

Residential child care and mental health practitioners working together

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Abstract

This article reports on research and professional development activities across six European countries, including Scotland, looking at the boundary issues that arise when children require both residential child care and mental health services. It locates Scottish findings within a wider European context. The intention of the project was to enhance mutual understanding and improve inter-professional working between the two services through the development of a joint training programme. However, the research identifies widespread and persistent divergences in the status and respective expectations of the two groups of professionals. It is suggested that these differences are not readily resolved through simple exhortations for better inter-professional working but may reflect more fundamental divides in status but also in professional knowledges. A conclusion that might be drawn is that residential workers cannot rely on the kind of expert support they might like from mental health professionals and hence have to find ways of addressing children's mental health difficulties within contexts of everyday care.

Keywords

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Introduction

This article reports on a project (RESME)¹ funded through the European Union's ERASMUS (European Community Action Scheme for the Mobility of University Students) Lifelong Learning Programme, involving six European partners: Scotland, Finland, Spain, Germany,

¹ European Union projects are identified through acronyms. In this case RESME brings together the terms RESidential care and MEntal Health

Lithuania and Denmark with distinctive historical backgrounds, socio-economic models and welfare traditions. Esping-Andersen (1991) provides a useful starting point in categorising types of welfare states, identifying three broad categories: social-democratic, conservative and liberal. The range of countries involved in this project spanned all of these, including two (Denmark and Finland) representing Scandinavian models of the Welfare State, one (Germany) operating within a Central-European model with a long tradition of public health services, one (Scotland) being a devolved partner in the British model, one (Lithuania) representative of the post-communist transition states in Eastern Europe and one (Spain) representing a Catholic, Mediterranean Welfare State. While most of Europe has witnessed a shift away from institutional care towards greater use of family or community based resources, there nevertheless remain marked differences across the participating countries. In Scotland, for instance, the use of residential care is particularly low (less than 10% of the total numbers of children in care), while other countries tend to use residential care more often – in Finland, for instance, 38% of the total numbers of children in care are in residential care and in Spain, 40% (Timonen-Kallio et al., 2015). Such comparisons, however, were not always straight forward as different countries applied different definitions to what they understood to be residential care. This could be further complicated by examples from project partners of definitions being manipulated to meet targets for reducing their country's use of residential care.

The Scottish partners were the University of Edinburgh and Kibble Education and Care Centre in Paisley. The subject matter of the project was negotiated in an initial partner meeting where all of the countries identified difficulties with that group of children and young people who operate on the borderline of residential child care and mental health services. Consequently, a proposal was developed to scope the nature of the problem and to produce educational materials to assist better collaborative working between professionals working with children at this interface. Two assumptions underlay the focus of the project: firstly that better cooperation between the residential care workers and mental health workers was desirable and would lead to improved outcomes for children. The second was that the research would uncover 'best practices' which could be 'scaled up' and 'rolled out' more widely through the development of an educational programme targeted at both groups of workers. These aims fit with two policy directions across much of Europe, a push towards better inter-professional working and a concern to roll out ways of working that are identified to be effective, all within a more general rubric of evidence based practice.

This article reports on some of the findings of the research and goes on to discuss whether these initial aims were realistic or whether there may be some fundamental divergence in professional status and knowledges that render problematic simple conclusions about the need for better collaborative working and the idea that we can identify and replicate best practices.

Context

It has been estimated that about 10 to 20 % of children and adolescents suffer from mental health problems worldwide (Braddick et al., 2009). Children and adolescents in out-of-home care are at much higher risk of mental health problems (Shin, 2005; Besier et

al., 2009). In some studies, as many as 80% of young people involved with child welfare agencies are adjudged to have emotional or behavioural disorders, developmental delays, or other indications suggesting mental health intervention (Burns et al., 2004). Moreover, those young people living in out-of-home care with mental health problems continue to experience mental health problems in adulthood (Shin, 2005).

