysis

The data analysis started with the transcription of recorded interview. After considering the aims of the research and the nature of the recorded material the accuracy level of the transcription was determined. (Hirsjärvi and Hurme. 2009, 139). As it was not important how something has been said, but what had been said, it was decided to write the transcription using low level accuracy. Thus, some additional or repeated sounds or words were edited off. However, strict care was taken in order to keep the essence of meaning in the text. Therefore, e.g. fragmented or somehow messy sentences were written down as they were said, because that might serve they purpose later on and e.g. latent content to be found, when the material was further studied. Used transcription characters can be found in the appendix 2.

After the transcription was done, it was went through and every participant was given they own colour which was used to colour all their comments in the transcription.

Editorial work of the text starts with classification of the material into categories, which creates the base or the frame in which the material can later to be condensed (Hirsjärvi and Hurme. 2009, 147.) Thus, as seen in the table 7, the whole written material was divided in three main categories: good, bad or problematic, and ideas. At first, there was one extra category to be used in case, if

there had been something in the material that would not have gone under any of the three main categories, but that could be removed as all fitted well in those three categories.

As the all material was coloured and now divided into those three main categories, it could be seen, that everyone had contributed the material in all areas in many ways. Thus, it clarified the assumption that the whole material was able to be used as a one piece of information and there was not need to examine further what individual persons had said.

Table 7. Categorising and condensation of the material.

GOOD	BAD	IDEAS	Main categories
dnssj sdfkasja kasjfda kdjsaksdfjslkdj kdjal kasj ladj	dnssj sdfkasja kasjfda kdjsaksdfjslkdj kdjal kasj l	dnssj sdfkasja kasjfda kdjsaksdfjslkdj kdjal kasj l	**Unedited text material into the main categories**
Sdfask kasdölkasöfk öakd fksdköadklfdkös jdsf sd fks	Sdfask kasdölkasöfk öakd fksdköadklfdkös jfsd fjs jsd	Sdfask kasdölkasöfk öakd fksdköadklfdkös jdfksjf jskd	
Sdfsadkjfdcnlsadnccccskan kdjaldkjflasj askjldkjflasjd ks	dnssj sdfkasja kasjfda kdjsaksdfjslkdj kdjal kasj la	Sdfask kasdölkasöfk öakd fksdköadklfdkössf dfjksadj	
GOOD	**BAD**	**IDEAS**	**Main categories**
dnssj sdfkasja kda kdjsaklkdj kdjal kasj l	dnssj kdjsaksdfjslkdj kdjal kasj lal	dnssj sdfkasja kasjfda kdjsl	**Unedited text material into condensed meaning units**
Sdfask kasdölkasöfk öakd f k	Sdfaasöfk öakdksdkö klfd	Sdfask kasdölkasöfk öakd	
Sdfsadkjfdcnlsadnccccskan kdjaldkjflasjskdjf	dnssj sdfkasja kasjfda kdjsjdjladj laskdjf ldl	Sdfask kasdölkasöfk öakdadklfdkös	
GOOD	**BAD**	**IDEAS**	**Main categories**
dnssj kdjsaklkdj kdjal kasj la	dnssjal kasj ladjladjlasksl	dnssj kdjsaj kdjal kasj ladj	**Condensed meaning units into doubly condensed meaning units**
Sdfask kasdöakd f	Sdfaasöfk ödkö	Sdfask kasdölkasöfk öakd	
Sdfsadkjfdcnlsadnccccskan ksjd ksj	dnssj sdfkasja kasjfda kdjsj kdjal skdjsl	Sk kasdölkasöfk öakd fk sdk kkös	

The categorising process was continued as illustrated in the table 7. Now, the text material in the three main categories was condensed, thus the meaning of what had been said there was examined deeper. After the condensation work, it was noticed, the material was not ready for coding yet and needed more compact format in order to be easier to work with and later to be translated into English. Therefore, the condensation was done once more, thus creating meaning units, which were called *doubly condensed meaning units*. Afterwards, when the

material was compact enough, but still entailed the essence of what had been said, the whole text was translated into English as seen in the table 8.

Table 8. Translation.

GOOD		BAD		IDEAS		Main categories
Finnish	**English**	**Finnish**	**English**	**Finnish**	**English**	
dnssj kdj saklkdj kd jss	Fddwjjf jdfsadjfsalkdfd	dnssj kdjslkdj ladjladjlaskdjfl	Kjdfs jfl jlas lask dfjla lsal	dnssj kdjsaj kdjal kasj ldj	Ola fjaf jadf jfhfjd ja fjs jd	**Doubly condensed meaning units into English**
Sdfask kasdölkasöfk f	Ejfowdoijfsdhf hfjsh jflsdfskfj	Sdfaasöfk ödköadklfdkös	Pj dslfjsale jdfjs	Sdfask kasdölkasöf	Oldf ajf jaflja fjksfjasjf j	

After the translation work, sub-categories were created under the main categories according to the content of the meaning units. The category of good got three sub-categories, the category of bad four and the ideas got three sub-categories in all. This is demonstrated below in the table 9.

Table 9. Creating sub-categories.

GOOD			BAD				IDEAS			Main categories
Kji	**Olj**	**Ejfd**	**Lk**	**Kj**	**Wk**	**Lkd**	**Kj**	**Fr**	**Edf**	**Subcategories**
dnssj kdj sak	Lkfji jfworjfj	Fddwjjf jdfsadjf jf	dnss j kd j	Kjf jfhk jskfjaf	Mjfdjs a fajf	Kjdfs jfl jlfjla	dnss kdjs k l	Ijfaf jajsdf jj	Ola fjaf d jf	**Doubly condensed meaning units (in English) into sub-categories**
Sdfask asöfk f	Ojfdslfj jsfdsa	Ejfowdoi jfsdhfhfjs	Sdfa asöf	Kjf jfasjf	Kjdf hjah a	Pj dslfjsal	Sdfask kasdöl	Kjdf ajrwhe	Oldf ajf ja fj	

The table 10 illustrates how the material in sub-categories was organised into code-categories. For example, the category of good has now three sub-categories and the sub-category one has three code-categories. Each three code-categories contain material that is similar in content and could be having one heading on them. Furthermore, e.g. the sub-category two, in the main category of good, has seven code-categories formed with the similar principle. The same code-categorising process was done with the all sub-categories.

Table 10. Creating code categories.

<table>
<tr><th rowspan="4"></th><th colspan="10">Main categories</th></tr>
<tr><th colspan="3">1 GOOD</th><th colspan="4">2 BAD</th><th colspan="3">3 IDEAS</th></tr>
<tr><th colspan="3">Sub-categories</th><th colspan="4">Sub-categories</th><th colspan="3">Sub-categories</th></tr>
<tr><th>1.1</th><th>1.2.</th><th>1.3.</th><th>2.1.</th><th>2.2.</th><th>2.3.</th><th>2.4.</th><th>3.1.</th><th>3.2.</th><th>3.3</th></tr>
<tr>
<td rowspan="4">C O D E
C A T E G O R I E S</td>
<td>1. dnssj kdj saklkdj kd jal kasj ladjlaskd jfldlssl
Sdfjds djfsdfj</td>
<td>1. Lkfji jfworjfj ajfowjf ajf aljo
2. Jkjf deifdfdjs jfdskja
3. Jds jfiefjfjjdfj</td>
<td>1. Fddw jjf jdfs adjfsalkd fds jfak sn jaj faj j jfakdj aj jjkd</td>
<td>1. Kjire jfnfngg eir
2. Rdnsv sj kd jslkdjk djal kasdls</td>
<td>1. Kjf jfajhk jsa kfjaf Yt</td>
<td>1. Oi fjwejrfjfa jfjfjdsk
2. Mjfd jsa jfaf jaj fsjfajf sjfjfa f jd</td>
<td>1. Kjdfs jfl jlas lask dfjla lsa lsej fldjf al
2. Csdsjf j jfds j</td>
<td>1. dnss kdjs kasj ladjlajfldl ssl</td>
<td>1. Ola fjaf jadf jfhfjd ja fjs jdfj aljf</td>
<td>1. Ddf e fjsfdafud jsk dfhjs
2. Ijf nvireajf sjfdi
3. Efj aue jfdfjsljff</td>
</tr>
<tr>
<td>2. Sdfas kasdölka söfk öakd f
Tifnadjfn dsjdfsj
Sdfwofj jfdkjsf</td>
<td>4. Oj fdslfjsdfjsj sfdsakfjjs
Skdfiswjfs ojfdsaof
5. Jfhhw fksksdsj</td>
<td rowspan="3">2. Ejfow doijfsdhf hfjsh jflsdfskfj Ksdjfsal jflasjfal jsljd lsjdlsw ljdla lasiej lasker la lai aleifj alke a k
Oijkj jk j jjh jh k j jh h jh kjjhiuyyg f jjj j</td>
<td>3. Sdfaa söfk ödköa dklfdk ös
4. Ijtj fdj djf ajfjsljfa</td>
<td>2. Kjf jfasjf aj faj jakf jjf aj
Ijfdfdns jdfskjd sk</td>
<td>3. Kjdf hjah hsdfjassa hf Dir
Pouioiyhig yug87tgyg hgyghj ih
ouyugjyg</td>
<td>3. Pj dslfjsale jdfjs Xisd j fsjd fj sjfsk j Iyghbjg uyg</td>
<td>2. Sdfas kkasdölk asöfk ödködkö s
Ijfnjsdfln sdjfjsd</td>
<td>2. Oldf ajf jaflja fjksfjas jf j Ne
Ofmwj fs js djfkjs</td>
<td>4. Sjksu jffld jfjd sifjsdkfjk jdkfj j
5. Pimfjg gmfjgoij dkjgdk</td>
</tr>
<tr>
<td rowspan="2">3. Sdfsa fdcnlsad nccccsk an kdjaldj aasjd ksjd skdjf
J kjkj jöloyhh gbjhbllm mj</td>
<td>6. Kh fhsn fnahksfffjJ Jjdfjajfjj jlasjfl
Ouioiyiyfg b iyigjgjb ggjgjh</td>
<td>5. dns sd fkasja kasjfsj kdjal skdjfldl ssl</td>
<td rowspan="2">3. Ljfjad sfj jfaksfd sajf ajdkfua js f</td>
<td>4. Kjd s jdfashfads ajd fhjasdh asjhjhfa hdjyrah</td>
<td>4. Kjds ab lkfj ljad ajdf la fja fj akf l jdf ajf a</td>
<td>3. Sk kasdölka söfk öakd fksdköa dklfdkös Ljdf sfnsdf kdfjajsdfj</td>
<td>3. Odlf ejjfasll sa sdj jsj dfjskdf l d aljd fjjd aske l</td>
<td>6. Dhf w idfjs jfsijafk sidfj lsjdkf osj
7. Ifmsrj ofjsa fd skf</td>
</tr>
<tr>
<td>7. Kjkdf sae jafshksajh fdahdsdj dshj</td>
<td>6. Kj fos wj ld sj fn
7. KJ djjn na</td>
<td>5. Rffjffnl j fajfk fjsaf jakdjf
6. Effjas kf jf jask</td>
<td>5. Vkdi kd sjd laokj sjdk ksjk ksjdkjkj kj k</td>
<td>4. Ijfwief jfwaf ajfiwjkslj d
Omfcn jf</td>
<td>4. Ij fdjsjf jfdskaf sjdkfo sjfkdsj dfkl</td>
<td>8. Fuf js vsmk fjnkl
9. Imv dfkjmsj s</td>
</tr>
</table>

After the material was divided into the code-categories, each category could have several separate piece of text in the same code-category. In next step, these same meaning texts were united under one sentence, thus creating one heading to present them all. This heading is called *a code*. The full list of codes can be seen in the Appendix 3. *Results for the qualitative focus group content analysis*, which can be found in the end of the thesis.

The last part of the analysing work was to examine created categories and their interaction together. It was about finding connections or discrepancies within the result material and giving interpretation for these found results. (Hirsjärvi and Hurme. 2009, 149-151.)

8 RESULTS OF THE FOUCUS GROUP INTERVIEW

The categories formed in the analysing process, are not separate elements functioning only by themselves, but active parts of the whole phenomenon of interaction between two different services. (See Figure 1.).

