Collaboration between child protection and mental health professionals: An empirical research in six European countries

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Abstract: Many children accommodated in residential care are in need of psychiatric treatment as well as child protection services, and thus the professional expertise of both sectors must be coordinated in their care. In collaborative work 'on the borders', professionals need to draw on perspectives and approaches from a variety of disciplines. Boundary work and the crossing of boundaries are at the core of interprofessional collaboration. Boundary work is related to professional excellence and differences in the distribution of tasks: how experts understand their competences, responsibilities and authority in a particular field in relation to other professionals in the field. The present article is based on a study on interprofessional collaboration between child protection and mental health care professionals in six European countries. In this article we bring together research data on the interface between mental health and residential child care services in Denmark, Finland, Germany, Lithuania, UK (Scotland) and Spain. In total, 49 individual interviews and 6 focus groups were conducted; overall 59 interviewees participated in this research. Results indicate that welfare states provide a spectrum of services, expertise, programmes and interventions in child protection and mental health sectors to facilitate interprofessional collaboration, but obstacles to cooperation and coordination remain, often related to lack of knowledge, mutual attitudes and ways of communication.

Key words: boundary work, interprofessional collaboration, residential child care work, children home, child protection, child welfare, institutional care, mental health treatment, RESME

1. Introduction

The aim of this article is to present information about the professional knowledge, experiences and perceptions generated in child protection and mental health care collaboration 'on the borders'. With this information we offer a general overview to contemplate the interprofessional collaborative practices between residential child care and mental health sectors in six European countries. We are representing different welfare regimes. The original hypothesis was that this would differentiate the care and treatment for children and outcomes of the residential child care. The collaborative practices are regarded emphatically in the residential child care context.

Literature is very scarce in international research about practices and collaboration between residential child care and mental health services (Ellilä & Lahti 2015; Kiuru & Metteri 2014, 168). The main concerns in developing collaborative practices are to identify the parties responsible for delivering information and expertise between these two systems, efficient communication (for example negotiating issues of confidentiality) and allocating resources appropriately (Darlington et al. 2005; Darlington & Feeney 2008; Janssens et al. 2010; Sloper 2004). In spite of these concerns, it is widely known that collaboration among these two agencies can improve the use of children's mental health services (Bai et al. 2009). Interestingly, in international studies, the focus in developing collaborative practices between

these two sectors has been in particular on delivering psychiatric knowledge and expertise into child protection services (Kiuru & Metteri 2014, 169).

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

Boundary work is related to professional excellence and to differences in the distribution of tasks (Abbott 1995): how experts understand their competences, responsibilities and authority in a particular field in relation to other professionals in the field. Obstacles for working together proved to be the competition between professions and administrative-structural restrictions as well as motivational restrictions (Hall 2005). Boundary work and the crossing of boundaries are at the core of inter-professional collaboration. Strengthening the professional identity, appreciating and respecting it as well as making hierarchies between professions 'opens' and 'closes' possibilities in collaboration (Auvinen-Tornberg 2013, 47). To coordinate professional collaboration between systems could be interpreted – directly or indirectly – as a battlefield of different types of expertise. Who has the last word in the content of the service provided? Who is the responsible party? Who has the capability to help?

2. Residential child care work

Professionalisation refers primarily to the extent to which practitioners and institutions are guided by sound knowledge and insight (into the nature, background and approach of the problems presented by clients), and how they express this by skilful and respectful treatment at the individual and organisational level. According to Anglin (2002, 49–56), there are three basic psychological processes in children's homes which are systematically linked to the core element *congruence in service of the children's best interest*: creating an *extrafamilial living environment*, responding to pain and pain-based behaviour and developing a sense of normality. The notion of an extrafamilial living environment captures a fundamental tension inherent in group home settings and helps to clarify the group home's unique nature in juxtaposition to foster care and institutional care in the continuum of residential services (Anglin 2002, 55). In turn, Cameron and Moss (2011) emphasise that the quality of those employed in residential care is associated with the extent to which practitioners were able to exercise some autonomy and make situated judgements at work, to be able to use knowledge and adapt it to the multiple and ever-changing situations that arise in work with children (Cameron & Moss 2011, 21, see also Ward 2009). Kristensen (2011, 243) argues that theories in institutional care do not encompass the consideration of children's pathway through

institutional life and do not encompass explicit goals or consideration of obstacles. Instead, the pedagogical language draws heavily on metaphors and implicit language.