The World Health Organisation Mental Health Declaration for Europe (2005) highlights the need for comprehensive evidence-based policies targeted especially for vulnerable groups such as children and adolescents. Against this backdrop of policy interest, there are few studies that report on collaboration between residential care and mental health services. Those that do suggest a need for better collaboration between services and personnel (Darlington et al., 2004) to ensure effective child welfare (Sloper, 2004). Collaboration among these two agencies is argued to improve children's experience of mental health services (Bai et al., 2009). However, there is little knowledge of what better collaborative practice might look like (Ward, 2006). Darlington et al. (2005) report difficulties in collaboration between these services around issues such as information sharing, communication, and confidentiality. Darlington (2005) and Davidson et al. (2012) both identify inadequate training and lack of knowledge of each other's respective disciplines. Nevertheless, they conclude that collaboration is of benefit to both workers and clients (Darlington & Feeney, 2008).

The Scottish Context

Scotland's approach to all child care issues is located within the Getting it Right for Every Child (GIRFEC) agenda, with Health being included within its list of wellbeing indicators. The thrust of GIRFEC is to provide adequate levels of support for all children and for considering the needs of children with additional support needs within a universal framework of children's needs.

The past decade has seen greater attention being focused on children's mental health. The Scottish Needs Assessment Programme (SNAP) Report on Child and Adolescent Mental Health in 2003 (Public Health Institute Scotland, 2003) emphasised that all agencies and organisations have a role in supporting children and young people's mental health. It set out three core themes that have underpinned policy in Scotland ever since. These are: the right of children and young people to be heard, the importance of mainstreaming mental health and the integration of promotion, prevention and care (White et al., 2012). The SNAP Report led to the establishment of Child and Adolescent Mental Health Services (CAMHS) for children who experience mental health problems.

CAMHS main function is to diagnose and treat children and adolescents who experience the most serious mental health problems (White et al., 2012). CAMHS teams include psychiatrists, psychologists, nurses, social workers, and a range of other therapists (Scottish Executive, 2005). CAMHS are typically considered as a 4-tier service ranging from support from universal services such as teachers, social workers, school nurses and health visitors to highly specialist hospital inpatient units. In this sense, the tiered level of CAMHS support echoes although precedes GIRFEC.

Access to CAMHS is typically through General Practitioner (GP) referral. That is, the young person would attend the GP who would refer if a mental health problem was considered to be clinically indicated. Services vary, however, in their mode of operation across Scotland. Edinburgh, for example, through its Edinburgh Connect service has linked CAMHS workers with residential units, thus facilitating local relationship building and responsiveness.

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

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

The issue of the mental health needs of children in residential care was highlighted *in extremis* in recent years with the death of two residents of the Good Shepherd Centre as a result of jumping from the Erskine Bridge. The Inquiry into these deaths (Anderson, 2012) recommended a series of protocols and guidelines for the management of children thought to be at risk of suicide. This article suggests that questions of addressing the mental health needs of children in care require more than protocols and guidance and calls for a wider examination of relationships and mutual expectations that exist between residential child care and mental health workers.

Methods

Initial research was undertaken involving a systematic international literature review, summarised above. National reports were prepared by each of the partner countries outlining the background and current organisational arrangements for mental health and residential child care services. This was supplemented by interviews and/or focus groups with relevant professionals in each country. Forty-five interviews and three focus groups were conducted across the partner countries (total n = 59). Participants were from a residential care background (n = 36) and from different areas of the mental health sector (n = 23). All interviewees had at least five years of work experience in their respective fields. Country-level researchers collected and analysed the interview and focus group data and fed this into national reports along agreed guidelines to allow for cross-country comparison. The data was analysed using a Qualitative Content Analysis approach, searching for patterns, contrasts, paradoxes and irregularities in work practices between the two sectors. While we attempted to ensure a degree of standardisation of approach, the reality was that there were variations in numbers and composition of respondents across the different countries, which made systematic comparison difficult. Different models of professionalisation and service delivery across the different countries (for example all countries other than Scotland had social pedagogy or social education professions undertaking care roles) could also make direct comparison difficult.