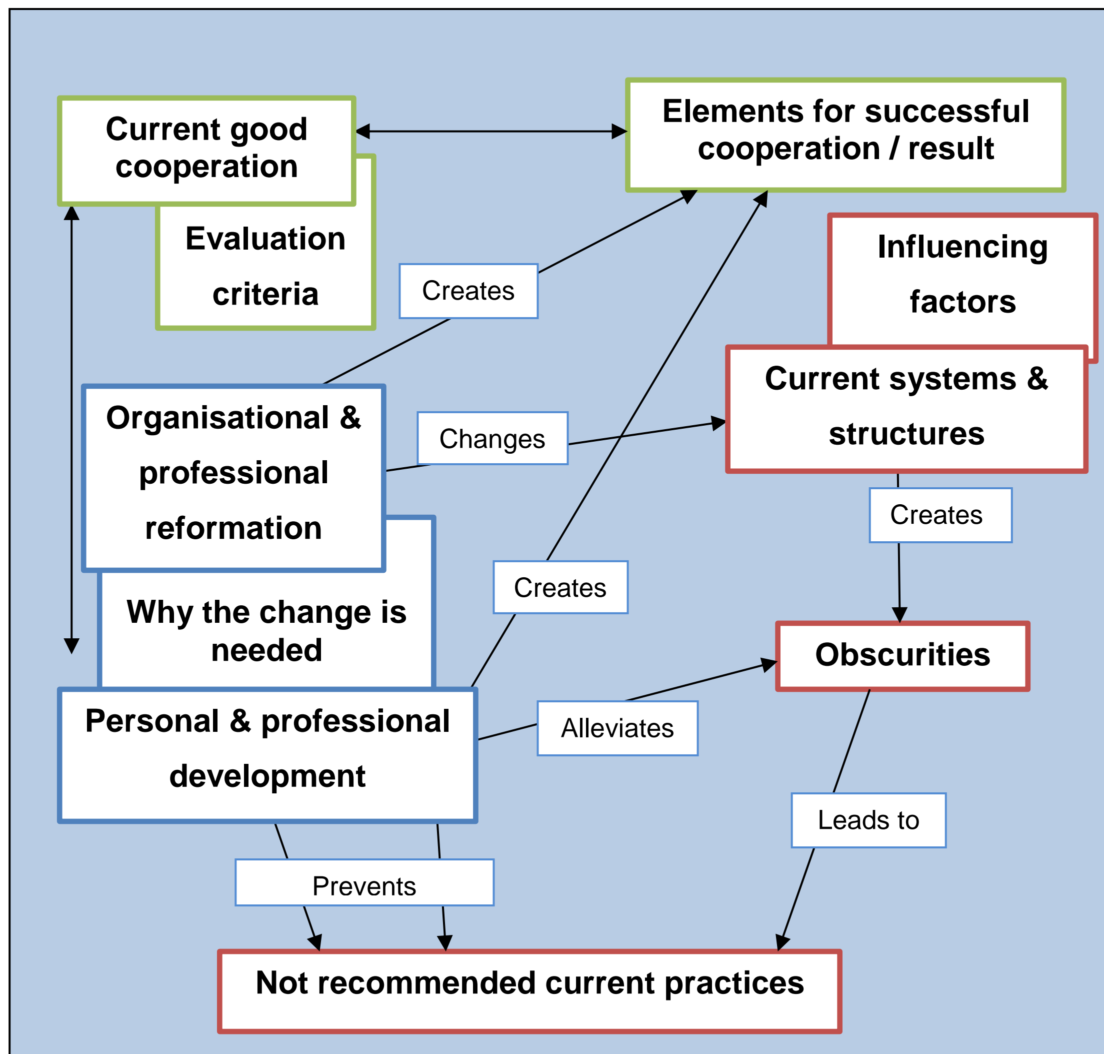


Figure 1. Interaction between different co-operative factors.

Existing current good cooperation is in constant dialogue with personal and professional development, as without the latter already being present, there would not be any good cooperation present either.

Elements, which build up successful cooperation, are found in current practices as well as some evaluation criteria can be seen arising from those experiences too.

Organisational and professional reformation together with already mentioned personal and professional development can create more elements for successful results. In addition, they act as prevention to not-recommended practices, which are currently used in real life situations.

There are some current systems and structures in health care and social services causing obscurities, vague and tangled cooperation situations, which then leads to non-recommended practices. However, these obscurities can be alleviated by personal and professional development. In addition, there are influencing factors such as community and background issues involved, which might create more challenges, thus reinforcing existing obscurities in cooperation.

8.1 The structure of the current good cooperation

The results from the analysis are showing how good cooperation do exists already. This good cooperation experienced by the participants is divided into three categories each of them having several codes underneath them. (See Figure 2.). The categories are as follows:

- Current good cooperation
- Elements for successful cooperation / result
- Evaluation criteria for successful cooperation

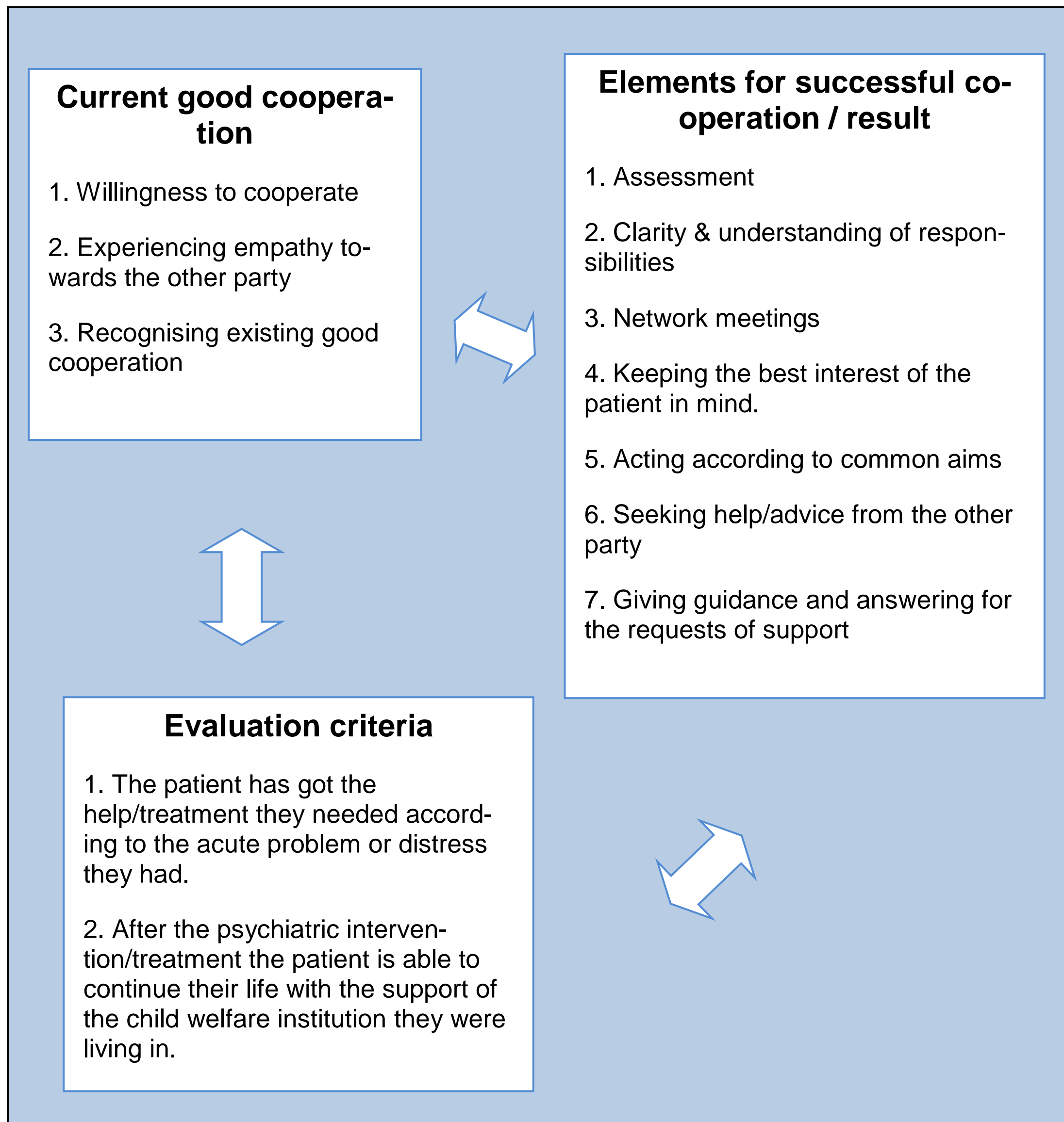


Figure 2. Results for current good in cooperation

8.1.1 Current good cooperation

Current good cooperation involves three codes as follows:

- Willingness to cooperate
- Experiencing empathy towards the other party
- Recognising existing good cooperation

Willingness to cooperate

Psychiatric personnel express their interest in creating forums for constant and regular cooperation. They are willing e.g. to attend training together as well as to provide training for child welfare personnel.

Experiencing empathy towards the other party

Participants understand the distress the child welfare personnel have as they need to work alone in difficult and possible dangerous, situations in which the needed help might not immediately be available.

Recognising existing good cooperation

The cooperation between individuals is mainly working well and psychiatric personnel feel able to speak freely with workers of other institution even in situations where the patient is present. In addition, child welfare institutions ability to possess psychiatric competence is recognised.

> Some institutions they already have psychiatric knowledge in there.

The custom of the child welfare institutions to use the services of consulting psychiatric is seen as a good practice. Likewise, a stability of some municipalities is praised, because social workers were not changing constantly there.

In addition, it is noticed, how occasions in which the psychiatric services had gone to see patients e.g. into the child welfare institution and not vice versa, had been taken positively by patients and staff in the social services.

8.1.2 Elements for successful cooperation / result

When looking into the material about the good cooperation, seven elements arises which can be seen as constructive elements supporting successful cooperation. These elements are as follows:

- Assessment
- Clarity & understanding of responsibilities
- Network meetings
- Keeping the best interest of the patient in mind.
- Acting according to common aims
- Seeking help / advice from the other party
- Giving guidance and answering for the requests of support

Assessment

The participants are telling how assessment is an important tool and how it is daily used in the ward for checking the wellbeing and needs of the patient. In cooperation with child welfare institutions, even if opinions about the right place for the patient disagree, the patient and their distress are always acknowledged. The adolescent receives an assessment whether the psychiatric treatment could help them. In addition, if the patient receives psychiatric outpatient care while living in the child welfare institution, adjustment of the young person for the institution is assessed before making any decision about the need of any further psychiatric care in the ward.

Sometimes situations can get tangled, progress is stopped or it is going to the wrong direction altogether and there, the assessment is needed. Halting the situation, making a decision to evaluate the situation and its aims from different angle, together with the other party, has proven to lead for a successful result.

> Once, in one very unpractical and poorly working situation, the crucial factor which led us to a success was the decision of the clinician to evaluate the whole situation from different angle. As the assessment was done together with both

> parties involved, new, better working system, was created and the patient finally got the help they needed.

According to participants, if the situation escalates in the child welfare institution, the good way to handle it is calling to psychiatric on-call services and asks guidance. Thus psychiatric personnel can assess the situation, advice accordingly, and if needed, they will recommend seeking referral to the psychiatric ward.

Clarity & understanding of responsibilities

As for requirements of successful cooperation the participants emphasise the importance of clearly divided responsibilities as well as the necessity of understanding of them. For example, when the child welfare institution is clearly understood to be the he patient's main guardian, outpatient services are used for the first hand psychiatric support as well as the ward treatment is used only for specific examinations, and finally, the workload is shared and done together with both partners, the good cooperation is accomplished.

> Child welfare institution is seen as a patient's home and as a main guardian of the patient.
>
> Psychiatric outpatient services are the first line of psychiatric help to be sought to the patient in need.
>
> Specialized psychiatric care in the ward is used for specific examinations only.
>
> With the new patient, who is in need of the help from both services, neither of parties is starting their interventions before there is an agreement what are tasks and responsibilities of each in this particular case.

Furthermore, it can be said, the best cooperation experiences exists when the division of work and responsibilities is clear, both parties understand the way of working as well as the frame of reference of the other party and people know each other due to past (good) cooperation experiences.

Network meetings

Used unofficial practice of organising network meetings is to organise and run them by the party which is calling it up. Division of the work e.g. who is going to be a leader, is also done within the calling party and its personnel. This, participants have experienced, is a good and well working practice.

In order to fulfil their purpose, these meetings should be part of the treatment and function as coordinators; have a clear agenda – the reason, why the meeting is held. Moreover, in a well organised network meeting, problems are discussed, division of the work is agreed and decisions are made together as well as everything is clearly documented.

Keeping the best interest of the patient in mind

The participants emphasise how keeping the best interest of the patient all the time in mind should inform all cooperation between services. For example, skilful, professional, primary nurse of the patient is making the patient's voice to be heard in network meetings. Furthermore, in order to prevent the patient, and their family, to be made to visit in many places, they are tried to meet up having both, social and health care, workers there together.

Acting according to common aims

When plans and agreements are done, it is vital for cooperation the both parties to make a commitment and act according to the aims and carry out their responsibilities. For example, as long-term relationships, activities and care plans are maintained, it creates trust as well as keeps the best interest of the patient in mind.

Seeking help / advice from the other party

Seeking help arises as a regular theme during the interview. For instance, in meetings child welfare personnel gets an opportunity to offload and ask guidance. Participants see the child welfare institutions asking guidance from psychiatric outpatient services as a positive thing which enhances the cooperation. However, seeking help and advice is sometimes been seen also as a burden; and later in this paper, that will be explored more.

Giving guidance and answering for the requests of support

Giving guidance does not serve only the recipients, but it easies the work of advisor too as e.g. psychiatric personnel gets an opportunity to inform the child welfare personnel about the patient's illness and medication as well as give requested guidance.

> Child welfare personnel were struggling with one adolescent, thus psychiatric outpatient services decided to call the whole personnel for meeting in which they discussed about the case. This offered support alleviated the problem and workers in the institution were able to continue with the patient by themselves.

Generally the participants argued that if the agreements are made humanely and other people are supported and advised when needed, the cooperation works well.

8.1.3 Evaluation criteria

The interview material of good cooperation included also a statement, which could be used as evaluation criteria. It suggests the cooperation / treatment have been a success:

- If the young patient gets the help and treatment they need in their acute problem or distress and

- after psychiatric treatment she or he can continue their life with the support of the child welfare institution they are living in.

8.2 What is bad or problematic in current cooperation?

The found problems and bad practices are divided into four categories:

- Systems and structures
- Influencing factors
- Obscurities
- Not-recommended current practices.

When these categories are further explored, they seem to form relationships and interact with each other. Systems and structures together with influencing factors create obscurities in people’s minds, actions and care / treatment results. Furthermore, these obscurities lead to non-recommendable practices between services. (See Figure 3.).

8.2.1 Systems & structures

Different structures and current systems affecting to cooperation arising from experiences of the participants are divided for seven codes, which each describe their influence in the situation:

- Non-patient-centred system
- Separated and/or overlapping services and organisations
- Lack of clinical supervision
- Lack of resources
- Inaccessible services
- Constantly changing personnel
- Inadequate operation or/and control of the third sector.

