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

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Annotation

The goal of the article is to discuss mental health services at tertiary level for children from residential care in Lithuania from professionals' point of view. Content analysis revealed several topics, three of which are discussed in the article: professional responsibilities and relations with other professionals, inter-professional collaboration inside and outside organizations, main obstacles for mental health services provision. Research data showed that responsibilities of different professionals (doctors (psychiatrists), psychologist and social workers) are clearly understood and separated. Also, interconnections are found, however, these interconnections reflect not only different professional identities, but hierarchical relations, as well. There is inter-professional cooperation inside and outside mental health and child care organizations. Lack of communication, organizational restrictions, imperfection of health care system and personal factors were identified as the main obstacles for a good practice. The key challenge is the collaboration at tertiary level when a child is hospitalized. Both sides, mental health and child care services providers, see the problems concerning communication, interconnection and continuation of services. The data reflected not only problems of inter-professional cooperation between mental health and child care organizations, but also not good regulations of information flow between professionals, as information could be provided only from the same professional to the same professional. It is not clear how other professionals, such as social workers, group teachers–supervisors, could receive this information in child care system. Usually, it varies from case to case and depends on regulations of a specific child care organization or personal interest of a professional.

Keywords: *mental health services at tertiary level, residential child care, professional responsibilities, inter-professional cooperation, obstacles for mental services provision.*

Introduction

World Health Organization (WHO) in the documents states the urgent need for improving mental health services for children and adolescence. ATLAS report (2005, 2011) by WHO states that there is a necessity for clarifying child and adolescent's mental health policies and guidelines. Prevalence of child and adolescent mental health disorders is approximately 20% and 4–6% of these young persons need clinical placement and observations. European Union follows WHO recommendations and has been implementing principles of Mental Health Declaration for Europe (2005) and principles of Green Paper Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union (2005). Mental Health Declaration for Europe (2005) highlights in the action plan for mental health that vulnerable groups, such as young people, are in special need for mental health treatment and services. Mental health services for children in Lithuania are also regulated by different legal documents (e.g., LR Seimo nutarimas "Dėl psichikos sveikatos strategijos patvirtinimo (2007), LR Sveikatos minsitro įsakymas "Dėl vaikų ir paauglių psichiatrijos ir psichoterapijos paslaugų organizavimo principų, aprašymo ir teikimo reikalavimų (2000)).

The scope of the problem documents relevance of the research. 606 children with moderate or severe disability are living in childcare institutions. Special needs have been established to 1,875 children; mental illnesses – to 318 children; emotional, behavioural and social development disorders – to 899 children. According to the statistics, 1,412 children with emotional, behavioural or social development disorders were in need of medical aid (The Social Report 2011-2012, 2012).

Different researchers proved (Stokes, Schmidt, 2012; Leathers *et al.*, 2009; Besier *et al.*, 2009, Baia *et al.*, 2009; Darlington, Feeney, 2008) that one of the key factor in providing efficient mental health services for children is inter-professional cooperation of practitioners. Psychiatrist, psychologist, nurses deliver mental health care and social workers are the main persons in providing child welfare services. Children suffering from mental disorders have a large number of different needs and for their satisfaction integrated psychosocial services are needed. Psychosocial environment of residential care raises additional challenges. Moreover, when a child is in residential care, inter-professional team increases in numbers, as practitioners from child care institution have to play an active part in services provision. Therefore, the research question is what kind of cooperation there is between mental health and child welfare services providers?

The goal of the article is to discuss mental health services at tertiary level for children in residential care in Lithuania from professionals' point of view. The object of the research is provision of mental health services.

This topic lacks attention among Lithuanian researchers. The issue has been discussed either from mental health (Psichikos sveikatos, 2007) or social work (Petrauskienė, Skrickaitė, 2010; Petrauskienė, Skrickaitė; 2010, Petrauskienė, 2007) point of view. This is the first such type of research in Lithuania, which joins mental health and child welfare services providers' opinion about the same issue – mental health services at tertiary level for children in residential care.