A central purpose of the research stage of the RESME project was to provide a platform from which we might construct a curriculum to be delivered jointly to residential care and mental health workers. Some of the issues that arose from this process are reported elsewhere (Timonen-Kallio et al., 2015). The remainder of this article focuses on some of the questions that the research stage pointed up in terms of the two groups of professionals working together, which perhaps merit some awareness or further exploration if joint working is to become more effective.

Findings

The findings from the various country reports were remarkably similar across each of the research sites. Perhaps the most striking finding was that it proved difficult to identify examples of consistently good practice. Each country identified common and persistent difficulties that arose when working at the interface of mental health and residential child care services. We have themed these under the following headings: understanding of role, status differentials, divergent expectations and useful knowledges.

Understanding of role

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

The attempt to create a 'family home' type atmosphere was particularly pronounced in countries where social pedagogy has a strong influence. In Spain, for instance, the growing numbers of young people admitted to children's homes with severe disruptive behaviours and the consequent demands on staff to be more specialised or therapeutic could be seen as representing a breakdown of the family model. Therefore, specialisation was criticised and clinical contributions were evaluated as stigmatising and contrary to the socio-educational model.

Status (and language)

Status differentials were evident across all countries; residential workers perceived that they were undervalued by society, certainly in terms of salaries. Beyond just financial

recompense, though, psychiatrists enjoyed a generally higher professional status than child care workers. This differential was viewed as a serious handicap by child care workers in reaching a position of real cooperation, as they perceived mental health professionals as having the last word and the power to take decisions. Specific manifestations of this status differential were evident in seemingly small things such as the expectation that joint meetings were almost always held in mental health offices, which gave the impression that psychiatrists' time was more valuable than their own.

In every country there were tensions around whether a particular case was considered to reflect a clinical problem or a social/environmental one. Often, child care staff might refer a child, believing that there was a clinical issue requiring specialist intervention only for mental health professionals to conclude that the problem was due to social and environmental factors and there was no diagnosable mental disorder. As a result they did not offer the kind of specialist intervention that child care staff were looking for and essentially referred the case back for the kind of socio-educational or care response that they believed care workers ought to be able to offer. Residential care workers felt that they would not be referring children to mental health services if they did not feel that they were confronted with behaviours beyond those that could be addressed in an everyday context and, as a result, regularly felt let down by such responses.

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

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

In most countries child care workers felt that initiatives to bring about better cooperation invariably come from the child care system. Yet, when child care services did organise training courses about residential care and mental health problems and invited mental health professionals to attend, it could be difficult to get them to do so. This finding was confirmed in the Scottish project where we struggled to get mental health workers to attend the training programme.

Divergent attitudes and expectations

Mental health staff across all countries felt that care workers harboured unrealistic expectations of what they could do. There was a sense that they ‘ask for miracles’, ‘wait for a miraculous medication’, ‘want very fast results’. Of course, child care workers make such demands under pressure and in circumstances of acute anxiety, sometimes asking for concrete interventions and diagnoses to support their own perception that behaviours and needs are beyond what might be understood within a ‘normal’ range of behaviours and must signify some psychiatric disturbance. It is perhaps understandable that they could feel annoyed when mental health professionals did not agree.

On the other side, mental health staff often complained that residential workers attending appointments with children had a serious lack of information about the family background, medical history, and personal circumstances of children. Moreover, when treatment extended over a long time it was common that residential workers accompanying children changed and different people appeared. Without knowing essential information and without stable adults to refer to made any therapeutic intervention difficult. An example of the paucity of information that is available at times was offered by a psychiatrist who commented that a child had been moved to another residential placement and only the child talked about this fact to the therapist.