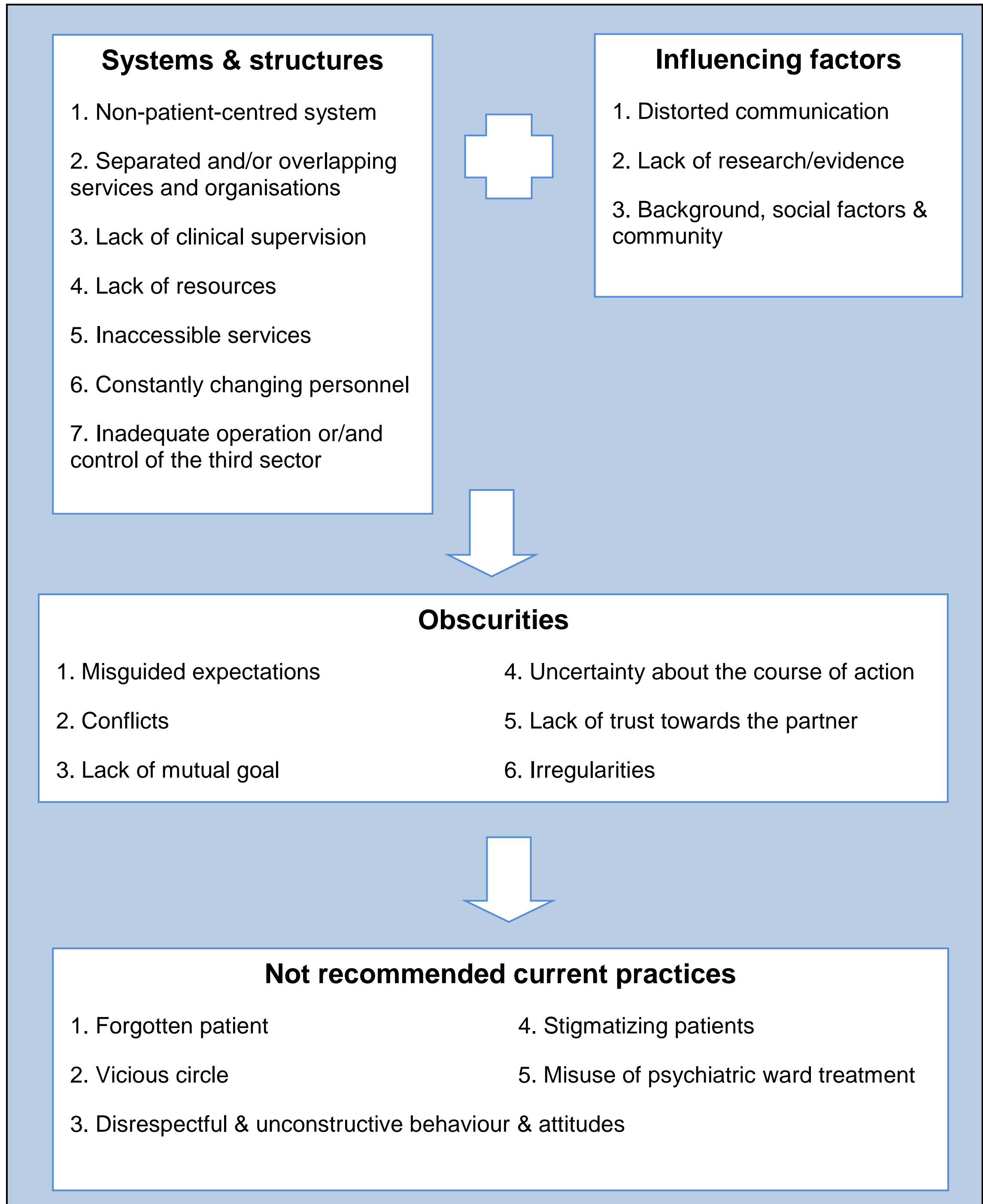


Figure 3. Results for current bad or problematic in cooperation.

Non-patient-centred system

The current, non-patient-centred system for help is working wrong way round, according to participants. They feel it is forgotten how the first and foremost place for the adolescent is in their own home, not in any institution or a ward. In addition, if the adolescent needs help from services, other things tend to take over and the patient and their needs easily are forgotten. As the one participant expressed it:

> The youngster is forgotten form the centre of the discussion and it's difficult for them to smoothly move within the system.

Separated and/or overlapping services and organisations

The patient centeredness and the issue about the right place for the young patient is seen as central also in structural questions. Rigid, separated structures: division between specialized health care and primary child protections are felt to be building a wall around separated actors. Thus, resulting conflicts and different opinions about the right place of the young person e.g. when the adolescent belongs to the care of the child protection and when to the psychiatric care instead. This system is hard and tiring for both, the patient, who would need help and for the health/social care workers, who find the situation very distressing at times.

> The current system includes many overlapping actors, thus organizing and making logistics is overwhelming. There are e.g. separately psychiatric services of the city and psychiatric services of the hospital district and those two aren't anything to do with each other. This leads the situation in which the everyday life is about surviving, which doesn't necessarily serve its purpose or anybody.

Current structures do not support the work that is needed to be done. For example, legislations about regions and institutionalization of children within the regions may cause even absurd situations in which e.g. the patient has to travel hours by ambulance in order to receive psychiatric care.

In addition, within a small area there are many operators, which are not clear in leadership and are not enough discussing together. This leads to rigidity and

situations in which no one knows what the other is doing and everyone is only assuming things.

> The lack of clarity in leadership creates inflexibility. The quarters responsible to coordinate policies and procedures aren't meeting each other enough.

Lack of clinical supervision

The personnel of the child welfare institutions have reported to the psychiatric personnel they lack of clinical supervision. However, undertaking a supervisory role for them feels like an unnecessary burden for psychiatric workers as they have their own work and responsibilities to take care too. Nevertheless, requested guidance is given when being able to do so. For example, in one case the whole personnel form the child welfare institution was invited to the meeting and the psychiatric personnel had "given them supervision" relating on the situation with one adolescent patient they were struggling with.

> Especially, when the youngster is institutionalized as a long-term basis to the child welfare institution, psychiatric outpatient care falls into the position where they act almost like a clinical supervisor for the primary care worker of the patient. They need to calm down the worker by telling them everything is fine and there is no need to panic.

Lack of resources

Resources for both, child protection and psychiatry are controlled by political decision making. Psychiatry is overloaded already within its field resulting the wards and outpatient care to be blocked.

> In outpatient care resources are already used and municipalities are struggling as there isn't money to keep clinics on.

Thus, it is challenging to try to put into practice plans for outpatient care, which do exist already, as no any extra resources were given for implementing them.

An enormous shortcoming when working in psychiatric admissions is the lack of social worker who would be present in the team there. In the current situation the social worker need to share their time with many units and it is impossible

for them to work in the ward as much as there is need for it. In the past, psychiatric admissions department had own social worker, which strengthened cooperation.

> Social worker helped to create understanding between psychiatry and child protection when e.g. there was a need for assertive cooperation and decision making for benefit of the patient.

Inaccessible services

As explained before, psychiatric wards are full; therefore, the route to the receiving psychiatric treatment is blocked as well. The participants explain how it can be difficult for a worker in the child welfare institution to get the treatment for the adolescent in case of need, if all wards are already full. In addition, they are wondering, whether the child welfare personnel have the adequate services available to request psychiatric support and help at whatever time they needed it.

Constantly changing personnel

Constantly changing personnel is felt making current structural division of labour even more challenging. Their experience is that the social workers of adolescents are changing often. Therefore, the specialized health care can fall into holding up the whole case of the adolescent. This can take even for years and will diminish psychiatric resources, which is then off from the work that really should be done.

> We have to take care of the whole package and inform the social services about the adolescent and their affairs, although it should not be responsibilities of the specialised health care at all.

Inadequate operation or/and control of the third sector

The operation and control of the third sector arises questions. Participants wonder if the third sector is all about doing business and therefore, those institutions

were taking in too challenging cases. Often these challenging adolescents are coming from outside the region, but end up in the care and responsibility of the local municipality, (despite of the original home region of the patient), as the institution could not cope with them anymore. This increases the work load and requests for the local psychiatric services, which then struggles trying to meet those demands.

> Youngsters from outside the region might have psychiatric care and rehabilitation plans done and it isn't said the municipality can meet these requirements.

Valvira's control over the operation of the third sector is seen as unsatisfactory, because inspectors will not see the real situation, when visiting those private institutions.

> Valvira isn't able to control private institutions. During the inspection everything seems to be OK, but when the inspector has gone, they go back to e.g. operating with short staff.

8.2.2 Influencing factors

Influencing factors are as follows:

- Distorted communication
- Lack of research / evidence
- Background, social factors & community

These influencing factors together with already explored systems and structures, creates obscurities and have their impact to the current "bad practices".

Distorted communication

Good, professional and clear communication is essential for all interaction between people. If the communication is disrespectful and it becomes tangled, unclear or even secretive, there is no chance for successful cooperation.

> Problems originate when interaction and communication get distorted.

Lack of research / evidence

According to the participants there is not enough research about the effectiveness of the psychiatric ward treatments in adolescents. Thus, different expectations thrive wild e.g. workers on the child welfare institution might have too high hopes about the helpfulness of the ward treatment.

> The influence and successfulness of the treatment in psychiatric ward is a little, if not at all, studied.

Background, social factors & community

Background, social factors and community creates the base for the patients' needs and thus, the base for the care and cooperation too.

For example, firstly, if situations and relationships in home environment, (whether it is the original home or the institution, where the adolescent is living) are not in working order, is the base taken off from the psychiatric ward treatment.

Secondly, recent heavy cuts in society have taken off e.g. the first hand support at schools. Therefore, adolescents who react on the situation are ending up into the child welfare institutions and straight to the specialized psychiatric care, policlinics or even to the institutionalized psychiatric care ward.

Thirdly, in the child welfare institution (or in the school) can be some kind of situation going on, which leads youths from the same place to end up to the psychiatric ward at the same time.

8.2.3 Obscurities

Obscurities are caused by systems and structures with the effect of influencing factors. Six codes are found under this category:

- Misguided expectations
- Conflicts
- Lack of mutual goals
- Uncertainty about the course of action
- Lack of trust towards the partner in cooperation
- Irregularities

Misguided expectations

According to the study, one of the biggest problems between psychiatric services and child welfare services is distorted comprehension about the purpose of the psychiatric ward and the side effects of that distorted understanding. For instance, over-expectations about the miracle making influence of the psychiatric ward treatment may be causing "wrong" referrals to the ward, if it is presumed that psychiatry can fix the patient's problems after long circulating period from the one institution to the other. In addition, this leads the adolescent to feel no one cares or does not want him/her, as the psychiatric ward (among other establishments) is saying it is not the right place for the youngster.

Divided structures are one reason behind the problem as separations create disagreements and twisted appreciations about the significance of the special health care as if it was better, more able and skilful and somehow above the others. This, participants are feeling, is accumulating overrated expectations on the shoulders of the psychiatric ward treatment and its personnel.

> It's a problem if, in the child welfare institution, it isn't understood that outpatient care is the base for the treatment and psychiatric ward treatment only answers for crisis with a short period of treatment. When it's imagined the ward treatment sorts out all the problems the youngster has, the base disappears leaving us on nothing, and the youngster isn't receiving the help he/she needs.

It seems specialized health care is given too much appreciation, which makes people to think it is that kind of special know-how challenging adolescents require. This leads to the situation in which the psychiatric personnel had to educate other parties involved the situation. For example, they need to guide the

child welfare institutions about the right (and wrong) time to psychiatry to come and to be involved. Therefore, psychiatry has a huge role by carrying the responsibility and acting as an educator and counsellor, which then again, increases psychiatry's status as an expert and a leader resulting more misguided expectations.

Conflicts

Not only misguided expectations, but current structures as well are causing problems and create conflicts and obscurities about the right place for the adolescent. The most common conflict seems to be whether the adolescent belongs to the care of the child protection or to the psychiatric care instead.

There arise conflicts about roles and job descriptions between services. For example, psychiatric personnel feel that pedagogic (behavioural) side of care should be done by the child welfare institutions.

> Especially during the on-call hours conflicts arise from different opinions whether the young person with demanding behavioural problems belongs to the ward or to the institution in which they are living.

When interaction and communication are distorted situations come to a head, become acute and people react with their emotion, which easily leads to competition between organisations and to arguments about laws and how they should be interpreted.

In addition, there seems to be lack of official guidance how to deal with the escalating situations. For example, when problems of the adolescent are escalating in the child welfare institution and he/she is wanted to be sent to the ward the psychiatric personnel might feel, the ward is not the right treatment/place for the patient. The personnel do not know how to act in these situations and often this creates conflicts between organisations.

Lack of mutual goal

If cooperating agencies do not have mutual goals and they are all working alone with their own aims and agendas, the cooperation is impossible leaving the adolescent without the support they would need and deserve.

> Distorted interaction and communication results if the worker of the child welfare institution has totally different idea about targets and aims than the worker from psychiatric unit.

Uncertainty about the course of action

As learned above, if the situation escalates in the child welfare institution the clear system and guidelines about the course of actions are missing. The psychiatric personnel feels the overall picture gets dimmer and they wonder how and with whom they should be cooperating when the adolescent is coming “too early” or without “a real need” to the ward.

> It’s not that single people would not want to act and work well, but there is missing of an ideology from background, which would guide everyone.

In addition, there is a constant obscurity among psychiatric personnel about the course of action when dealing with child welfare institutions.

> There can be the common goal, but it cannot be reached, because there are so many obstructing things ceasing operating together.

The common problems are e.g.

- How and where to draw the line between pedagogic and psychiatric needs/behaviour?
- What is the correct order to sort out problems?
- What is the dominant law behind the course of actions?

Lack of trust towards the other party

If the situation with an institutionalized adolescent escalates, and psychiatry and social services are cooperating, psychiatric personnel have the feeling that social services doesn't necessarily know how to deal with the adolescent. They feel the social workers have not posses the psychiatric view to the adolescent's situation as a whole.

> I'm wondering whether they in child protection are aware, when they make those official decisions to institutionalize the young person, about the nature of the decision.