Collaboration between child protection and mental health systems is linked to the professional competencies and the frames of knowledge of staff working within the field. In the UK, residential care has developed from social work, and as a result most of the training has, historically, been linked to the training given to field social workers, although this has changed in recent years towards a more vocational and less professional set of requirements. In Spain the roots seem to be more in education, as in some of the countries in Europe. In Canada and the US, much of the training is connected with youth and community work. In Romania, residential care is firmly placed within the health care sector, as is the training. Thus the training for residential child care workers is generally a subset of other training for other professional groups. This means that skills which are considered appropriate and also the content of the courses are decided according to models which are not drawn from the field in which the staff will work after completing the training (Lindsay 2002, 77–78). Lindsay (2002, 79) concludes that currently residential work does not generally have training that would be considered parallel with the majority of other professional groups, either in terms of length, content or specificity, nor in the legislative requirements for such training.

Partly because training is not mandatory before entry, residential staff has tended to pick up the culture and values of the particular service in which they work. Yet, there is a need for practitioners to know and demonstrate mastery of relevant data and theory; what must be known for competent professional practice (Shealy 2002, 88; see also Petrie et al. 2006, 146–148). But what is the 'relevant data and theory' that underpins residential care work? As Milligan (1998) argues, attempts to improve residential care by way of social work training have largely failed and residential child care work is a separate profession requiring a separate educational framework. In countries without a tradition of social pedagogy, those who work directly with children in settings such as residential child care, are rarely professionally qualified and are heavily regulated. The status of such workers is lower than that of social workers and mental health professionals.

Lately there have been determined efforts to strengthen the professional quality of residential child care work and its theoretical background. Social pedagogy has been introduced in many European countries as a discipline which addresses the professional skills needed in residential child care. Recently in the UK there has been a significant growth of interest in social pedagogy and its possible application in children's services, accompanied by exploration of employer-based training and education. The focus is especially on the potential that social pedagogy offers children's residential care (Bengtsson et al. 2008; Cameron & Moss 2011, 17; Cameron & Petrie 2009; Hatton 2013; Smith & Whyte 2008). The social pedagogical approach broadens perspectives to the 'whole child' which includes the integration of the individual in society and the promotion of social functioning, inclusion, participation, identity and competences as members of society with shared responsibilities to that society (Smith &

Whyte 2008, 24; Smith 2009), where pedagogues act as 'upbringers' on behalf of society (see Cameron & Moss 2011, 13).

It can be challenging to work with the 'whole child' with all the needs and traumatic backgrounds these children usually have. Furthermore, according to Hämäläinen (2003, 76), social pedagogy concentrates "on the question of integration of the individual in society; both in theory and practice", the basic idea being "to promote people's social functioning, inclusion, participation, social identity and social competence as members of society" and dealing "with the process of human growth that tie people to the systems, institutions and communities that are important to their well-being and life management".

Those professionals working in the context of daily living are regarded as the main resource to promote changes in children, through addressing behavioural and emotional problems. There is solid knowledge about the *profile* of the children in residential care. 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, these young people living in out-of-home care with mental health problems continue to experience mental health problems in adulthood (Shin 2005). The World Health Organisation Mental Health Declaration (2005) for Europe highlights the need for comprehensive evidence-based policies targeted especially for vulnerable groups such as children and adolescents.

3. Materials and method

3.1 Sample

The empirical part of this paper is based on individual interviews and focus group interviews in six European countries: Denmark, Finland, Germany, Lithuania, UK (Scotland) and Spain. The study was carried out with professionals (n= 59), who work together with mutual child clients in child protection and mental health sector; there were 36 practitioners from child protection and 23 practitioners from the mental health sector, with different professional tasks and expertise (see tables 1 and 2). All interviewees were well experienced; everyone had at least five years of work experience in residential child care or mental health care. The method for analysis is Qualitative Content Analysis with a directed approach: searching for patterns, contrasts, paradoxes and irregularities in borderline work practices.

