COMPARATIVE REPORT ON THE CHILD CARE AND MENTAL HEALTH SYSTEMS IN **RESME** PARTNER COUNTRIES

Introduction

This report includes the following partner countries in the RESME Project: Denmark, Finland, Germany, Lithuania, Scotland and Spain. Each of these countries have written a national report describing both mental health (with respect to children and young people) and child care systems (specially child residential care) and the interaction between them, analyzing particularly the way that children in care are referred and attended by therapeutic services. Finally, some good practices were presented in some countries about how to cover mental health needs of children in residential care, as well as mention to some special groups in care.

The range of countries involved in this project includes two countries representing the Scandinavian Model of Welfare State (Denmark and Finland), one country framed in the Central-European Model (Germany) with a long tradition of public health services, one country (Scotland) being a differentiated part of the British Model, one representative of the post-communist transitions (Lithuania) in Eastern European Countries, and Spain as a country with characteristics of the Mediterranean model of Welfare State. Therefore, the project involves an interesting and varied group of countries with distinctive historical backgrounds and socio-economy models.

There are also differences in the size of the countries in terms of population, as three of them have similar figures, about 5 million inhabitants (Denmark, Finland and Scotland), but two of them are among the most populated countries in Europe (Germany 81 million and Spain 46 million). Finally, Lithuania is a small country of 3 million inhabitants.

On the other hand, as a feature with very important consequences on the structure and functioning of mental health and child care systems, the two biggest countries have a complex system of administrative decentralization, with 16 Federal States in Germany and 17 Autonomous Communities in Spain. Federal States and Autonomous Communities have the responsibility for organizing health and social services with the implication of the municipalities as well.

Denmark has a system of 5 regions responsible for health services, but municipalities are in charge of education and social services (including a department for child care). In Finland, a Ministry of Health and Social Services exists, but municipalities organize both services. Scotland has autonomy in education and child care with respect to UK being the Scottish Office in charge of those services since XIX Century until 1999 when a Scottish Parliament was re-established. However, day-to-day responsibility for social work and social care functions are located with 32 local authorities. Also in Lithuania child care competencies were transferred to municipalities. Therefore, we can say that a process of decentralization could be appreciate in all countries trying to approach the administration of health, education and social services to citizen's homes and communities. This is a relevant impact of the community model started in the 60s in the field of mental health and afterwards expanded to all welfare services.

Child and adolescent mental health

A description of the MH system in each country will be introduced in this part. It includes prevalence of MH disorders, as well as the structure and functioning of MH services fro children and young people.

Prevalence figures

Some of the countries have figures of epidemiology for children and young people. **Denmark** estimated 2% of children expected psychiatric help and remarks the enormous increasing of ADHD diagnosis, doubling numbers from 2007 to 2008 and being triple that 2004. That means a huge expense of medication (for example Ritalin) rising a 2,400% from 1991 to 2006. In recent years there was a marked increase in the number of referrals to child and adolescent psychiatry services (47% from 2004 to 2006). Also students in extensive special education have increased by 50% in the period 1997 to 2007. In 2009 there were 16,049 referrals to child and youth psychiatry (about 1.25% of the total population under the age 18).

Epidemiological studies in **Finland** showed that 7.5% of children at age 8 had a long lasting severe psychiatric disorder and most of them had more than one diagnosis. Outpatient treatments showed a significant increment of visits; this increment was also noticeable in inpatient treatments rising a 47% from 1995 to 2004.

Germany presents data about prevalence of disorders in minors about 17-18% and also a growing number of inpatient beds: 12,5% from 2002 to 2005. An important data is that 50% of severe mental health disorders in minors need also welfare services, connecting both problems.

In **Lithuania** mental health problems is the most important cause of disability for children and there is an increasing prevalence of disorders.

In **Scotland** a reference was made about the fact that ten percent of all young people in the UK are identified as requiring mental health support at some point in their lives.

Spain doesn't have national figures about mental health problems in children and adolescents (due to the autonomous community organization each region has a different system or no system at all and there is no national agency collecting global data). Some researches show percentages between 15-24% of prevalence at that age.

Structure and functioning of Mental Health services

In **Denmark**, services for children and youth at risk have two points of departure: at one site the municipal responsibility for day-care, school and social service and at the other site the regional responsibility for health services. At one hand there is the general practitioner (GP) making diagnosis in relation to mental health and refer to specialists; at the other hand there is the day-care institution and the school noting when children and youth do not function well and communicating with more specialized services. There may often be a need for a professional clarification between involved professionals about what should be defined and understood as well-being, social and cognitive issues to be handled by the relevant municipal contexts, and what must be considered mental problems or psychiatric disorders, including what should be referred for diagnostic evaluation and treatment of child and adolescent psychiatry in hospitals.