1. Methods

Data Collection. In order to analyse the issue in a deep way and find the answer to it, a methodological part is needed. Few main data collection and data analysis methods were used to obtain data and interviewees' opinion of this research – qualitative structured interview method (in order to collect data) and qualitative content analysis (in order to analyse and interpret the collected data). The interviews were made with reference to the principle of deep knowledge and individual experience based on the issue; the interviews and its questions were structured and formulated in advance.

The research was carried out in the period of March–May, 2013 in Vilnius, Lithuania. 5 interviews were done. The interviews lasted from one hour and a half to one hour and forty-five minutes. All interviews were recorded to a dictaphone, then transcribed and entered into separate computer files, maintaining anonymity and confidentiality.

Participants. In order to find out professional knowledge and experience in mental health and child care practice, five individual interviews were carried out with professionals working at mental and child care organizations. Nonprobability purposive sample was used. Two professionals – a social worker and a psychologist working at psychiatric hospital – represented mental health services, whereas three professionals – a psychologist and two social workers at (different) child care organizations – represented child care services. All informants were women, having university education and professional experience in the field for 2–10 years.

Data Analysis. For data analysis, qualitative content analysis with a direct approach was done. Interview data in the article is not a direct translation of interviewed people speeches, therefore, quotation marks are not used. However, the attempt to keep interview texts as authentic as possible was made. Validation of the data was done in two ways: by a researcher–report writer and a researcher–interviewer. In the first case, content analysis formulating categories and subcategories was done by extracting interview data, when the data analysis was

done, the report text was revised by reading the whole interviews once more and comparing the meanings. In the second step, written analysis was read and validated by the researcher–interviewer, who was in the field, knew it and was more sensitive to the context.

Ethical issues were taken into account. The respondents were informed about the aim and the process of the research, there was a free will of participation. Confidentiality was ensured. The data is presented in a generalized manner.

2. Professional responsibilities and relations with other professionals

For effective cooperation, a clear distinction of responsibilities is needed, at the same time interconnections with other professionals are essential in service provision.

The interviewed people clearly defined responsibilities in providing services for a child. The main responsibilities included the following: of psychiatrists: *they are more oriented to medical help (4)*; of psychologists: *there are two main tasks: assessment and consultation (2), we are like mediators between inner world of the child and other people, we can help the child to understand himself/herself better, and to help others to understand better the child (4), provide recommendations (2);* of social workers: *my main work is to organize occupational activities. I also consult and cooperate with different institutions, involve in problem solving process. I could say my work is very complex (1).*

The interviewed professionals saw the interconnection of their own profession and other professions, e.g., the interconnection of the psychologist and the social worker, the psychologist and the psychiatrist from a psychologist point of view: *work of the psychologist and the social worker could overlap, for example, we [psychologist] also can train social skills and social workers can consult children (4); they look at psychiatrist differently as they can provide a receipt, and it is easier; but from the psychologist they are waiting for a miracle (4).*

Social workers identified themselves as being closer to a client: *We are not doctors or psychologists, who keep distance from a client, we always know more about a client than they do (1).* However, social work and the social worker is not valued: *nobody says to me directly, but there are other things like nonverbal communication, I can feel that social work is not prestigious (1), our government's and public opinion about social work is stereotypical, it is devaluated (5).*

From a social worker's point of view, the interconnection of the social worker and the psychiatrist, psychologist reflects not only cooperation, but also superiority over the social worker: *doctors ask us about, for example, how a child communicates with others, then I search for such information, phone, or, for example, some unclear situation about child schooling (1), I always try to consult with a psychologist, doctors, how to communicate with a child if there are some difficulties (1).* The provided quotations illustrate that the social worker usually fulfills the requirements of doctors or asks for help from the psychologist and allocate themselves at different levels. The interview data also show with which professions social workers associate themselves closer: *all professions are very different, maybe there are more similarities between doctors and psychologist because they do similar activities, and social workers, I would say, they are closer to nurses (1), doctors and psychologists, they are somewhere high, and social workers with nurses are somewhere at a lower level (5).*

The research data showed that responsibilities of different professionals (doctors (psychiatrists), psychologists and social workers) are clearly understood and separated. Also, interconnections are found, however, these interconnections reflect not only different professional identities, but hierarchical relations, as well.