Irregularities

Participants feels, the persevering leadership is missing from health care. Single operators develop their own models of practice and another may copy that for them too, but some other operators do not think it is adequate and decide to do something else. Thus, regional and institutional irregularity and differences in the course of actions results irregularities in the success of those actions too.

> Irregularities in standards of child welfare institutions are causing problems. Some institutions are coping well, but others are in real distress when situations escalate.

8.2.4 Not recommended current practices

Not-recommended current practices involve ways of cooperation informed by obscurities in current systems and practices. There are five codes taken to be looked into more carefully:

- Forgotten patient
- Vicious circle
- Disrespectful and unconstructive behaviour and attitudes
- Stigmatising patient
- Misuse of psychiatric ward treatment

Forgotten patient

When disputes about principles of the child protection law and the mental health law are on, the conversation can be strong and often, the young patient, the subject and the reason for the conversation, disappears from the centre.

Generally, according to participants, when the situation escalates in the child welfare institution, specialized psychiatry is involved too easily. In these situations, the young person, and the fact the institution is their current home, is forgotten. Especially, if the psychiatric outpatient care is already there, they feel, it is not recommended too hasty to contact on-call psychiatric services as that can activate the course of action which leads the young person to be taken into the ward unnecessarily/ against their needs.

In addition, often the adolescent is taken to the ward without having a discussion with the child welfare institution and the psychiatric personnel together about the situation and possible need for the treatment in the ward. For example, it has happened that the adolescent has been sent to the ward due to insufficient resources in the child welfare institution. The help the psychiatry can offer in these cases does not meet the needs of the patient.

Moreover, if the young patient has to stay longer at the psychiatric ward, some side effects may arise. For example, using limb restrains might become regular, weekly used intervention, which results the adolescent to stay put in the ward, which is harmful in the long run for the patient and their life.

In network meetings, the voice and needs of the adolescent is not always heard. Especially, if they are shy and find it difficult to open up even for their primary nurse. Furthermore, the official way of speech (jargon) can be too much for the youngster to comprehend.

In addition, participants feel the importance of the relationship between the patient and their primary nurse is not always understood. The adolescent is left without secure relationship in which their voice could be heard. Thus the young

person is left out from their own care, which often leads to the increase of their behavioural symptoms.

> Sometimes, if asked who the primary nurse is, it is said there is none or it is not known.

Vicious circle

Some kind of vicious circle formation can be seen in participants' experiences about cooperation and the care of the adolescents. For example, when the adolescent's affairs escalate, the circle develops easily as difficulties the youngster posses are spread among the personnel resulting ball games started to be played with the youngster within the care system. The adolescent moving almost endlessly from the institution to the other, increases problems the young person has and reinforce the feeling no-one cares about them.

In addition, the poor cooperation can cause the patient to circulate to and fro between the psychiatric ward and the child welfare institution.

> The worst cooperation situation between child protection and psychiatry occur when the adolescent fall into going round in circles and is coming with a M1 referral to the ward almost in every week.

Disrespectful and unconstructive behaviour and attitudes

Generally positive thinking or seeing things differently is not supported in workplaces (or in cooperation).

> Things that are not working tend to arise easier into the surface and the attitudinal atmosphere supports talking about them more.

In the past, some attempts had done to create a forum for cooperation, but it had come to nothing as the child protection has not taken any cases in to be discussed.

In addition, respect seems to be missing between the child protection personnel and psychiatric workers. There appears to be lack of knowledge, or it is not be-

lieved, that on the both sides, there are equally talented and qualified people working.

Confrontations and poor cooperation exist not only between different services, but even between different psychiatric operators, which of course, has its affect to the cooperation between separate agencies too. For example, the doctor-led management and staff may differ in opinions about the best practice and interest of the patient, when it is discussed whether the adolescent should stay in the ward or go back to the outpatient care. At the same way, people working on the ward and people in outpatient care, may belittle work the other party is doing and feel that they are not doing anything, although both were working as much.

Stigmatizing patients

The participants are worried, if the psychiatric ward's quality to be the last resort is emphasised too much as it may lead the ward patients to be stigmatised. This is a stigma, which is strongly maintained even by the personnel on the psychiatric services.

> Greatly graded care system, special health care, creates stigma.

Adolescents are not required to have a mental illness in order to get the referral to the ward; suspect to be in danger to themselves or others is enough. Therefore the child welfare institution should not too lightly to be able to start the processes which lead to involuntary care in the psychiatric ward.

> It's questionable how good it is for the average youth if they have spend time, even only a day or two, in the psychiatric ward as the most likely it will be one more label on the forehead for them.

When the adolescent has got the M1 referral to the ward, things easily become complicated. According to participants, unravelling the whole tangle when the patient already is in the closed psychiatric ward, is a wrong way round and causes the adolescent to be stigmatized e.g. in the eyes of clinicians working on health centres.

> After the youngster has been on the ward, they are not listened anymore and with a smallest reason ever they are referred back to the ward.

Misuse of psychiatric ward treatment

As learned earlier, sometimes when situations escalate in the child welfare institution and their resources are insufficient, they might send the young person to the psychiatric ward. For example, it has happened that, when the child welfare institute workers have been inquired about the reason behind the young person to be referred to the ward, the straight answer has been that the patient has got severe behavioural problems and they have only one night worker on.

In addition, psychiatric ward treatment has been used as a punishment and youths have been threatened to be taken there, if not behaving as requested. However, this sometimes has turned against it itself as it has led having been in a ward treatment to become a wanted status among the adolescents.

> It feels like the personnel of child welfare institutions were using psychiatric wards as storage, sanctuary and for a break for themselves.

8.3 Arising theme about seeking advice

Issues around seeking advice or help and giving support to others, come apparent throughout the interview. At first, asking guidance is seen as a positive thing, which boosts the cooperation and leads to successful result. However, even more often, it is mentioned as a burden and no one seems to know how those arising requests for guidance and supervision should be dealt with.

When the issue is examined further, certain elements can be seen affecting in the situation and possible even to be preventing successful cooperation and results in care of adolescents. (See Figure 4.).

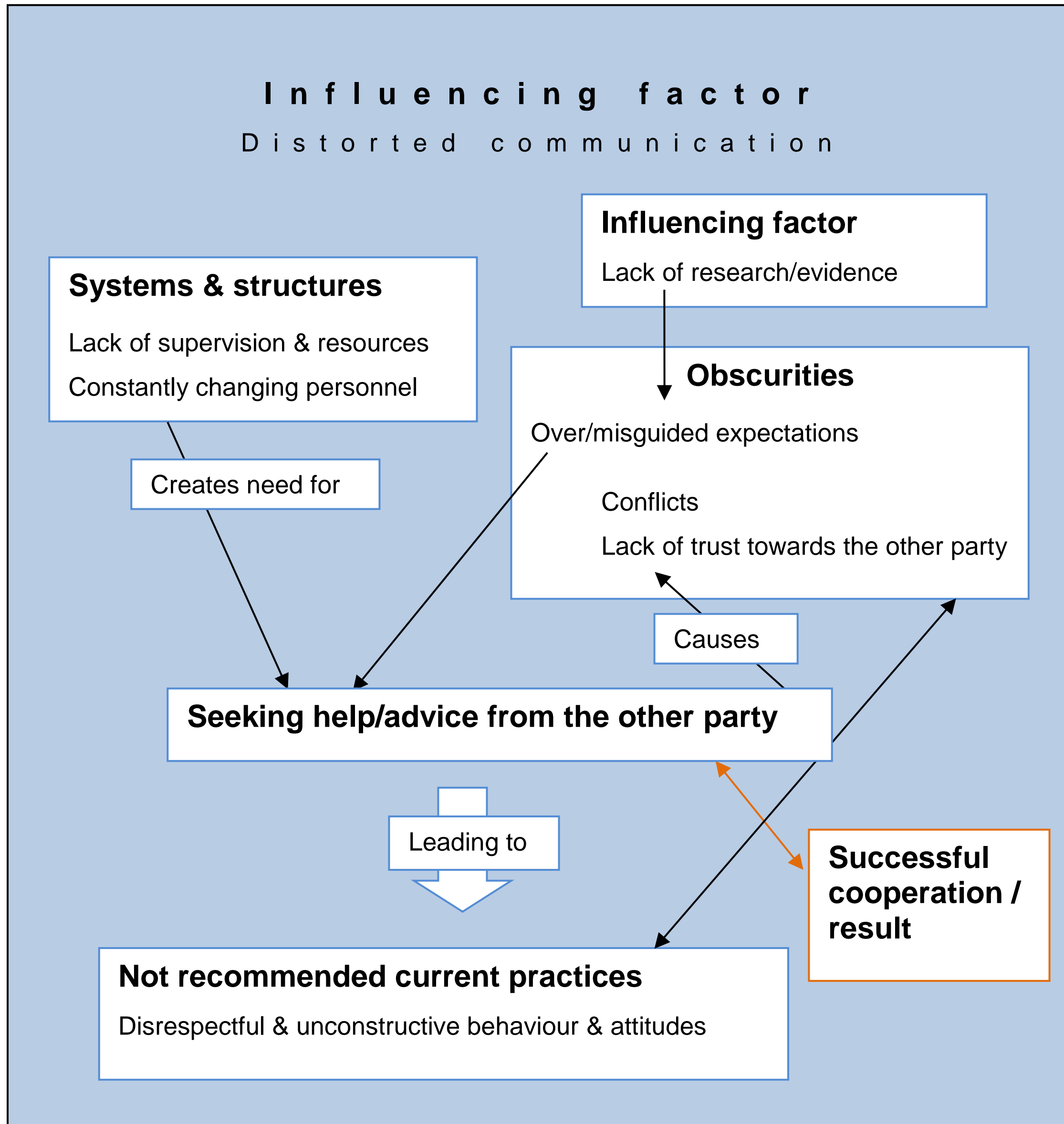


Figure 4. Main elements in the problem of seeking and giving help and advice.

One influencing factor, distorted communication, may be working all the time on the background, which makes cooperation challenging. Systems & structures e.g. lack of supervision and resources in child welfare institutions as well as constantly changing social workers, who should be taking care of the young patient’s case as a whole, creates the need for seeking help and advice from personnel of psychiatric services. However, the answer for the request might happen through not-recommended current practices e.g. by acting disrespect-

fully with unconstructive behaviour or attitude, which inhibits successful cooperation or result to follow.

Furthermore, these not recommended current practices are strengthened by obscurities e.g. misguided expectations (influenced by lack of research and evidence) which create more need and motivation to seek help from psychiatric specialised services. This creates even more conflicts between services and reinforces already existing belittling attitudes towards the advice seeking party.

Therefore, it seems, the current ambiguous practice of cooperation in advice seeking situations, can lead to reinforcement of current bad practices rather than to the successful cooperation which would be the desired outcome.

8.4 Ideas for the development of the current cooperation

At first this developmental section is considering, why the change and development is needed, and then it further explores what could be done. At first it looks into the organisational and professional reformation and then it takes the view of personal and professional development. (See Figure 5.). The categories are as follows:

- Why the change and development is needed?
- What could be done? – Organisational & professional reformation
- What could be done? – Personal & professional development

8.4.1 Why the change and development is needed?

The research found four reasons to improve current systems and practices:

- The best interest of the patient
- Development of clear systems and procedures
- The world has changed and is changing
- Lack of appropriate services

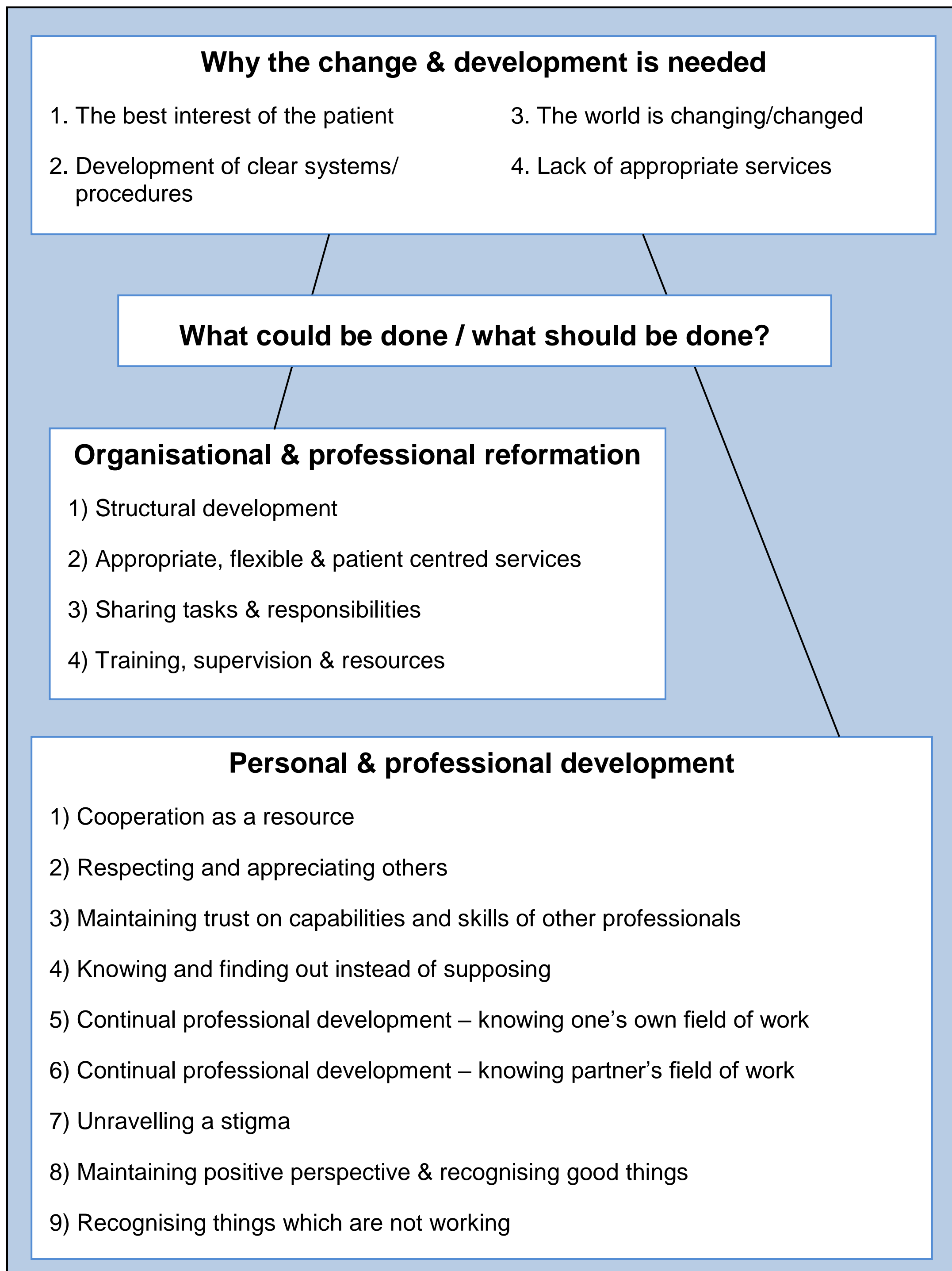


Figure 5. Results for ideas for development of the current cooperation.