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

Lack of useful knowledge

There was no common view about the knowledge residential workers have or ought to have about how to manage behavioural problems. There was a unanimous opinion across countries about the expectation and need for guidance and advice about how to work with challenging children. A common perception was that residential workers lacked practical advice or strategies as to how to work with the most challenging children. When mental health professionals did offer advice it could be felt to be overly simplistic and general, such as ‘*the child needs love*’. One of the Scottish respondents commented that ‘*we need to know how to do not only what to do...*’. This kind of clarity of advice was rarely felt to

be forthcoming, contributing further to the sense of mutual frustration in inter-professional relationships.

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

The Scottish situation

The wider concerns outlined above largely reflect and are reflected in the Scottish findings, albeit there was no one model of practice across the country. Particular concerns were expressed about the lengthy waits in many areas of the country from referral to a child being seen by the CAMHS service. Residential workers could feel that they had done much work to get a child to the point of agreeing to a CAMHS referral only for the waiting time to give the impression that the child's problem was not treated with due seriousness.

The Edinburgh Connect model seemed to offer possibilities for overcoming many of the difficulties identified above. Within this model CAMHS staff spend time in children's homes and work from the assumption that cooperation is successful when everyone has a holistic and realistic understanding to the young person's presenting behaviours and this is communicated to all staff (including domestic staff). This level of connection allowed CAMHS staff to be proactive in identifying problems and offering advice but also offered children's homes the chance to think ahead and call in to say that they were concerned about a particular child or situation.

Ironically, perhaps, this model, which sought to locate mental health within a broad social context, could be criticised on the basis of its ordinariness and what could be seen as a perceived lack of expertise among CAMHS practitioners, who came from a range of different professional backgrounds. This 'ordinariness' might be contrasted with an image of the psychiatric 'expert' that residential workers might like to imagine were available to offer insights and treatment. This tension is reflected in the following exchange from a focus group

I. Are you seen as the experts?

R2. We try not to be.

R1. I think it is very important to find a common language ... I think very often in CAMHS, they are seen as experts, they don't speak the same language and it is about finding that common language and actually it is about demystifying mental health ... But of course you still find that residential units don't really want us because we are just ordinary and they know us, so they really want the real people (the psychiatrist). And that is something that we sometimes have to deal with.

Edinburgh Connect staff also identified contextual factors that could impact on the effectiveness of inter-professional working, around, for instance, how seemingly settled a children's home was at any point in time. When it was settled, staff were better able to understand the nature of the support CAMHS could offer. At points of crisis, they tended to look for more concrete and immediate advice and strategies.

Discussion

It is clear across each of the European countries studied that, while there may be pockets of effective practice on a local scale, there is no definitive model of 'best practice' in inter-professional working between mental health and residential care workers that might be 'rolled out' more widely. We have identified a number of structural and cultural barriers to such an approach. This is an interesting finding inasmuch as it challenges the assumption upon which the project was initially constructed. Specifically, the intention to improve inter-professional working perhaps underplayed some of the existing knowledge on how difficult this can be (e.g. Brown and White, 2006). It also perhaps was unrealistic in hoping that we might find examples of good practice and then seek to boost the scale and pace at which these were taken up across the partner countries. Again, the literature points to the difficulty of trying to do this across disparate sites and in different contexts, either internationally or locally; there is no commonly understood or universalisable 'best practice' on this issue. Askeland and Payne note, 'the creation and use of knowledge within a profession is a social process' (2001, p. 13). It is constructed and co-constructed in localized contexts by those involved in professional practice. Attempts to improve practice in this or any other area need to start from an appreciation of local context. In this case, for example, against a backdrop in Scotland of increasing austerity but also uncertainty about the future qualifications landscape in relation to residential child care, it was unrealistic to expect agencies to release staff for the extended periods of training initially envisaged by the RESME project.