There is a department for counselling (PPR) in each community that often coordinates services from the social system and the mental health (MH) system in relation to children. Professionals in the (regional) MH system include: psychiatrists, psychologists, nurses, pedagogues, social counselors and teachers.

MH system in **Finland** is organized into primary health care and specialized health care. Primary services are provided by health centers, where psychologists and nurses have visits according a schedule. When this treatment is ineffective or there is

a serious disorder, the treatment is provided by MH specialized outpatient or inpatient services. Curiously, there are two different MH services in Finland to attend children and adolescents being separate specialties of psychiatry, what is probably the unique case in the world.

Primary MH services for children are provided by municipalities and include a variety of interventions to prevent MH disorders: nurses and physicians in maternity and child care guidance, nurses and some times physicians and psychologists at schools and workers in family home care (this program was dramatically reduced recently due to financial cut budgets).

Specialized MH services for children and adolescents (separate subspecialties) is a duty of communalities and consist of clinics with outpatient and inpatient services. There are 15% of beds for day care and 85% of beds for 24-hour treatment. When minors need hospitalization they must be placed in specific unit for the age. According to the MH Act 1990 (and 2001 amendment) government tried to minimize people restriction in MH services. Involuntary treatments have a period of 4 days for assessment under a legal process.

There was an evolution toward primary care from a past of institutionalization in MH care. Also there is a current concern about the rate of return to psychiatric inpatient care due to relapse, being in Finland higher than any other OECD country.

Germany MH system is decentralized in 16 Federal States. This country had already created a separated section of child psychiatry in the 60s and evolved from an institutionalized model to a community model in the 70s. The provision of healthcare can be divided in the *outpatient/ambulatory* and the *inpatient sector*.

Outpatient services in mental health care for children and adolescents are provided mainly (as in somatic health care) by independent physicians and doctors (primarily for child and adolescent psychiatry and/or pediatricians) and by licensed,

approbated psychotherapists (mainly psychologist and pedagogues with a special postgraduate education). These physicians and psychotherapists practice as self-employed persons on a freelance basis. In caring for patients with a statutory health insurance they have to be registered by law and under contract to the health insurance (also there are lots of therapists working without this contract on a private base). Child and adolescent psychiatrists and psychotherapists for children and adolescents provide the assessment of mental health problems, diagnosis and treatment in form of psychotherapy and pharmacotherapy. To a certain extent also residential pediatricians take care of children and adolescents with mental health problems.

Since 1994 specific forms of surgeries/practices for child psychiatry with a social psychiatry orientation and framework have been promoted by law. These interdisciplinary "social psychiatry" practices with a multi-professional team have to be under the authority of a psychiatrist and also have to employ other relevant professionals like psychologists, pedagogues or social workers or have to prove an intense collaboration with them. Similarly, there are so-called "social pediatric" practices, which care with a multiprofessional team, too, mainly for children with retardations and different kinds of development disorders.

Additionally, many hospitals for child psychiatry (see below) provide outpatient services (including assessment and treatment), usually occupied by psychiatrists and psychotherapists. Also there is a public child psychiatry service provided by local health authorities; these services are usually located in bigger cities mainly and limited in their extent of supply.

The services mentioned above are generally free for the families looking for help. The expenses are paid by health insurance (or just for public child psychiatry services by municipality). For most services there are usually waiting periods from some weeks to several months.

Additionally, usually as part of the youth welfare system, there are also many public counseling services for educational and family counseling. These services deal with educational problems of parents, family problems (e.g. divorce, grief) or emotional and behavioral problems of children and adolescents. In Germany there are more than 1,000 of such counseling services. These public services do not belong to the health care system. They are offered by local youth welfare services or welfare organizations. The counseling is free of cost.

There is also a school psychology service in some schools and in most areas, where students with psychological problems and their parents can get counseling or referrals to further help.

With respect to *inpatient services, different* kinds of hospitals and clinics offer inpatient treatment in Germany. They are separated in public hospitals (managed by local authorities), university hospitals, hospitals run by non-profit making welfare organizations and private hospitals (free commercial enterprises). Private hospitals for mental health care of children and adolescents actually are still rare. Occupation rates are specified by the federal states. Local authorities organize public mental health services.