The best interest of the patient

The questions whether current services and practices were about the best interest of the patient and meeting the needs of adolescents are considered.

> Basis of the child welfare is letting the child to live with their family as long as there isn't any other choice. The adolescent have to be in danger at home, mentally or physically and parenting to be really damaged, before the youth is taken away.

It is questioned, whether the young person were better to spend e.g. from their 13 years to 17 years in the child welfare institution rather than in the closed psychiatric ward. Additionally, would not it be better, if the psychiatric services could be more present and go there, where the situations are taking place. Thus services were able to answer the acute distress in escalated situations, without the adolescent needing to leave their place of residence.

> It's important cooperation to be controlled and to be carried out the way it makes sense from the point of view of the patient. They shouldn't have to be thrown back and forth between services.

Development of clear systems and procedures

Developmental work needs to be done in order to procedures and practices about cooperation between psychiatric services and child welfare services to be clear to all involved. Clear systems create well working cooperation, where is no vagueness in practices how to take care of affairs of the adolescent.

The world has changed and is changing

The participants emphasise, that adolescent psychiatry should be able to take into consideration difficult and complex problems adolescents have, as those are becoming even more difficult in the future.

Lack of appropriate services

Those adolescents coming from different regions to the placement for the child welfare institution belong under the regional psychiatric policlinic in the area they are placed to. These adolescents often require special services like knowledge, skills and resources, which are not necessarily available at the moment.

8.4.2 What could be done? – Organisational & professional reformation

In organisational and professional reformation four aspects should be considered:

- Structural development
- Creating appropriate, flexible and patient-centred services
- Sharing tasks and responsibilities
- Training, supervision and resources

Structural development

Separate structures between social and health care are strongly questioned by the participants and they feel those services should be able to be unified in order to provide good cooperation and adequate care for adolescents.

> If thinking of managerial and organisational matters, the health care and social care should be under the same roof.

As well as separated structures, also unclear structures and procedures should be thought again and clarified. The principle of the care of children is, according to the participants, that children should be able to stay at home and go to school. If they need help, the helps should go to them and not vice versa. In those cases in which the child cannot live with their family anymore and is put into the child welfare institution, the institution will become the home of the child

and help should be available there (or go there) without the child needing to go to the ward in order to get it. The ward treatment of the specialized psychiatric care in which the adolescent have to leave their place of residence should only be used in extreme situations and even then as little as possible. This should be done also with the constant cooperation with the quarter, where from the adolescent is coming from, whether it is their own family or the institution or both. Thus, the treatment on the ward could act as a support which makes the treatment stronger and makes possible the outpatient care to continue. The first and foremost, improving preventative measures and supporting the adolescent before they are in that condition that they will need ward treatment, should be the first priority.

The question about causing and maintaining a stigma seems to produce two different ways to look at the situation. 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 could get. Or in the other hand, the admission to the ward could be made even more difficult, in order to prevent the adolescents to be stigmatised and the whole care to start from the wrong direction altogether.

> Coming to the ward should be the last resort after everything else has been failed. Not like, first the youngster is taken to the ward and after that is thought what to do now.

However, this could increase the desirable status of the psychiatric ward treatment among the adolescents. Thus, the stigma becomes a reason for youngsters to want to the ward as they could then boast about it to their friends. Nevertheless, it seems the participants are not really sure what would be the best direction to take in this particular case, although they emphasise the importance of trying all other care methods before taking the adolescent to the ward.

Some of those methods could be, not only making sure that community health nurses were available in every school, but also the workers from psychiatric field should go into schools too. The ideal situation would be, the youth, aged between 13 to 17 years, is living at home and goes to school. Then, if problems

occur in the school, that is noticed there and the personnel of the school would take care of the welfare of the adolescent by supporting them appropriately. Therefore, from this primary situation, it should be a long way to the situation in which the youth is being regularly followed up on the psychiatric policlinic, or even needed to be institutionalised to a child welfare institution or to the psychiatric ward.

Appropriate, flexible & patient centred services

Situations should be taken care and carried out appropriately.

In an appropriate system, practices were carried out always by thinking of the adolescent and making sure they will not be suffering due to borderlines or inflexibility of the services. They would get the help they needed in an acute situation and were able to continue their life with the (outpatient) support, which suits for their individual situation and requirements. This kind of appropriate system would be more latitude according to the demands and challenges of the situation or the requirements of the patient's needs. In addition, 'on the foot –model', in which the services are going to the place where the client is should be more dominant practice.

Workers on this field should follow the principle that the youth's case is not going anywhere if he or she has a feeling of no-one cares about them. Someone has to care about them and this caring has to be done visible for them. For example, it is important to terminate all kind of circle formations if they develop and to create care and cooperation plans from the point of view of the adolescent. Likewise, after cooperative negotiations between services, the plan and the aim, which is pursued, should be written up. The targets, necessary transitional steps, procedures and practices should be written up. In that way, if plans have been made according to the adolescent's needs, the adolescent's voice will be made visible too.

Psychiatric services also should be able to renew themselves according to situations. For instance, it should be able to answer for the needs of the young

people who have been placed further from their place of domicile, for example, due to drug problems.

In addition, psychiatric services might be good to consider appropriateness and necessity to perform so called ‘mental autopsy’ for a young person. The ‘autopsy’ takes time and resources, produces loads of data about the adolescent into the health care databases, but is not necessary the most appropriate way of help.

> Much smaller interventions, with boundaries and love if to use this cliché, the life of the young person is possible to get on the same track, if not even better, than with that huge analysis, which is offered to the youth now.

Sharing tasks & responsibilities

Cooperation meetings between organisations are essential for sharing tasks and responsibilities properly. People with enough power, who are aware of the work done in the field, should meet up together, maybe yearly, and agree about procedures.

This kind of leadership is a big challenge, for example, if thinking how to lead the meetings successfully without them becoming rigid and unproductive. However, the meeting with high significance, in which few primary principles could be discussed, would be meeting in which had representatives from all areas. For example, representatives from the municipalities’ outpatient care policlinics, from the psychiatric ward care and senior social workers from child welfare services.

Furthermore, sharing the work and working together when the child welfare notification has been done, is important. Social workers should not go to see the family by themselves, but always together with a psychiatric worker. This would prevent overlaps in work, help with the assessment of the immediate care needs of the adolescent, easier the one’s workload as well as to be easier also for the family.

In addition, cooperation can act as preventative measure, which could get the demand of child welfare institutions and psychiatric wards reduced. For example, centralised home visits together by personnel from psychiatric and child welfare services and unifying outpatient care the way that social and health services are together, could be one means of easier the requests for institutional care.

Training, supervision & resources

Participants are feeling, in order to make cooperation working better, more clinical supervision for the personnel of the child welfare institutions and more staff for both sides (psychiatry and child welfare) is needed.

The participants also believe if managerial organising and meetings are appropriately held and documented, improving the cooperation could be done with reasonable financing. In addition, giving resources and supplying acute outpatient services would make possible valuable dialogue between different agencies.

Especially, when the situation escalates in the child welfare institution, extra staff and psychiatric know-how were needed to be taken there. Likewise, when the child welfare institution has got the need for psychiatric help/ services, those services should be available for them.

However, increasing psychiatric training for the personnel of child welfare institutions would benefit all and it would dispel the structural separations.

> They could have their own nurse who has had psychiatric training there, who could assess the need for M1 referral and possible need for transfer to the hospital.

Moreover, reorganising and increasing clinical supervision in child welfare institutions seems to be important for participants. Lack of clinical supervision and unclear roles between services are playing crucial part in cooperation problems between psychiatric and social care agencies. It is central to make clearer, for both parties, what kind of supervisory role, if any, the psychiatric personnel

should have there. At the moment, requested guidance and help is given to the child welfare personnel, but at the same time it is questioned, whether it should be done somehow differently, somewhere else, and done by different quarter.

> Quite often, in network meetings, the need for clinical supervision arises among the child welfare institution workers and they want to discuss and ask guidance from psychiatric personnel before the adolescent arrives.

However, clinical supervision and guidance should be also available when the situation is on in the institute. Thus, the adolescent does not need to leave to the ward, only because the help and support has not been available for the personnel in the child welfare institution at the time it was needed.

Possible solution for the situation could be sending the psychiatric outpatient care to work in child welfare institutions. If acute psychiatric outpatient services were more able to be there in child welfare institutions as a regular bases, they could in time, and in more neutral manner, to notice possible problems or situations which have the potential to develop such, and via clinical supervision and educational interventions help the personnel of the child welfare institution to unravel the situation.

8.4.3 What could be done? – Personal & professional development

Personal and professional development consists of nine codes to think about:

- Cooperation to be seen as a resource
- Respecting and appreciating others
- Maintaining trust on capabilities and skills of other professionals
- Knowing and finding out instead of supposing
- Continual professional development – knowing one’s own field of work
- Continual professional development – knowing partner’s field of work
- Unravelling a stigma
- Maintaining positive perspective & recognising good things
- Recognising things which are not working

Cooperation as a resource

Changing one's mind-set to see cooperation as a resource is a good base for the cooperation between services.

> Cooperation between psychiatry and child welfare isn't necessary to be seen as a nuisance or a burden, because at its best, it is a resource also for the psychiatric services.

Respecting and appreciating others

Seeing the value of people on the other side of cooperation, have a high importance in interaction between people and services. Both parties should be appreciated equally and their great know-how and professional skills, which are found within every service involved, should be recognised.

Maintaining trust on capabilities and skills of other professionals

Recognising of other's capabilities is a good start, but also it is needed to have and maintain trust between services. As the participants emphasise, if two separate organisations are maintained, it has to be based on trust that both organisations are taking care of their responsibilities. Thus, the cooperation is not based on individual relationships, but it is going to be good interaction between organisations, only supported by relationships between people knowing each other.

Knowing and finding out instead of supposing

> When we are talking about management, organisation and cooperation we should not think or suppose anything. We should only know and act according to that knowledge.

In order to maintain trust, it is important to adopt the way of working that things are not assumed. If something is not clear or one is not sure what would be the

right procedure to follow in the situation, facts and guidelines need to be found out before acting.

Continual professional development – Knowing one's own field of work

Knowing your own profession, your work place and being willing to know, understand and learn about the agency's policies and procedures are vital elements in delivering good services. In addition, this is a key component when carrying out the professional principle of supplying the same service-package to everyone regardless of who is working at the time. If this is accomplished, dialogue, discussion and mutual targets stay clear regardless of the individual who is on duty.

Continual professional development – Knowing partner's field of work

Well-functioning cooperation requests good and real professional dialogue and targets set together. Therefore, in order to make this possible, knowing one's own field is not enough in cooperation. Partners in cooperation should be willing to know, understand and learn about the other agency's policies and procedures too.

Unravelling a stigma

> The stigma, still strongly associated to psychiatry, need to be unraveled.

The young person being put into the institution can be seen as a tragedy, but in some cases the situation in the family is so escalated that it is better for the youth to be placed in the institution.

However, as learnt before, sometimes even psychiatric personnel is maintaining stigma by seeing patients, if they once have been on the ward, forever carrying

the label of mental patient on their forehead. Therefore, there is an utmost need for everyone working with these adolescents to ponder, at first, how might their own actions stigmatize patients or maintain the stigma, and then, to think about, how they in their everyday actions and attitudes could reduce the stigma.

Maintaining positive perspective & recognising good things

> One has to remember positive perspective and recognise there are plenty which is working.

If one is always seeing things that are not working and only trying to find faults in everything, will all eventually look and become dark and faulty. Recognising good thinks, things that are working, will create positive and supportive atmosphere in which also good cooperation and partnership can flourish.

Recognising things which are not working

As important as recognising things that are working, is to be able to recognise things that are not working. However, it is not enough to recognise them, but there is also needed willingness to do something for those faults. The atmosphere which is supporting open discussion about things, also about those which are not well, is paramount in order to develop systems and create good cooperation and interaction between people and services.

9 RELIABILITY, VALIDITY AND ETHICS

The reliability and validity, including possible limitations, as well as ethics concerning the research, are evaluated and discussed here.

Although among researches the emphasis is on avoiding mistakes and errors, reliability and validity of the researches varies. The reliability of the research refers to repeatable qualities of the research results. If the results are repeatable, not just random results, the reliability of the research can be demonstrated. In addition, the validity of the research refers to the study's ability to measure what it was meant to be measuring instead of getting answers for something else, which was not meant to be researched. (Hirsjärvi et al. 2009, 231.)

One limitation, concerning the whole research, was not been able to compare and discuss results from this thesis study with the other thesis studies done for the RESME-project and originally under the same plan. Discussion was not possible as other thesis works were not ready in time, however these two combined studies were tried do in the manner it would be easy, if wanted, afterwards take these study results and compare them with others as well.