3. Inter-professional collaboration inside and outside organizations

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

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

In mental health settings, inter-professional collaboration is a daily routine and is natural: *At the department level [in the hospital] we are all together, doctors, the psychologist, the social worker, nurses, we meet and we talk, we have like mini meetings and we have meetings for specific cases. We do not need to put some special efforts for that, we are at the same time at the same place and work (2).*

In specific cases, additional efforts are put and initiation of it reflects hierarchical structure of the organization: *It depends on every case. If we have an urgent case, we always mobilize ourselves and all professionals work together as a team […]. Most often such initiative comes from doctors or the psychologist (1).*

In child care settings, inter-professional collaboration is also structured: *We have case discussions every second Monday, also organizational meetings, round table discussions (3).*

It also reflects hierarchy at both types of organizations, as it is the responsibility of a formal leader: *Usually, the doctor leads multi-professional meetings, sometimes – the psychologist, but looking at hierarchical structure, the doctor has the biggest responsibility (2). The director initiates and leads meetings, then distributes tasks, asks for info from different professionals (3).*

Inter-professional collaboration outside organization differs in mental health and child care settings. The research data proved to be controversial from mental health and child care service providers.

While a child is in a mental health setting, this organization leads cooperation and two parties participate in it: *In the case of child care, we need to work with professionals from child care institution. Usually, we have two meetings with professionals from the child care institution, at the beginning when they bring a child, and at the end. But what we really lack, it is the meeting in the middle (2).*

If the social worker tries to initiate such meetings at the hospital, he/she usually faces resistance from child care organization: *They [child care organization] are not interested, it is like they brought a child and forgot him/her. It is like this child does not exist anymore. I phone them and remind about the child. And a common answer is – what? Already to take home? So soon? Such is our collaboration (1).*

The same situation from the child care organization point of view looks differently: *If they [from mental health institution] phone usually only to tell us that it is time to take a child home. They do not phone to invite for a conversation. We have the first meeting, when we arrive with a child to hospital, they collect information, it is obligatory for them, and after that the final one, when we come for a child. If you want a meeting in between, you have to ask for it (4).*

For the transition from mental health services back to everyday environment, the psychologist prepares recommendations. If a child is in child care, often these recommendations substitute the final meeting and that means that mental health and child care professionals

do not have any direct personal contact: *It could be in words or in a written form; we do not have strict rules for that. We do not write recommendations in all cases, but in reality, if a child is from child care institution, we do that in written as we do not know who will come to take a child, if this person knows or does not know a child, will understand or not, what we will tell (2).*

Professionals in child care services face challenges concerning recommendations and extracts from the health history: *We receive recommendations at the end. Written recommendations are very short, some pattern sentences. If we want detailed information, we have to ask for them and to tell where to send. As they send only for a family doctor [primary level] or a child psychiatrist [secondary level] or a psychologist, not for us, they cannot give it to us as a child care organization. Only professional to professional (5).*

The quotation from the social worker at a psychiatric hospital could be one explanation of the situation: *For me, cooperation is like a network of different fields and different professionals, who communicate with each other for one common goal, that it would be better for a child, but if we keep relation only with one person from a team, this imbalances everything, then it is only the relation between two people, but not cooperation (1).*

The research data showed that inter-professional cooperation is better inside than outside mental health and child care organizations.

4. Main obstacles for mental health services provision

According to the informants, the main obstacle in providing services is the lack of communication between institutions. Professionals at mental health settings blame those, working in child care institutions and *vice versa*.