Table 1. Interviewees; education and field of expertise, **child protection**

Number of respondents	Education	Position and field of expertise
17	Bachelor's Degree in Social Pedagogy	Residential workers in children's home
1	Bachelor's Degree in Nursing	Residential worker
3	Bachelor's Degree in Social Pedagogy	Clinic for child and adolescent psychiatry
2	Bachelor's Degree in Social Pedagogy	Residential worker, manager
1	Practical nurse, vocational training	Residential worker
1	Bachelor's Degree in Social Pedagogy	Head of a youth welfare board for residential care
1	Master of Psychology	Psychologist in child and adolescent psychiatric out-patient clinic
4	Master of Education /Social Work	Manager in residential home
1	Bachelor's Degree in Social Science. Post graduate in drug and alcohol studies	Manager of psychology and therapies in residential care
1	Bachelor's Degree in Psychiatric Nursing and in Social Work	Manager in residential home
1	Doctorate in Psychology	Manager of residential child care services of the regional Government
3	Bachelor's Degree in Psychology	Managers of residential child care services of the region
Total 36		

The table shows an overview of the staff working child protection sector. However, the category 'Bachelor's Degree in Social Pedagogy' (n=17) includes a heterogeneous group of residential workers because there is no coherent terminology of the terms of the social professions in Europe.

Table 2. Interviewees; education and field of expertise, **mental health care**

Number of respondents	Education	Position and field of expertise
2	Bachelor's Degree in Social Work	Social worker in child and adolescent psychiatric out-patient clinic
1	Master of Psychology	Psychologist in child and adolescent psychiatric out-patient clinic

3	Bachelor's Degree in Psychiatric Nursing	Psychiatric nurses in child and adolescent psychiatric in-patient clinic
4	Bachelor's Degree in Psychiatric Nursing	Psychiatric nurses in child and adolescent psychiatric out-patient clinic
1	Occupational therapist	Manager, child and adolescent mental health team
1	Bachelor in nursing, master in child psychology	Staff at psychiatric in-patient care
1	Doctorate in Psychology	Psychologist in child and adolescent unit of public mental health services
6	Physician	Paediatrician in NHS, Head of child psychiatric services of the region, 4 child and adolescent psychiatrists
3	Psychiatrist	Consultant at residential home, psychiatrist (2) in child and adolescent unit of public mental health services
1	Bachelor's Degree in Psychology	Psychologist in private out-patient clinic
Total 23		

3.2 Instruments and procedure

The research aim was to collect professional knowledge; experiences and perceptions generated in child protection and mental health care practice for collation and exchange of good practice, so the interviews were selected as most appropriate to the task. Regarding the validity in knowledge production, individual interviews as well as focus group interviews were chosen to elicit perceptions and remarks of the characteristics of working together. Mixed focus groups interviews, where these two orientations – residential child care and mental health treatment – meet, were conducted to elicit collaboration practices between systems.

Experienced academic experts conducted national studies in each country. The responsible researcher collected and analysed the data and wrote a national sub-research report alongside the agreed guidelines to make the sub-reports as coherent as possible for further comparison and to achieve the international approach and context. We were not only interested in describing the systems. In contrast, our goal was to focus on the *practice-oriented comparisons* (Meeuwisse & Swärd 2007, 491–493) – that is similarities and consistency of the findings between the countries that are involved in research. It is argued that comparison requires more sophisticated methods like for example vignette method with fictitious cases which are as true to life as possible (Meeuwisse & Swärd 2007, 492). It is undisputed, that we have not *systematically* examined what the practitioners actually *do* in the collaborative practices but, however, the practical working roles and tasks were present thgroughout the interviews.

There is in total six sets of interview data from six countries. Different models of interviews were used: individual interviews, focus group interviews and mixed focus group interviews (see table 3).

Table 3. Interviewees; country and model of interviews

Country	**Model of interview (s)**
Denmark	5 interviews (8 participants)
Finland	1 residential child care focus group, 1 mental health staff focus group, 3 mixed focus groups (10 participants)
Germany	12 individual interviews, 3 in focus groups (19 participants)
Lithuania	5 individual interviews
Scotland	9 individual interviews
Spain	8 individual interviews
Total	**59 interviewees**

Boundary work is related to professional excellence and to differences in the distribution of tasks. To reach these elements, the interviews were semi-structured and the following topics were involved in the interviews:

1. Understanding professional responsibilities and authority in relation to other professions,
2. Understanding (personal) professional identity, expertise and competencies (as a residential care worker, psychiatric nurse, social worker, psychiatrist), cf. working in a different frame of knowledge, different role, responsibilities, division of labour,
3. Main obstacles to delivering a service better able to address mental health need of children in care,

4. Good collaborative practice**:** specify the different phases of the practice, describe the kind of responsibilities and actions that **i**t requires from both sides, specify the resources (certain tools and other facilities),
5. Suggestions how borderline work between child protection and mental health workers and organisations should be developed to support interprofessional cooperation.