Children and adolescents in inpatient treatment are a high-risk population. Beside severe mental health-problems they often are characterized by low social and familiar resources. Data show need for child welfare service for 50% of 776 young patients of a university clinic for child psychiatry. In more than every third of these cases residential care was initiated.

MH system in **Lithuania** has a legal framework from 1995. Hospitalization is the most usable treatment with big hospitals and funding for medication, but there is a process of trying to bring services closer to citizens. Services are provided by the four sectors: residential psychiatric hospitals, mental health centres (which are self-employed or in primary personal health care content), non-governmental

organizations and the private sector. To the MH centre the person can apply under the residence or may be directed from a family physician institution. Moreover, Lithuania's MH care services include 4 main cycles, which combine individual and public MH items for everyone:

1) Prevention of mental disorders: training, counselling, briefing. Target groups: society (individual prevention groups provide different target groups and their needs); methods of information provision are defined, and so on.

2) Early diagnosis of mental disorders: training, counselling, briefing. Target groups: society, family physicians, employers, and other persons.

3) MH diagnosis and treatment: diagnosis, counselling/analysis, briefing. Target groups: psychiatric patients.

4) Psychiatric patients rehabilitation: medical, psychosocial, vocational rehabilitation; briefing, counselling, medical assistance; support at home, employment, housing programs, and so on. Target groups: psychiatric patients after hospital stay, followed by more serious disorders; patient family members.

In order to develop that complex psychiatric help for children and teenagers, where the outpatient-consultation, day inpatient, crisis intervention, inpatient care play a big role, children's and teenagers' psychic health care has been enhanced on the level of regional centres where the complex of services will be concentrated. These regional centres will provide aid in cases of children's and teenagers' psychic and behavioural disorders, children's crisis intervention services and family consultation services". Thus, it is important to have a flexible network of services, which would help to effectively heal all the children and young people having (severe) mental disorders. Strictly speaking that network should consist of these treatment forms: individual and group psychotherapy for children, family psychotherapy, day hospitals/hospitals for children and adolescents, long-term psychosocial

rehabilitation for children and adolescents having severe problems with social adaptation; early rehabilitation services network for children with developmental disorders. NGOs play a huge role providing free psychological, medical and social help.

There are child and adolescent crisis intervention units, which provide emergency psychiatric-psychological assistance for children and adolescents with serious psychological problems. In the room should be no more than 8 beds, they accept only children and young people aged 3-18. Treatment lasts up to 7 days. The mental health professionals' team for child and adolescent consists of child and adolescent psychiatrist, clinical psychologist, social worker and mental health nurse.

In **Scotland** a National Health Service Report on Child and Adolescent MH (2003) set out three core themes: the right of children and young people to be heard, the importance of mainstreaming MH and the integration of promotion, prevention and care. This led to the establishment of Child and Adolescent Mental Health Services (CAMHS) for children suffering from mental health problems. Practitioners in CAMHS teams include: psychiatrists, psychologists, nurses, social workers, and others which may include psychotherapists (including child/analytical, systemic/family, cognitive behavioural), creative therapists (including art, music and drama), play therapists, liaison teachers, speech and language therapists, occupational therapists and dieticians. Referrals are made by General Practitioners and waiting time varies (80% attended in 26 weeks). CAMHS services are typically considered as a 4-tier service:

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

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

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

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

A Strategic Review of the CAMHS Workforce (2005) report noted that there was a lack of capacity in the existing CAMHS workforce to meet the agreed policy objective. The subsequent government investment increased staffing and improved training and development. In 2007 a new report ("*We can and must do better"*) included mention to child care: *"Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to looked after and accommodated children and young people, and to those in the transition from care to independence."*

As in other countries, the **Spanish** historical background must be taking into account to understand health and social services structure and functioning. The Spanish civil war (1936-1939) and the following dictatorship (1939-1978) established a model of health and social services based on charity and with strong influence of the Catholic

Church. During those decades mental heath services were based in big institutions for severe psychiatric disorders where people live for many years apart from the society. Likewise, social services such as child care were also based in long institutionalization.

A new model of services started with a national report to reform MH services in 1985, followed by a new law on health services in 1986 including core ideas such as: a) MH problems should be attended in the community, reinforcing ambulatory resources, partial hospitalization and home care and special attention should be paid to children and elderly people; b) patient hospitalization should be in psychiatrist units of general hospitals; c) services for rehabilitation and social reinsertion should be developed in order to achieve an integral attention, looking for the necessary coordination with social services; d) MH services should address, along with social services departments, primary prevention aspects and psychosocial problems usually correlated with mental diseases.