9.1 Systematic literature review

Several factors limit the validity of this systematic literature review. The first of them is the own limited skills and knowledge of the researcher himself. Had the researcher had experience on the field, and a more solid base of knowledge previous to initiate the review, time and resources could have been used more efficiently, and better results attained.

The second limitation of the study is the lack of research that directly address the issue of collaboration between minors residential care institutions and psychiatric services. This fact eventually led to the need to slightly modify the research question: "*What are the good practices in minors residential care that lead to effective collaboration with mental health services?*", in favor of the ac-

tual one: "*What are the good practices to address mental health problems among minors in residential care?*". This last question was thought to embrace also, but not focus alone in the question of collaboration between agencies. In an attempt to cover as much as possible the issue of inter-agency collaboration and given the lack of suitable research, two works were included in this study that do not fit the optimal criteria; a bachelor thesis (Pitkänen 2009) was included in the background, for it addresses the original topic of this research, and no other material was identified that provided more reliable information. The reliability of this source is nevertheless difficult to determine, and constitutes a serious limitation of the validity of the data provided. A second paper which approached the question of inter-agency collaboration (Collado and Levine 2007) was used in this thesis work although it did not focus on residential care but on foster care agencies instead, which places a question mark on the transferability of its findings to a residential care setting.

A total of four articles were appraised, which is a not very big number. A bigger number of articles could have added more evidence of the efficacy of the interventions presented. Moreover, articles that were themselves literature reviews were excluded. They could have provided additional material and reinforced already identified practices. The appraisal of literature reviews would have demanded a different approach from that of direct research, more time and more skills from the researcher, which would go beyond the resources available and planned to produce the actual bachelor thesis work.

On the other hand, the articles selected describe each a significant number of practices, and the researcher is satisfied in the belief that a reasonable set of interventions has been produced in this paper, and that such spectrum of practices will provide the reader with a general overview of some available tools that can be used in residential care when working with children and adolescents with especial needs and mental and behavioral problems.

9.2 Qualitative focus group content analysis

The focus group for the interview was summoned by RESME- project workers and the approval for interviews was given by the head nurse of the department of child and adolescents psychiatry. (The letter of approval is seen in the appendix 1.) Participants took part in interviews on voluntary bases and all of them were informed about the aims and purpose of the research. They were also told they could refuse to participate at any point of research if they wish to do so. In addition, the identification of the participants was made impossible.

Ensuring the reliability and validity of qualitative research is different from how it is done for quantitative study, but it is achievable. The process of checking, confirming, making sure, and being certain is called verification. In qualitative research it means ensuring reliability and validity of a study by constantly during the research to identify and correct errors before they are immersed to the developing model and before they undermine the analysis. (Morse et al. 2002, 9.)

In this focus group study the researchers checked participants their understanding and asked clarification when needed. In addition, during the analysis the high importance was put on the keeping the essential meaning and voice of the participants clear and untwisted. The study material was went through several times and checked frequently as the analysis progressed. The research and its results were also checked and evaluated by the other writer of the thesis as well as by supervising tutor teacher, who also is the member of the RESME-project and was present at the focus group interview.

However, it is said the quality of a research is related to generalizability of the result. (Golafshani 2003, 63). Thus, as the research sample was that small in this focus group study, the results of it cannot be generalized.

Nevertheless, triangulation is a typical strategy for improving the validity and reliability of research. Golafshani 2003, 63; Hirsjärvi et al. 2009, 233.) Therefore, it can be thought that using systematic literature review and focus group analysis together, could add some amount of validity and reliability into the re-

sults, because some same findings were apparent in both studies. As research questions were taking different angles, one could argue that to diminish the trustworthiness again. However, this can be seen as a reinforcing factor as well despite of different research questions and samples, because some commonalities were still found in the results.

In addition, Graneheim and Lundman (2004, 110) emphasize the importance of creating the right size of meaning units in order to achieve credibility. Too big meaning units are difficult to manage and short ones might cause fragmentation and loss of important information. Therefore, could be said that an extra care has been taken in order to achieve credibility here as lot of time was used in creating the meaning units and the extra phase was introduced in order to condensate units without losing the essence of meaning.

However, there were some limitations in the study, which have had their effect on the research. As mentioned before, the sample of the analysis was small as only four participants were in the group. In addition, one of them had been working for child welfare services previously and it can be questioned, if that had affected the results.

Furthermore, possible group dynamics and power hierarchy can affect for what is said and how it is said in the group. As well as personal qualities can have their effect as some people are quieter than others. (Hirsjärvi and Hurme. 2009, 63.)

Writing the transcription had it own limitations as it was sometimes difficult to know who was speaking as voices were so similar. However, as it was more important, what was said, not who was saying it, because the material was studied as one unit, it did not really matter in the end.

Finally, although several dictionaries were used and careful thought put into the translation work for finding the right words and expressions, there is always the possibility that something was lost in translation.

10 DISCUSSION

In this section, the both part of the study are discussed separately at first and then the results from both are discussed together.

10.1 The systematic literature review

The examination of the results of this systematic literature review offers us the opportunity to extract some relevant and straightforward points:

1) Incidence of mental health problems among minors in residential care.

The phenomenon of mental health problems among children and youth in out-of-home settings is widely recognized in the literature (Ward 2006; Hukkanen 1999 & Hunter et al. 2009). In spite of this fact, Hunter et al. (2009, 165) identify a significant gap between the needs of that particular population and the help that they receive from mental health professionals. The consequences of unsolved mental and behavioral problems can follow those in care, and have a negative effect on their lives, much later after leaving residential care and starting an independent life as adults.

Addressing minors' mental health problems takes place mainly through psychotherapy, but many other factors are to be taken into account to guarantee the provision of successful interventions. Stanley (2007, 264) identifies a lack of information and support for residential personnel and foster parents by other professionals – mental health professionals – and the need of residential staff for feedback about the situation of the people under their care. It is necessary in order to provide effective mental health services for minors in residential care, that psychiatric services and child welfare institutions work more smoothly, that they understand each other agency's dynamics and procedures, and that provision of mental health services is not limited to specific, isolated situations, but rather that they are part of a continuous process of care (Collado & Levine 2007). Collaboration between agencies should take place in different levels;

Collado and Levine (2007, 138-139) mention the clinical, the administrative, and the structural level. In their case study, psychotherapists in charge of treating children's mental problems play a multidisciplinary role, provided ongoing counseling, and participated in regular meetings and events – e.g. family visitation – of the agency's staff. In this way, psychotherapist got first-hand insight into the situation of their clients, and could better follow up their evolution and act early, instead of waiting for children welfare personnel to call them when the situation had already escalated to a level where they could no control the child or adolescent's problematic behavior.

Pitkänen (2009, 46) in her bachelor thesis on the same subject comes up with a suggestion by one child residential care worker that a psychiatric nurse would be a permanent member of the staff of the residential unit and participate in everyday care, and so be of the signs and dynamics of mental and behavioral problems among children. This would suppose, no doubt, a significant dedication of human resources by the psychiatric services, which means that enough qualified personnel should be available. Being that the case, it is the opinion of the researcher that the benefits in the well-being of the client in the long-term would outweigh the costs.

Fluent collaboration will demand from agencies a big deal of time and effort, and Inter-agency continuous contact through meetings and discussion is necessary, especially in the early stages of the process when establishing new policies and procedures. It is important that agencies and their personnel do not give up in front of these difficulties, and continue to pursue their efforts towards the desired goal of a more effectively articulated system of care.

2) Lack of research on minors residential care and psychiatric services collaboration.

There is no consistent body of literature that addresses the issue of collaboration between children and youth residential care and mental health services. A single research was identified (Pitkänen 2009) which although provides relevant information on the topic, does not meet the inclusion criteria of this review – for

it is a bachelor thesis, and therefore the reliability of its findings is uncertain. Nevertheless, such work has been included in the background, with appropriate clarifications that it is a bachelor thesis work. A different work was also identified, which provides insight into the successful process of collaboration between foster care institutions and mental health services (Collado & Levine 2007). This article, although presenting some flaws or gasps at the light of the analysis realized in section 5, has been included in the present work, for it is believed by the researcher that its findings, and the procedures described, though used in the context of foster care can be extrapolated and adapted to residential care institutions.

Given the lack of research mentioned above as well as the importance that for children and youth have the adequate provision of services focused on their especial needs, it is recommended in the future to undertake such investigations, so a base of knowledge and evidence-based procedures can be established for the use of the agencies implicated.

3) Staff's lack of training on mental health.

Residential care workers often feel overwhelmed by the especial needs and mental problems of those under their care. They often have not enough knowledge about mental health issues, strategies to address those problems, or when and who to contact when those problems arise (Pitkänen 2009, 32-33 & Ward 2006, 337). Hukkanen et al. (1999) and Barth (2002) see the lack of psychiatric education of the staff as factor that is hindering the psychological improvement of children in children's homes. Shealy (1995) presents a figure of the residential care worker as someone who should partially act as both, a therapist and a parent (see Barth 2002, 5). In such a context in which residential care staff needs to deal with mental health issues in a frequent basis, education of care personnel on such issues is recommended (Collado & Levine 2007, 148). Education for care staff can occur in a variety of settings; psycho-education (Collado & Levine 2007) from mental health personnel, staff-cross training, and participation of staff in open forums (Hummer et al. 2010) with other professionals who can occupy a similar position in a different unit, or a com-

pletely different position, as psychiatrist or social workers, are some practices oriented to improve residential care workers knowledge and skills. Better educated care workers can use approaches like *opportunity-led work* (Ward 2006, 343-344 & Houston 2010, 361) to provide non planned, immediate therapeutic intervention or discussion oriented to positively influence children and youth, whenever the possibility arises.

4) Staff's high turnover rate.

In relation to the previous point, it is noted by different authors (Wards 2006, & Hummer 2010, 87) that high turnover rates of staff working in residential care settings places some serious problems in the quality of the services provided for minors in those settings. Barth (2002, 6) refers to inadequate selection and inadequate compensation of care workers as factors that negatively influence the quality of care in residential settings. In Stanley's paper (2007, 263), when asked "what was least likely to contribute to good mental health for looked-after young people, both professional carers and kin carers cited placement disruption and changes in care staff". High turnover rates makes it more difficult to keep an adequately trained and updated staff, and it makes it difficult for those under care to establish long, stable and trustworthy relationships with those adults that they have more contact with – and therefore, probably more influence them. Moreover, as Pitkänen (2009, 42) comments in her bachelor thesis, new workers will have more problems to respond to individual preferences and needs.

It is not the purpose of this study to explore in depth this particular problem. Nevertheless, given the influence that this factor may have in children and adolescents wellbeing, it is advisable to those agencies that suffer a high turnover rate among their personnel to look into the causes, and develop measures to reduce the rate with which personnel changes occur. By reducing personnel turnover, institutions may progress towards the goal of keeping a well-trained, experienced and skillful staff. Staff support and recognition is mentioned by Houston (2010, 364) as one of the background factors that enable worker's interventions, and could probably as well help to prevent workers turnover.

5) Need for continuous assessment and planning.

Assessment of the minors' needs and planning of interventions to cover those needs are vital to the process of children care in residential settings (Houston 2010 & Hummer et al. 2010). Moreover, assessment should be continuous, and planning should be referred to the community as a whole as well as to individual adolescents and children who vary in their needs and preferences. Systematic debriefings after relevant incidents – e.g. seclusion, restraint, aggressions... – bring the possibility for continuous assessment both of the needs of clients and the efficacy of the procedures, if any procedure is applied – e.g. protocols for de-escalation. Houston (2010, 362) speaks of *weekly planning*, in which the activities schedule is planned between the youngster and his or her personal care worker, and so participation in activities that can provide a sense of well-being to the individual is promoted, personal preferences are taken into consideration, and it helps the young person not to remain indulgently inactive and develop negative habits or attitudes that may reinforce actual problems, for instance, of depression or anxiety. A planned routine may also promote a sense of security – by reducing anxiety related to uncertainty of what is going to happen next – especially for adolescents who have restlessness and behavioral problems (Pitkänen 2009, 39).

The force-field analysis is an instrument developed by the sociologist Kurt Lewin (1951) which helps to plan action taking into account not only the driving forces that help the individual to move towards a desired end, but also the restraining forces that discourage such movement (see Houston 2010, 361).

6) Need for continuous evaluation of current practices.

The use of systematic and continuous evaluation of interventions and practices allows agencies to identify which ones are effective, and which ones should be modified or abandoned. This continuous process of evaluation in turn leads to the actualization and improvement of the services offered, and it complements the search of evidence-based practices in the literature (Holstead 2010, 359 & Houston 2010, 123-124). Therefore, it is recommended to minors residential

care institutions to implement guidelines that effectively assure such processes of feedback as a way of promoting best practices available.

7) Documentation

Documentation of policies and procedures is a necessary and valuable part of residential care. Hummer et al. (2010) and Collado and Levine (2007) both identify documentation process as helpful in maintaining clarity, delimiting responsibilities and avoiding misunderstandings, at the same time that enables staff to access information necessary for their work, e.g. for planning and implementing interventions such as debriefings, de-escalation, etc... This is more necessary in the context of individuals with especial mental or behavioral problems, who cannot be effectively cared for by merely recurring to ordinary, non-individualized procedures or forms of care.

8) Family involvement.

Family involvement is mentioned as a contributing factor to the wellbeing of the children and youth in out-of-home care (Houston 2010, 358 & Holstead 2010, 120-121). Psychoeducation and participation in therapy of family members are interventions mentioned by Collado & Levine (2007, 138) which may contribute to family implication and promote parental skills. If children and youth have contact with their biological parents, it may be not enough to treat the mental problems of the child if parents' problems remain untreated. The mental and behavioral problems of parents may continue to affect their children even while they are in residential care. Efforts should be made to promote participation of biological parents – at least one of them, or a relative – in the planning and activities of children and youth. Nevertheless, it is acknowledged that such goal may encounter many obstacles when it is the case of parental problems with drugs or alcohol, or severe behavioral issues.