The criterion for selecting the sample with experienced professionals was based on a voluntary basis. All respondents were chosen by the employers to guarantee the expertise in interprofessional practices.

3 Results

All of the countries involved in the present research identified difficulties in inter-professional working between mental health and residential child care services. Data across different welfare state regimes identified a number of consistent key themes and issues that are outlined below: understanding of professional role, professional status, divergent attitudes and expectations and lack of useful knowledge. Summarised results of the national studies to reflect common concern regarding collaborative practices between residential child care and mental health care in Europe are presented in this chapter.

3.1Understanding the professional 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 the everyday life, home routines, preparing young people to become citizens and support for reflection but defining what it meant to work *as a professional* with young people with severe behavioural problems became harder. Many participants felt their job was difficult to define and sometimes unpredictable requiring a flexible and spontaneous approach. Some of them felt that this reality can make them appear less assured in their position when engaging with mental health staff. On the other hand, some believe that this is one of the most exciting features of their job but the general perception in most countries is that residential work is very demanding, covering lots of different responsibilities and tasks. As a consequence, while mental health staff had a clear idea of the tasks and limits of their role, the residential workers' job is far more diffuse and workers can feel that they are expected to do everything related to children.

The attempt to create a 'family home' type atmosphere was particularly pronounced in countries where social pedagogy has a strong influence. In Spain, for instance, the growing numbers of young people admitted to children's homes with severe disruptive behaviours and the consequent demands on staff to be more specialised or therapeutic could be seen as representing a breakdown of the family model (Bravo & Del Valle 2009). Therefore,

specialisation was criticised and clinical contributions were evaluated as stigmatising and contrary to the socio-educational model by some professionals, triggering an exciting debate (Whittaker, Del Valle & Holmes, 2014).

3.2 Imbalance in Professional status

Status differentials were evident across all countries; residential workers perceive that their profession is undervalued by society, certainly in terms of salaries. Beyond just financial recompense, though, psychiatrists enjoyed a generally higher professional status than child care workers. Residential workers have been subsumed in different countries into different professional groups as: residential social worker, social educator, nurses, guards, youth workers, counsellors (USA, Finland). A term speaks volumes about how these workers are perceived (Lindsay 2002, 85). This differential is perceived as a serious handicap by child care workers in reaching a position of real cooperation as they perceive mental health professionals as having the last word on decisions about a child. Specific manifestations of this status differential were evident in the expectation that joint meetings were always held in mental health offices, reflecting a belief that psychiatrists' time was more valuable than their own.

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

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

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

In Spain and Germany, a professional works as a mediator between both systems to improve communication and cooperation and in other cases good practices are related to some specific mental health units to treat children in care. In Finland, every child who is taken into custody has a key social worker who makes decisions for all child welfare and health care services for the child and can be seen as a mediator between the services. In turn, other 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 there could be a struggle to get them to do so.

3.3Divergent attitudes and expectations

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

On the other side, mental health staff often complained that residential workers visiting with children have a serious lack of information about the family background, medical history, and personal circumstances of the children. Moreover, when treatment extends over a long time it is very common that residential workers accompanying the children change and different people appear. Not knowing the essential information and no stable adults to refer to makes any therapeutic intervention difficult. An example of the paucity of information that can be provided was offered by a psychiatrist who commented that a child had been moved to another residential placement and only the child talked about this fact to the therapist.

However, while recognising this concern from mental health workers, residential workers also complained about the lack of information given back by psychiatrist in the process of therapy. In some countries child care staff says they do not receive follow-up or even final reports. For example, someone commented that mental health staff likes 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 perceive an unbalanced situation where psychiatrists need information to be received from child care workers but they do not see the need to feed back on their own work.

3.4Vague frame of knowledge

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

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

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 recognition of a 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 environment a children's home is, with many different children, a lot of pressure and a lot of tasks to do. A consequence of this lack of knowledge about what residential workers do is that mental health workers can also fail to realise that sharing everyday life with children can afford a privileged access to observe and know children.

5 Discussion

Bringing about better collaborative working is not simple. Such an aspiration assumes an equality of status between professionals that does not always exist, especially amongst social pedagogues and mental health professionals. The results in our study indicates a possible tension that, in deploying *ordinary* discourse – parallel to what happens in a family context, residential care workers might be seen in a non-professional frame when collaborating with other professions. If residential educators lean too much on other professionals' judgements, it has a certain influence on their professional identity. Residential child care work might, as a result, be conducted through a diagnosis and treatment model which does not necessarily reflect the educational and pedagogical expertise that exists and which characterises such work.