From the social workers working at mental health institutions point of view, child care workers pay not enough attention to a child, who is in a mental health setting: *They bring a child to us and leave; nobody takes care of them, nobody phones them, or brings clothes only for one day, no toothbrush (1).*

Very often a child is brought to mental care institution only by a driver, who does not know the child at all and cannot provide any information about him/her. Child care organizations explain the situation in the following way: *Who takes a child to a hospital? We have a staff person, who is responsible for children health, so it is his/her responsibility. But in reality it depends. Sometimes she is very busy, then a group teacher goes or anyone who is free at that moment. It is a problem, if the group teacher leads; it means that he/she leaves all other children without supervision. I can imagine that they [at psychiatric hospital] have many arguments for that (4).*

From the mental health point of view, child care institutions have unrealistic expectations and do not recognize their own responsibilities: *They expect that a child will come back totally recovered, normal, to behave like an angel. And they think that they do not need to invest in treatment of the child, very often it is not child's problem, but the problem of his environment (1). When a child is at our institution for a child care institution it is like relaxation time, it seems for them that the child does not exist (1).*

Organizational structure of the institution also could cause obstacles: *Our organization as a hospital is very big, there are a lot of levels, sometimes it is difficult to cooperate with other institutions because of that, for example, if I need something I need to get many signatures, I even do not know exactly whom, as I am at the lowest level in my department (2). We get good recommendations from the hospital, but we are not able to implement them, for example, we*

are not able to give him/her so many personal attentions or change other children around him/her. One or two group teachers–supervisors have around forty children, it is impossible to follow recommendations. The main obstacle is a big workload and time limits (4).

Imperfection of health care system was mentioned as another obstacle: *The majority of children [at psychiatric hospital] are with behavioural problems, or emotional, it means that they do not have "real" diseases, for which medical treatment is necessary. For them, it is more important to have structured environment, clear requirements, rules, occupation. Yes, we have all of that at the hospital and when a child comes back home, it should continue (2). I think we do not have appropriate institution for such kind of children. They cannot be in a regular hospital but the psychiatric hospital is too strong for them, all these medicaments. I understand that when we take a child there, it is like a punishment for him/her for not good behaviour, but I do not have another option (3).*

Personal attitude was also mentioned as an important factor for cooperation: *There is lack of willingness, not competences (2), we need to understand each other and to accept, accept that other person could have a different view and a different opinion (3), it is much more easier when you have personal relations (5).*

Thus, it could be concluded that lack of communication, organizational restrictions, imperfection of health care system and personal factors are the main obstacles for a good practice.

5. Discussion of the results

Three topics discussed in the article allow describing what kind of cooperation there is between mental health and child welfare services providers.

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

The research data showed that inter-professional cooperation is better inside than outside mental health and child care organizations. Researches (Baia *et al*., 2009; Ward, 2006) showed that cooperation among these two systems can improve children's mental health use. Darlington and Feeney (2008) added that both sides – services providers and clients – benefit from such cooperation. Different authors defines different barriers for cooperation, e.g., Darlington and Feerley (2008) named inadequate resources, lack of confidentiality between professionals, gaps in cooperation in interagency process, unrealistic expectations between disciplines, discrepancy between professional knowledge domains and professional boundaries. In the Lithuanian research, lack of communication, organizational restrictions, imperfection of health care system and personal factors were mentioned as the main obstacles for a good practice. Darlington and Feeney (2008) also acknowledged that communication along with professional knowledge and skills as well as adequate resources were important for a

good cooperation. Davidson *et al.* (2012) in his research found that inadequate resources and unclear structure in the systems hinder a good cooperation.

Both sides – mental health and child care services providers – see the problems concerning communication, interconnection and continuation of services. Janssens *et al.* (2010) emphasized that a good partnership should develop only in an atmosphere of mutual respect and with intention to provide the best care for a child. The data from Lithuania showed that the attention of mental health and social welfare practitioners is paid to a child very rarely and the child is remembered mostly in the case of contradictions among the services providers, but not in discussions about the best interest of the child.