9) Personal relationships.

Besides family relationships, other personal relationships are recognized to play an important part in minors' mental health. Törrönen (2006. 133) describes how children in residential care develop what she calls *institutional networks*, which show similarities to other types of networks, as those of friendship, neighborhood, or kinship. Promoting positive peer relationships (Houston 2010, 361) – also referred to as contact with pro-social peers (Holstead 2010, 121-122) – serves the young person not only to gain satisfaction, but also to learn positive models and practice social skills, one of the factors – the lack of social skills – related to development of behavioral and mental problems. Holstead (2010, 121-122) describes the agency's interest in promoting participation of their youth clients in community activities which favored interaction with pro-social peers.

Minor-staff relationships are equally important, and conscious efforts should be made to create an atmosphere where residents feel safe and comfortable with their caregivers. Therapeutic presence, being present, support from the staff, creating a homely environment, flexible rules, discussing options rather than imposing rules, or team communication, are practices or approaches thought to contribute to the establishment of positive relationships between staff and residents (Houston 2010, 363-364). Stanley (2007, 262) presents the possibility to implicate care leavers – previous users of child welfare services – in residential care. Young people in such problematic situations tend to confide more in those who have had similar experiences, who can constitute a positive model from which actual users can learn. At the same time, previous service users who were able to overcome their difficulties are equipped with an especial type of understanding of the looked-after system, which derives from their personal lived experiences, and that can benefit those currently in care.

Establishing positive minor-staff relationships will bring the opportunity for care personnel to create modeling figures from which residents can learn positive behavioral patterns (Ward 2006, 341-342).

10) Feelings of power and control.

The last point, but not the least important, is that of feelings of power and control. In a study by Nicky Stanley (2007, 261-262) young people in residential care emphasized the importance of choice and control related to therapy or counseling interventions. Very often children and youth in residential care feel disempowered and not able to exert any control over their situation. In this line, some interventions were identified which could help to reinforce a sense of power and control over their environment and their lives; namely, *motivational interviewing* (Houston 2010, 361) tries to identify strengths and to build resilience on them, utilizing the techniques or strategies that are responsive to the person. Romanelli et al. (2009) support a similar strength-based approach.

House council (Hummer et al. 2010, 85) and *team communication and problem solving* (Houston 2010, 364), give young residents the opportunity to speak and be listened to, and take part in decisions concerning community rules and activities, and so may contribute to their feeling empowered.

Some of the points made in this section find support in previous literature reviews. For instance James (2011) in her literature review by the tittle "*What works in group care?"* supports the importance of positive peer relationships, parental and staff training by mental health professionals, ongoing evaluation of residential units, psycho-education exercises used by staff on a daily base, or strength-based approach in residential care.

Finally, it would be good to note that a qualitative case study is not intended to produce – and it does not often produce – robust and objective evidence on which to establish or recommend clinical practice. Instead, it describes a unit or phenomena – in the present cases it describes the projects or units within which minors received out-of-home care, focusing on the interventions thought to address behavioral and mental health issues of such population. Two studies present additional quantitative data, but nevertheless the focus is still on description of the object of the study, and it is difficult to know what concrete intervention produces what effect, and to what extent. Another factor which hinders di-

rect generalization of described practices is the lack of homogeneity between their target groups; children and adolescents are different between them, each possesses his or her own personality, preferences and needs, and even if they come from similar backgrounds – e.g. neglected parental care, alcoholism, cumulative traumatization... – what works with one individual does not necessarily work with another. Also residential care units are not all alike; policies, practices, resources, staff expertise, all may vary from one country to another, even regionally or within one same municipality.

However, under the limitations given in certain settings case studies provide the only attainable evidence given actual restraints – given ethical issues, availability of resources, or other types of restraints. It is recommended by the author that the findings of this literature review are considered in the light of the mentioned context, not as hard objective evidence, but rather as a set of possible interventions and approaches from which other residential care units and their residents may benefit, always that they are applied with caution and attending to the traits of the particular unit where they are to be implemented, or to the personal needs and preferences of the minor under care. Common sense and even intuition – born of years of experience in the field – should be used when planning and implementing evidence-based practices within the child welfare context, to compensate for the inevitable uncertainty that is inherent to the social work field (Parton 2000). Houston (2010, 367-368) states that "training, supervision and mentoring has to encourage the worker's agency to not follow the system's protocols blindly, but actively shape them, drawing in theoretical ideas and research to build a practice theory specific to residential care with its life space/ life-world orientation".

More important, if possible, than an adequate process of planning and implementing interventions is the process of evaluating such interventions, and if proving itself ineffective, modifying, discarding, or substituting for a new one, in a constant endeavor to improve care, and to bring the maximum benefits to those that are being cared for.

10.2 Qualitative focus group content analysis

The study findings explain there is good cooperation already in action and further explores what kinds of elements are supporting good interaction between people and services. Results are showing problems and challenges in systems and structures as well as how attitudes and cultural atmosphere in the workplace can affect the quality of cooperation.

Although the research consists only of views of four participants and the views were interpreted by the researcher, it can give one valid view to look at the situation as it, after all, is based on real experiences of people working on the field and dealing with the questions of cooperation almost daily in their work.

In addition, it is showing some ideas based on real life experiences of these professionals, about the issues to consider when renewing services and planning cooperation. Furthermore, it encourage everyone working in the fields of child protection or psychiatry to evaluate at themselves and their current ways of working and strive for self-awareness and self-development as it is shown in the study, how that can improve not only the person themselves, but the interaction and cooperation between services too.

Especially, careful thought should be put on considering how to cooperate in situations, where someone is asking help or clearly needs it, despite of not asking it. In addition, stigmatizing patients is a phenomenon that everyone should take seriously and think about how they can in their own actions diminish it to be happening. Furthermore, applying patient centered approach in all practices is highly recommended if thinking of how the study findings are showing patients easily to be forgotten in the middle of confused arguments about what should be done. However, this all is only possible, if the personnel are given time and resources to develop themselves as well as are given free lead that much that they are able to practice flexibility at least at some degree in their daily work.

Some questions have arisen from the research, which might be worth of studying further. At first, the question of the status of psychiatric ward seems to provoke strong feelings. Many times participants emphasized how the status of the "last resort" led easily to stigmatization of patients, bad practices e.g. using the ward as a threat, or having been in the ward to become wanted status among adolescents. However, at the same time, they made it clear, how they wanted the status as a last resort to be even clearer and stronger in order it to be very strict what kind of patients were treated in the ward. As this seemed to raise strong emotions, it would be interesting to study, what is behind it; what is really happening there and in what kind of situations these strong emotions occur.

Secondly, according to the participants of the study, there would be need of research more the efficiency of closed psychiatric ward treatments in adolescents.

Thirdly, as the need for psychiatric training for child welfare personnel was seen as highly important to be increased, the further research could be done in finding their exact needs of mental health training.

10.3 Correlation between findings

The present bachelor thesis work is composed of two different studies – a literature review and a focus group analysis – both having slightly different views on the topic. The literature review has focus on finding good practices to address mental health problems among minors who were in residential care, and the focus group interview was set to find out what kind of experiences psychiatric personnel have relating to cooperation between child welfare and mental health services. However, despite of these different angles many commonalities are found in the results.

Mental health training, cooperation and availability

Increasing mental health training in residential care settings was seen to have a high importance among focus group participants. Likewise, Hummer et al.

(2010, 82) desire staff in residential settings to be trained to recognize and respond effectively to manifestations of trauma that children and youth may present.

According to studies, it is evident that minors in residential care experience more mental health problems (Sourander et al. 1997; Hukkanen 1999; Meltzer et al. 2002; Ward 2006) than their peers cared for by their families at home. Therefore the request by psychiatric personnel of getting psychiatric help and developing psychiatric skills in the child welfare homes where minors live seems justified. In addition, Pitkänen (2009, 38) argues in her bachelor thesis, that adolescents were not always able to deal with their issues in separate and individual visits in psychiatric care. Therefore she similarly with the focus group participants requests for more cooperation between services and for more mental health education and clinical supervision to the personnel of the child welfare services.

Moreover, Ward (2006, 337) argues that the lack of training of residential staff leads on adolescent who have special (mental health) needs to be neglected. This view is supported by both, Pitkänen (2009, 32-33) as well as by the participants of the focus group study. They all are concerned about the lack of mental health knowledge and skills in child welfare institutions and are worried if all residential care homes are able to provide adequate care for adolescents. Especially, because the lack of psychiatric education of residential care staff can lead to hindering the psychological improvement of children (Hukkanen et al. 1999 and Barth 2002).

However, Ward (2006, 343-344) reminds also how it is not only the adequate staff training, which creates feeling of safety and trust among people, but the staff needs to be also quickly available. This according to focus group participants is seen currently as a challenge as adequately trained personnel is not always available especially in sudden escalating situations.

Support, information and clinical supervision

Moreover, Stanley (2007, 264) has identified residential care workers experiencing a lack of information and support from other professionals such as mental health workers, as well as lack of feedback about what they are doing. Similarly the focus group members commented on how the personnel in child welfare institutions did not get the support they needed. In addition, they highlighted how the child welfare personnel would need support within their own services as well e.g. clinical supervision, but were not getting it and therefore requested support from other services too.

Minor – staff relationship

In the focus group interview participants emphasised the importance of the relationship of primary nurse and an adolescent. Positive minor-staff relationship is highlighted by Ward (2006, 341-342) as well, because in a good relationship the personnel could act as a role model for adolescents and thus youth could learn positive behavioural patterns from the staff.

Therefore, the focus group participants were worried how the relationship with the primary nurse and the adolescent is not always realised in the child welfare institutions. Especially, as according to Barth (2002, i), if children in residential care have got no possibilities to close relationships with a significant individual, they are in danger to develop disorders and have more difficulties in life.

In addition, Houston's (2010) article, based on the model of Daniel and Wassell (2002), also highlights the importance of relationship between youth and care personnel. In the research, a model of care was developed in which the stages of assessment, planning, intervention and evaluation are undertaken periodically together with the adolescent. Both, Houston (2010) and Hummer et al. (2010) think assessment of the needs of the children and youth and planning of interventions to cover those needs are essential. In addition, they encourage children and youth to participate in their treatments. Similar ideas are found in the

focus group analysis results as there participants underlined the significance of assessment as well as patient-centred treatment in which the patient's voice would be heard.

Escalating phenomenon

The focus group participants explained the phenomenon, in which adolescents from the same place e.g. school or residential institution, needed the psychiatric attention at the same time. Barth (2002, 7) explores to some extent similar situation by stressing how those children who have behavioural problems influence their peers and those might end up copying their negative behaviour. Thus it can be argued, factors mentioned above: training, cooperation and positive relationship between a minor and staff, could be of help in these escalating situations too.

Turnover rates of personnel

Hummer (2010, 87) and Wards (2010) both noted high turnover rates of staff in residential settings and how that presents problems in the quality of the services provided for children and youth. Respectively, the personnel from psychiatric services had noticed how the constantly changing social worker of the young patients is making their work harder causing the continuity and the quality of the care to be compromised.

Cooperation and integration of professional knowledge and skills

Both, Pitkänen (2009, 46) as well as participants in the focus group interview, suggest including a psychiatric nurse in the team of caregivers in the residential setting. Thus, this person could identify symptoms of mental problems or escalating episodes, and initiate action, either by providing adequate intervention or seeking additional support from mental health services, or both, if needed.

Moreover, the focus group participants saw it important not only to increase the child welfare institutions knowledge about mental health, but to include the knowledge from social services into the psychiatric setting as well. They illustrated how in the past the psychiatric services have had their own social worker placed in the ward, which had improved the cooperation and the care of the patient significantly.

Similarly to the focus group interviewees, Collado and Levine (2007) emphasise the necessity of cooperation between services to be working smoothly, in more flexible manner, as well as the necessity of both parties to understand each other agency's dynamics and procedures. Furthermore, they both had the same view how the psychiatric services should provide their services more on the site where the patients are and not vice versa.

Clear documentation of policies, procedures and agreements

Documentation of policies and procedures is seen as necessary and valuable part of the care in both study results. For example, Hummer et al. (2010) and Collado and Levine (2007) both see the documentation process needed in maintaining clarity, delimiting responsibilities and avoiding misunderstandings. Similarly, the focus group interviewees emphasised the significance of clear documentation not only of policies and procedures, but all network meetings and treatment plans as well.

In addition, the focus group participants desired clear guidelines, agreements in responsibilities and network meetings in which cooperation could take place. This seems to be what Collado and Levine (2007, 139-141) were doing in their process of building trust in the beginning of the program. For example, agreements between agencies were settled down in securing formal letters, the personnel was made familiar with the project as well as guidelines and protocols were created. Furthermore, they had one person designated to coordinate the program, and a psychotherapist, who also consulted caseworkers, was placed to work full-time at each foster care agency. Thus again, fits well with the focus

group interviewee's wishes to have a clear leadership, a mental health professional included into the group of workers taking care of the children as well as child welfare personnel to get clinical supervision and guidance.

Challenging systems and lack of resources

Houston (2010, 359) describes factors believed to constrain the work of social workers e.g. lack of resources/time; challenge of applying therapeutic care; risk averse culture; performance culture and organizational requirements, which goes parallel with the views of focus group interviewees as well. For example, interviewees address difficulties arising from organisational structures e.g. divided services and highlights how it is impossible to implement plans for out-patient services, because there is no money or other resources given for it.

Reducing stigmatization

Finally, one part of the program Collado and Levine (2007, 140) studied was to change the perception of mental health services from a crisis-oriented focus to a less stigmatizing orientation, which empathises more participation of mental health professionals in everyday life issues and common foster care procedures. To some extent this idea is similar to the views of the focus group participants as they also think mental health professionals should participate more in the everyday life of minors in residential care. However, although agreeing with the need for reducing stigma, psychiatric personnel tend to feel it is important to keep psychiatric wards guarded, specialised and not so easily accessed.