The obstacles to better joint working between the different sectors are complex and are partly related to a vague frame of knowledge, mutual attitudes and ways of communication and the status differentials between the two groups but also perhaps to wider professional and perhaps epistemological differences in how the two groups understand their respective tasks. What is perhaps evident from our results is that a positivist epistemological paradigm appears to be dominant. Those professions, such as psychiatry, based around what can be thought of as 'hard' scientific knowledge are thought to possess a more robust and useful knowledge than professions such as social work and residential child care which operate on a territory where knowledge is messy and harder to pin down.

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

Finally it should be pointed out that this study has some limitations that should be taken into consideration. Our qualitative analysis is based on a relatively limited data of each country for making any decisive conclusions about collaborative practices between residential child care work and psychiatric nursing. However, the study provides a reflective mirror to look at professionals' perceptions of working together and despite of its limitations delivers us allusive comparative information that obstacles for residential workers and mental health staff for working together are consistent across Europe. And yet, it is noteworthy that comparative studies (of social assistance systems) showed a decade ago that the differences between different welfare models are less than might be imagined (Heikkilä, 2001). Scope of the national measures is become narrower in the increasingly globalised economy. Countries are being forced to effectivise and rationalise, and are more inclined to try new solutions (Meeuwisse & Swärd 2007, 488).

6 Conclusion

Children in residential care in all countries need more and better therapeutic intervention and cooperation between professionals from both sides becomes crucial. In its best, interprofessional networking supports the service system to incorporate both sides' competencies and expertise. The examples of good collaborative practices between sectors seemed to be those where these two professional groups actually knew each other and worked closely together, perhaps on the same site or within the same project. It seems that more practical experience of each other's working structures and environments is needed. Examples of good practices included the use of mediator professionals, which has been perceived as

really valuable from both sides. These might be improved by means of increasing spaces for joint discussions and training. After offering in this article reflected and compared information about collaborative practices in international context, we suggest that the starting point for any improvement needs to take into account the particular local contexts and to find spaces and forums to promote dialogue and common and realistic understanding between the professional groupings.

To conclude, it seems that the obstacles for collaboration between residential child care and mental health sector are quite similar across Europe. Theoretically it is interesting that in addition to status differentials there may also be epistemological differences between the professions. The distinction between the generalist and the specialist is one that needs to be taken into account in any attempts to get professionals to work more closely together. Our results support the previous studies, that many times in developing collaborative practices the delivering psychiatric knowledge and expertise into child protection services is on focus. Notwithstanding, the professional identity of the residential workers need to be strengthened. Residential child care work is less clearly defined area where several different professional groups are counted as residential workers. One course to empower residential workers' professional status might be the same qualification requirements for the residential workers in Europe.

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References

Abbot, A. 1988. The Systems of Professions. An Essay on the Division of Expert Labor. Chicago and London: The University of Chicago Press.

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

Auvinen-Tornberg, O. 2013. Nuoren identiteettityön tukeminen lastensuojelun avohuollollisena kodin ja koulun kanssa tehtävänä työnä. [The support of the identity work of young people in open care child welfare executed together home and school]. Unpublished thesis for a master degree in youth work and youth Research. Tampere: University of Tampere.

Baia Y, Wells R, Hillemeier M. 2009. Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. Child Abuse & Neglect 33, 372–381.

Bengtsson, E., Chamberlain, C., Crimmens, D. and Stanley, J. 2008. Introducing Social Pedagogy into Residential Child Care in England: An Evaluation, Social Education Trust and National Centre for Excellence in Residential Child Care.

Besier, T., Fegert, J., Goldbeck, L. 2009. Evaluation of psychiatric liaison-services for adolescents in residential group. *European Psychiatry* 24, 483–489.

Braddick, F., Carral, V., Jenkins, R. & Jané-Llopis, E. 2009. Child and Adolescent Mental Health in Europe: Infrastructures, Policy and Programmes. Luxembourg: European Communities.

Bravo, A., Del Valle, J.F. 2009. Crisis and review of child residential care. Its role in child protection. *Papeles del Psicólogo*, 30(1), 42–52.

Burns, B., Phillips, S., Wagner, R., Barth, R., Kolko, D., Campbell, Y. & Landsverk, J. 2004. Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(8), 960–970.