Another finding that we might posit is an epistemological one, epistemology being concerned with the nature of knowledge and knowing. The difficulties identified in working across the professional boundaries of residential child care and mental health, encountered across all of the partner countries, was not due to ill-will on the part of the professionals themselves or even to status differentials. Rather, it might suggest that they come from different ways of knowing and understanding their respective worlds. Holligan et al. (2014) in a recent article in this journal initiate an important discussion about the epistemological positions that underpin policy and practice. They note that dominant perspectives derive from Enlightenment thinking, that period of great scientific and philosophical advance that swept across much of Europe in the 17th and 18th Centuries. Enlightenment ideas privileged positivist ways of knowing, based on an understanding of the natural sciences that were seen to be 'value-free, mathematized and scientific' (St. Pierre, cited in Holligan et al., 2014, n.p.).

The dominance of a positivist epistemological paradigm has a knock-on effect for the professions. Those, such as psychiatry, based around what can be thought of as 'hard', technical-rational or scientific knowledge are thought to possess a more robust and useful knowledge than professions such as social work and residential child care which operate in

what Schon (1983) calls the 'swampy lowlands', where knowledge is messy and hard to pin-down. In the context of this research, residential workers might be thought of as operating on these swampy lowlands; they are what Cameron (2014) calls experts in the everyday, generalists rather than specialists. Their epistemological foundations are moral and practical, rather than scientific and technical (Moss and Petrie, 2002). This is a messier form of knowledge. And, perhaps because of this, it is less valued. Tasks like getting children up in the mornings, creating a homely environment and encouraging a concept of citizenship are inherently value laden but also require practical 'hands-on' interventions from practitioners. So, when it comes to dealing with behaviours that they do not understand, that seem to be located within a mysterious psyche, residential workers often do not value their own knowledge but may fall back on a quest for a harder, more valued 'scientific' knowledge. And they can experience frustration when this does not materialise.

This highlights a fundamental problem for residential care. In an important, if brief, paper, Phelan (2001) notes that 'treatment language reflects frameworks that do not have a "fit" for the kind of work which child and youth care practitioners do'. Bondi et al (2011) argue that technically rational forms of knowledge are problematic in 'people professions' such as social work and residential care. Improved practice needs, not just political exhortations towards improved inter-professional working or more organisational protocols but recognition of the distinct form of knowledge that residential workers can bring to addressing children's mental health needs in the context of everyday living. This is not easy as the very 'everydayness' of residential work 'can mask the very sophisticated and complex interventions' that residential workers do' (Phelan, 2001, n.p.).

Perhaps what is most needed in practice in working with children with mental health issues is to enhance the confidence of those who work most closely with children. As Brown and White (2006, p.16) argue 'attention should be given to improving the organisational climate of agencies rather than increasing organisational co-ordination or the kind of protocols that go along with such efforts. Organisations where staff reported greater job satisfaction, role clarity and fair organisational practices were found to deliver significantly better outcomes for children and families'. This perhaps ought to direct attention towards enhancing the public and indeed self-perception of residential care workers in terms of what they do know and can offer children and young people with mental health difficulties in the context of everyday care.

Conclusion

So, where might all this leave us? It does not mean that residential care workers and mental health workers cannot and should not aim to work better together. It does not seem realistic, however, on the basis of this project to assume that improved procedures or even arrangements for joint training will alone improve practice. Such an aspiration assumes an equality of status that does not exist but it also masks underlying epistemological differences between the professions. The distinction between the specialist and the generalist, between scientific and practical knowledge, is real and deep and cannot readily be glossed over through better procedures or greater exhortations to work more effectively together. There are perhaps two fruitful avenues for improvement

in this area of policy and practice. The first is, undoubtedly to maintain a dialogue. The literature on inter-professional working and on knowledge exchange highlights the centrality of personal contact – effective inter-professional working is more a social process than it is a policy or procedural one. But for this dialogue to be meaningful may require that residential workers need to feel confident in their own role before they can make the most of what other professionals can bring to the table in pursuit of improved outcomes for children.

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