10.4 Conclusion

This thesis work has presented children and adolescents in residential care having mental health problems which need to be taken care. In addition, it has shown how, according to both, literature and narratives of the interviewees, some of these needs have been addressed already and good practices do exist. However, clear guidelines, policies and procedures are needed to deliver adequate mental health care for each individual.

Furthermore, it has been found out that in order to practices and treatments to be successful smooth and well functioning cooperation between services is required. Ideally, it has been suggested, this would happen by uniting the social and health care services under the same management or by integrating them by having permanent/own social workers placed on psychiatric wards as well as a mental health nurses into the child welfare institutions.

In addition to integration of professional knowledge and skills, high professional and personal qualities are required from all staff working with children and adolescents. Thus, support, ongoing training and clinical supervision need to be available for the personnel. However, in order to develop services and the care of minors, adequate resources are needed as well.

Finally, this thesis results emphasize, how through out the care, the patient/service user has to stay in the middle of the process and person centred approach need to be applied, which is best done in a positive minor – staff relationship.

.

REFERENCES

Anglin, J. 2002. Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth. Haworth Press, New York.

Barth, R. P. 2002. Institutions vs. Foster Homes. The Empirical Base for the Second Century of Debate. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Berridge, D. & Brodie, I. 1998. Children's Homes Revisited. Jessica Kingsley, London.

Berridge, D. (2002) Residential care. In: What Works for Children? Effective Services for Children and Families (eds D. McNeish, T. Newman & H. Roberts). Open University Press, Buckingham.

Burns, B. J.; Hoagwood, K. & Mrazek, P. J. 1999. Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Review, 2, 199– 254.

CASP UK 2010. Case Control Study Checklist. Accessed on 16.04.2013 at: http://www.casp-uk.net/

Collado, C. & Levine, P. 2010. Reducing Transfers of Children in Family Foster Care Through Onsite Mental Health Interventions. Child Welfare, 86, 5, 133-150.

Daniel, B. & Wassell, S. (2002) Adolescence: Assessing and Promoting Resilience in Vulnerable Children 3. Jessica Kingsley, London.

Dockar-Drysdale, B. (1990) The Provision of Primary Experience Winnicottian Work with Children and Adolescents. Free Association Books, London.

Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. Violence Against Women, 5(2), 134– 154.

Elo, S. & Kyngäs, H. 2007. The qualitative content analysis process. Journal of Advanced Nursing Vol. 62, No. 1/2007, 107-115. Consulted 15.10.2013 http://academic.csuohio.edu/kneuendorf/c63309/ArticlesFromClassMembers/Amy.pdf.

Golafshani, N. 2003. Understanding Reliability and Validity in Qualitative Research. The Qualitative Report Vol. 8 No. 4/2003, 597-607. Consulted 15.10.2013 http://peoplelearn.homestead.com/MEdHOME/QUALITATIVE/Reliab.VALIDITY.pdf.

Graneheim, U. & Lundman, B. 2004. Qualitative content analysis in nursing research: concepts procedures and measures to achieve trustworthiness. Nurses Education Today, 24,105-112.

Graneheim, U.H. & Lundman, B. 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Education Today Vol. 24 No. 2/2004, 105-112.

Hirsjärvi, S. & Hurme, H. 2009. Tutkimushaastattelu. Teemahaastattelun teoria ja käytäntö. Helsinki: Gaudeamus Helsinki University Press.

Hirsjärvi, S.; Remes, P. & Sajavaara, P. 2009. Tutki ja kirjoita. 15., revised edition. Helsinki: Tammi.

Hoagwood, K. & Cunningham, M. 1992. Outcomes of children with emotional disturbance in residential treatment for educational purposes. Journal of Child and Family Studies, 1, 2, 129–140.

Holstead, J.; Dalton J; Horne, A. & Lamond, D. 2010. Modernizing residential treatment centers for children and youth – an informed approach to improve long-term outcomes: the Damar pilot. Child Welfare, 89, 2, 115-130.

Holtan, A.; Ronning, J.; Handegård, B. & Sourander A. 2005. A comparison of mental health problems in kinship and nonkinship foster care. European Child & Adolescent Psychiatry 14, 4, 200-207.

Houston, S. 2010. Building resilience in a children's home: results from an action research project. Child and Family Social Work 2010, 15, pp 357–368

Hukkanen, R.; Sourander, A; Bergroth, L. & Piha, J. 1999. Psychosocial factors and adequacy of services for children in children's homes. European Child & Adolescent Psichiatry, 8: 268-275.

Hummer, V. L.; Dollard, N.; Robst, J & Armstrong, M. 2010. Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change. Child Welfare Vol. 89, No. 2, 79-95.

Hunter, L.; Landsverk, J; Mass, J; Leslie, L.; Hurley, M.; Bellonci, C.; Gries, L.; Pecora, P; Jensen, P. 2009. Best Practices for Mental Health in ChildWelfare: Screening, Assessment, and Treatment Guidelines. Child Welfare, 89, 1, 163-188.

James, S. 2011. What works in group care? — A structured review of treatment models for group homes and residential care. Children and Youth Services Review, 33, 308–321.

Jennings, A. 2004. Trauma informed mental health service systems: Blueprint for action. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Ko, S. J., Ford, J. D., Kassam-Adams, N.; Berkowitz, S. J.; Wilson, C.; Wong, M.; Brymer, M. J. & Layne, C. M. 2008. Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. Professional Psychology: Research and Practice, 39(4), 396– 404.

Landsman, M.J.; Groza, V.; Tyler, M., & Malone, K. 2001. Outcomes of family-centered residential treatment. Child Welfare, 80(3), 351–379.

Meltzer, H., Corbin, T., Gatward, R., Goodman, R. & Ford, T. 2002. The Mental Health of Young People Looked After by Local Authorities in England. Summary Report. A Survey Carried Out by the Social Survey Division of ONS on Behalf of the Department of Health. Her Majesty's Stationery Office, London.

Morse, J.M.; Barrett, M.; Mayan, M.; Olson, K. & Spiers, J. 2002. Verification Strategies for Establishing Reliability and Validity in Qualitative Research. International Journal of Qualitative Methods Vol. 1 No. 2/2002, 1-19. Consulted 15.10.2013 http://www.ualberta.ca/~iiqm/backissues/1_2Final/pdf/morseetal.pdf.

National Institute for Health and Welfare. Official Statistics of Finland. 2012. Child Welfare 2011: Statistical Report.

Parton, N. 2000. Some Thoughts on the Relationship of between Theory and Practice in and for Social Work. British Journal of Social Work, 30, 449-463.

Petrenko, C.; Culhane, S; Garrido, E. & Taussig, H. 2011. Do youth in out-of-home care receive recommended mental health and educational services following screening evaluations? Children and Youth Services Review, 33, 1911–1918.

Pitkänen, J. 2009. Facing Mental Health Problems in Children's Homes: Voices of caretakers.

Rogers, C.R. 1995. A Way of Being. New York: Houghton Mifflin.

Romanelli, L.; Hoagwood, K.; Kaplan, S.; Kemp, S.; Hartman, R.; Trupin, C.; Soto, W.; Pecora, P.; LaBarrie, T. & Jensen, P. 2009. Best practices for mental health in child welfare: parent support and youth empowerment guidelines. Child Welfare, 89, 1, 189-218.

Ryan, B., Bashant, C., & Brooks, D. 2006. Protecting and supporting children in the child welfare system and the juvenile court. Juvenile and Family Court Journal, 61– 69.

Samuels, B.H. 2011. Addressing Trauma to Promote Social and Emotional Well-Being: A Child Welfare Imparative. Child Welfare, 90, 6, 19-28.

Shealy, C.N. 1995. From boys-town to oliver-twist—separating fact from fiction in welfare-reform and out-of home placement of children and youth. American Psychologist, 50, 565–580.

Silius, K. 2005. Sisällön analyysi. Consulted 15.10.2013 http://matwww.ee.tut.fi/hmopetus/hmjatkosems04/liitteet/JOS_hypermedia_Silius150405.pdf.

Sourander, A.; Hukkanen, R. & Piha, J. 1997. Mental Health Among Children in Children's hiomes and in Psychiatric Hospital. Psychiatria Fennica, 28, 183-191.

Stanley, N. 2007. Young people’s and carers’ perspectives on the mental health needs of looked-after adolescents. Child and Family Social Work, 12, 258-267.

Suomalainen Lääkäriseura Duodecim. 2009. Ohje M1-lähetteen täytöstä. Consulted 22.11.2013 http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/nix01384

Törrönen, Maritta 2006. Community in a Children’s Home. Child and Family Social Work, 11, 129-137.

U.S. Department of Health and Human Services, Center for Mental Health Services 1998. Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program.

Valvira. 2013. Valvira. National Supervisory Authority for Welfare and Health. Consulted 22.11.2013 http://www.valvira.fi/en/

Ward, A. 2006. Models of “ordinary” and “special” daily living: matching residential care to the mental-health needs of looked after children. Child and Family Social Work, 11, 336-346.

Webb, M. B. & Harden, B. J. 2003. Beyond Child Protection: Promoting Mental Health for Children and Families in the Child Welfare System. Journal of emotional and behavioral disorders, 11, 1, 49-58.

Turun Ammattikorkeakoulu, Terveys ja hyvinvointi

Resme projekti

Tutkimuslupa

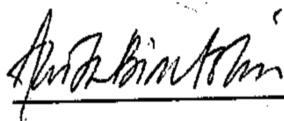
Turun Yliopistollisen keskussairaalan nuorisopsykiatrian klinikan hoitohenkilökunnan osallistuminen RESME projektiin kuuluviin tutkimushaastatteluihin vuonna 2013.

Kansainvälinen RESME projekti (Life long learning ohjelma) pyrkii kehittämään lastensuojelupalveluiden sekä lasten- ja nuorisopsykiatrisen palveluiden välistä yhteistyötä kuudessa Euroopan maassa.

TYKS:in nuorisopsykiatrian klinikan hoitohenkilökunnan jäsen voi niin halutessaan osallistua Turun Ammattikorkeakoulussa toteutettavaan kansainväliseen RESME projektiin kuuluviin ryhmä- ja yksilöhaastatteluihin.

Hoitohenkilökunnan osallistuminen haastatteluihin perustuu vapaaehtoisuuteen. Osallistuja voi peruuttaa tai keskeyttää osallistumisensa, milloin tahansa tutkimusprojektin aikana. Osallistujille kerrotaan tutkimuksen tarkoituksesta ja tavoitteista ennen haastatteluiden alkua. Tutkimukseen osallistuvien henkilöllisyys ei tule esille missään tutkimuksen vaiheessa. Jokaisen henkilökunnan jäsenen vapaaehtoinen osallistuminen haastatteluihin katsotaan henkilökohtaiseksi luvaksi tutkimukseen osallistumiselle.

Turussa 5.3.2014



Anita Birstolin, ylihoitaja

Used transcription characters

Transcription of the Focus Group Interview
– Personnel of the Psychiatric Services

Used transcription characters:

Interviewers:	H1 and H2
Interviewees:	V1, V2, V3 and V4 in addition, Vm = at the same time several interviewees, who were not able to be recognised separately
A unclear word	()
Interpretation of the word or a speaker	(text)
Writers comment/explanation	((text)
Simultaneous speaking	[ ]
Possible identifier made unrecognisable	”Name”, ”Number”, ”Locality”

Results for the qualitative focus group content analysis

1. GOOD			2. BAD				3. IDEAS		
1.1 Current good co-operation	**1.2. Elements for successful co-operation / result**	**1.3. Evaluation criteria**	**2.1. Systems & structures**	**2.2. Influencing factors**	**2.3. Obscurities**	**2.4. Not recommended current practices**	**3.1. Why the change and development is needed?**	**3.2. Organisational & professional reformation**	**3.3 Personal & professional development**
1. Willingness to co-operate	**1**. Assessment	**1.** Patient has got the help	**1.** Non-patient-centred system	**1.** Distorted communication	**1.** Misguided expectations	**1** Forgotten patient	**1.** The best interest of the patient	**1.** Structural development	**1.** Cooperation to be seen as a resource
2. Experiencing empathy towards the other party	**2**. Clarity & understanding of responsibilities	**2.** Patient is able to continue their life	**2.** Separated and/or overlapping services and organisations	**2.** Lack of research / evidence	**2** Conflicts	**2.** Vicious circle	**2**. Development of clear systems and procedures	**2.** Creating appropriate, flexible and patient-centred services	**2.** Respecting and appreciating others
3. Recognising existing good co-operation	**3**. Network meetings		**3.** Lack of clinical supervision	**3.** Background, social factors & community	**3.** Lack of mutual goals	**3.** Disrespectful and unconstructive behaviour and attitudes	**3.** The world has changed and is changing	**3.** Sharing tasks and responsibilities	**3.** Maintaining trust on capabilities and skills of other professionals
	4. Keeping the best interest of the patient in mind		**4.** Lack of resources		**4.** Uncertainty about the course of action	**4.** Stigmatising patient	**4.** Lack of appropriate services	**4.** Training, supervision and resources	**4.** Knowing and finding out instead of supposing
	5. Acting according to common aims		**5.** Inaccessible services		**5.** Lack of trust towards the partner in cooperation	**5.** Misuse of psychiatric ward treatment			**5.** Continual professional development – knowing one's own field of work
	6. Seeking help/advice from the other party		**6**. Constantly changing personnel		6. Irregularities				**6.** Continual professional development – knowing partner's field of work
	7. Giving guidance and answering for the requests of support		**7.** Inadequate operation or/and control of the third sector.						**7.** Unravelling a stigma
									8. Maintaining positive perspective & recognising good things
									9. Recognising things which are not working