Cameron, C. and Moss, P. (2011) *Social Pedagogy and Working with Children and Young People: Where Care and Education Meet,* London: Jessica Kingsley Publishers.

Cameron, C. & Petrie, P. 2009. Social Pedagogy and its Prospects in England's Children's Services. European Journal of Social Education 16/17 2009, 49–61.

Darlington, Y. & Feeney, J. 2008. Collaboration between mental health and child protection services: Professionals' perceptions of best practice. *Children and Youth Services Review 30*, 187–198.

Darlington, Y., Feeney, J., & Rixon, K. 2005. Practice challenges at the intersection of child protection and mental health. *Child & Family Social Work* 10 (3), 239–247.

Ellilä H. & Lahti, M. 2015. Collaboration among child protection and mental health care staff: A systematic literature review. In E., Timonen-Kallio, J., Pivoriene, M., Smith, J.F. Del Valle (eds.). On the Borders between Residential Child Care and Mental Health Treatment in Europe. Turku University of Applied Sciences, 18–32.

Gilbert, N. 2011. A comparative study of child welfare systems: Abstract orientations and concrete results, *Children and Youth Services Review*, 34(3), 532–536.

Hall. P. 2005. Interprofessional teamwork: Professional cultures as barriers. Journal of Interprofessional care. VOL: 19,SI, 188–196.

Hatton, K. 2013. Social Pedagogy in the UK. Theory and Practice. Russell House Publishing Ltd. Dorset.

Heikkilä, M. 2001. The role of Social Assistance as Means of Social Inclusion and Activation: A Comparative Study on Minimum Income in Seven European Countries. Report 1, Contexts, STAKES, European Commission.

Hämäläinen, J. 2003. The concept of social pedagogy in the field of social work. *Journal of Social Work 33, 1,* 69–80.

Janssens, A., Peremans, L., Deboutte, D. 2010. Conceptualizing collaboration between children's services and child and adolescent psychiatry: A bottom–up process based on a qualitative needs assessment among the professionals. *Clinical Child Psychology and Psychiatry 15 (2),* 251–266.

Kiuru, K-E. & Metteri, A. 2014. Miten lastensuojelun ja nuorisopsykiatrian välinen raja rakentuu palvelujärjestelmässä? In A., Pohjola & M., Laitinen & M., Seppänen. Rakenteellinen sosiaalityö. Sosiaalityön tutkimuksen vuosikirja 2014. UNIpress, 162–190.

Lindsay, M. 2002. Building a Professional Identity: The Challenge for Residential Child and Youth Care. In E.J. Knorth, P.M. van der Bergh, F. Verheij. Professionalization and Participation in Child and Youth care. Challenging understandings in theory and practice. Ashgate, 75–86.

Kristensen, O.S. 2011. The institutional set-up: an analysis of social pedagogues' accounts of treatment in everyday practice. European Journal of Social Work. vol 14. Issue 2, 229–245.

Meeuwisse, A. & Swärd., H. (2007). Cross-national comparisons of social work—a question of initial assumptions and levels of analysis. *European Journal of Social Work,* 10:4, 481–496.

Milligan, I. (1998) Residential child care is not social work! Social Work Education, 17(3), pp.275–286

Petrie, P. & Boddy, J. & Cameron, C. & Wigfall, V. & Simon, A. 2006. Working with Children in Care. European Perspectives. Open University Press.
Shealy, C. N. 2002. Knowing a way toward professional child and youth care: The Therapeutic Home Parent Model. In E.J. Knorth, P.M. van der Bergh, F. Verheij. Professionalization and Participation in Child and Youth care. Challenging understandings in theory and practice. Ashgate, 87–106.

Shin S. 2005. Need for and actual use of mental health service by adolescents in the child welfare system. *Children and Youth Services Review* 27, 1071–1083.

Sloper, P. 2004. Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health and Development 30*, 571–580.

Smith, M. (2009) Rethinking Residential Child Care: Positive Perspectives, Bristol: Policy Press

Smith, M. and Whyte, B (2008), 'Social education and social pedagogy: reclaiming a Scottish tradition in social work', *European Journal of Social Work,* 11 (1).

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.

Whittaker, J.K., Del Valle, J.F. & Holmes, L. 2014. The current landscape of therapeutic residential care. In J.K., Whittaker, J.F. Del Valle, L. Holmes (eds.). Therapeutic residential care for children and youth. Exploring evidence-informed international practice. London: Jessica Kingsley, 23–34.