The data reflected not only problems of inter-professional cooperation between mental health and child care organizations, but also not good regulations of information flow between professionals, as information could be provided only from the same professional to the same professional. In child care system, it is not clear how other professionals, such as social workers, group teachers–supervisors could receive this information. Usually, it varies from case to case and depends on regulations of a specific child care organization or personal interest of a professional. This example shows irregular, case-varied activities, which, according to Janssens *et al.* (2010), could not lead to a true cooperation.

Conclusions

Qualitative research data analysis revealed that cooperation between mental health and child welfare services providers is controversial.

Description of responsibilities of different professionals and their interconnections in providing mental health services for a child at tertiary level reflects hierarchical relations, which shape inter-professional cooperation inside mental health and child care organizations.

Inter-professional cooperation between practitioners from mental health and child care organizations is described differently by both sides. The informants understand the importance of inter-professional cooperation between organizations, but most often they blame each other for not taking initiative. Lack of communication, organizational restrictions, imperfection of health care system and personal factors were mentioned as the main obstacles for a good practice.

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TRETINIO LYGIO PSICHINĖS SVEIKATOS PASLAUGOS GLOBOJAMIEMS VAIKAMS: SPECIALISTŲ POŽIŪRIS

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Santrauka

Straipsnio tikslas – pristatyti kokybinio tyrimo, kaip institucijų globojamiems vaikams teikiamos tretinio lygio psichinės sveikatos paslaugos, duomenis.

Kokybinio tyrimo duomenys rinkti interviu metodu. Pokalbio su tyrimo dalyviais kryptį ir turinį lėmė tyrimo problema. Buvo pasirinkta struktūruota interviu forma iš anksto suformulavus interviu klausimus. Interviu su tyrimo dalyviais pokalbis buvo užrašytas į diktofoną, vėliau interviu duomenis tyrėjai transkribavo rašytine forma. Interviu su kiekvienu dalyviu truko 1.30–1.45 val.

Siekiant atskleisti specialistų požiūrį į tiriamą reiškinį, netikimybinės tikslinės atrankos būdu parinkti penki informantai (tyrimo dalyviai), dirbantys sveikatos priežiūros ar vaiko gerovės sistemose. Interviu metu kalbėta su dviem psichologais ir trimis socialiniais darbuotojais.

Kokybinė turinio analizė atskleidė keletą temų, iš kurių trys nagrinėjamos šiame straipsnyje: skirtingų specialistų atsakomybės, teikiant paslaugas vaikui, bendradarbiavimas organizacijų viduje ir tarp sveikatos priežiūros bei vaiko globos organizacijų, psichinės sveikatos paslaugų teikimo trukdžiai.

Tyrimo duomenys atskleidė, kad specialistai diferencijuoja savo atsakomybes, teikiant psichinės sveikatos paslaugas globojamiems vaikams, taip pat suvokia bendradarbiavimo organizacijoje būtinybę. Ir sveikatos priežiūros, ir vaiko globos organizacijose tarpprofesinis bendradarbiavimas yra grindžiamas hierarchiniais ryšiais. Socialinis darbuotojas yra priimamas kaip žemesnio rango specialistas komandoje.

Duomenys apie tarpinstitucinį bendradarbiavimą nevienareikšmiški: sveikatos priežiūros ir vaiko globos specialistai pateikia priekaištų vieni kitiems dėl bendradarbiavimo trūkumo. Organizaciniai apribojimai, sveikatos priežiūros sistemos netobulumas ir asmeniniai veiksniai minimi kaip psichinės sveikatos paslaugų teikimo bendradarbiaujant trukdžiai.

Reikšminiai žodžiai: *tretinio lygio psichikos sveikatos paslaugos, vaikų globa, specialistų atsakomybės, tarpprofesinis bendradarbiavimas, psichinės sveikatos paslaugų teikimo trukdžiai.*

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