Autonomous Communities (there are 17) have the responsibility for organization and functioning of education, health and social services, including development of strategic plans and legislation in Autonomous Parliaments. The range of services included in most Autonomous Communities to accomplish those principles is the following: community mental health centres; day care hospitals; units of children and youth psychiatry; therapeutic communities (for addiction disorders); unit of community rehabilitation; unit of psychiatric hospital.

According to this framework, children and young people must be attended in specialized units of MH community centres. The problem is that there are few of them (for example in Andalusia, one of the biggest Autonomous Communities, there are 70 Centres for adults and 17 for children). There is a high demand of this services and resources are very limited. Consults have a frequency of one or two months, mostly by psychiatrists using psychotropic medication, and very few can receive

psychological treatment in a more intensive way. Therefore, it is really frequent that children and adolescents under 18 use private mental health services, particularly clinical psychologists, when they need a more intensive or longer treatment. Patients must pay these private services on their own.

With respect to hospitalization of children due to severe mental health diseases, they are usually placed in the public general system of hospitals. For children under 14 years old they are hospitalized in paediatric hospitals, that must have special units properly conditioned for those cases. Adolescents over 14 are hospitalized in specific units for acute crisis in general hospitals. However, some autonomous communities have created specific hospitals for children and young people in order to attend severe diseases in intensive treatment (1 month maximum). Spanish legislation demands that the court must approve non-voluntary hospitalisation of minors.

Detection of mental health disorders is a main objective for community paediatric services (till 14 years old) and General Practitioners services. In case of detection they should refer the case to children and youth specialized MH services (community centres).

Child care system

In **Denmark**, the Parliament lays down the overall guidelines and aims for the placement of children and youngsters into care. It is up to the local authorities to provide the required number of places and to approve of the institutions involved. The local authorities also fund and manage actual placements. Local authorities have three different placement options when a child or a youngster is to be placed

outside their homes: foster care, residential care centres and private residential care centres. In addition, children and youngsters with special needs can be placed into day care while living with their families. In January 2006 a new law "Anbringelsesreformen" (child welfare reform) was implemented. The purpose of the reform is to improve the care of children and young people with respect to early intervention, improve the case work at municipalities, and to keep a greater focus upon education for those in care, more incorporation of the vulnerable children themselves and their families and leaving care support. This reform can be seen as an extension to the Law of Social Service (Serviceloven) and includes (for the first time) a specific duty on local authorities to promote the educational attainment of children they look after. The tool to combat this challenge is the action plan. It is required, that an action plan is in place before a young person is placed into care. The action plan describes goals regarding development, behavior, family conditions, school conditions, health, spare time and friends. However, it seems that not all action plans are fulfilled as requested and mistakes were detected in designing coherent case work.

Around 14,000 children and youngsters in Denmark were placed outside their homes in 2006 (and about 12,500 in 2011), corresponding to just over 1% of all children and youngsters. According to data from 2006, a 49% were in foster care and 45% in residential care (state, semi-private, private or boarding schools). The number of outplacements has been falling since, both for economical reasons and because of a priority of less intrusive measures. From 2007 to 2011 the number of (new) outplacements fell from 3,710 to 2,690. In the same period, the number of children and youth outplaced in residential care (the most expensive service) fell even more (from 1,336 to 750) and the number outplaced in private and foster care and placed in private studios (youngsters) with a contact-person rose.

In the period from 2009 to 2010 the costs for prevention raised about 25 million Kr. and the costs for outplacements fell about 235 million Kr. In 2011 the costs of

outplacements fall about 500 mio. Kr. Researchers are worried, as it seems that municipalities save money by outplacements in less specialized institutions. In relation to our project that may have a consequence: as it may be more difficult to include children with severe problems in those places, it is more likely that they are stigmatized and diagnosed with psychiatric problems, as this can be the ticket for more help.

The main reason for outplacement is insufficient care. For 34% there is severe disharmony in the family, for 17% there are addiction-problems in the home, for 15 % parents suffer of mental illness, and 2% of the children have been abused.

Although national government determines child welfare legislation in **Finland**, central control has weakened over the recent years. Now national government guides municipal services mainly through resources (state subsidies) and information. Basic education, health and social services, which are publicly financed, are the responsibility of Social Welfare Boards in 448 municipalities. Child Welfare Act 2007 is aimed at meeting the child's best interest through support and early intervention with the family rather than through foster care or residential care. Children in Finland may be placed away from home either as part voluntary 'open care' measures, with the aim of supporting the family on a temporary basis, or as part of more formal procedures – taking the child 'into care' and placing him in substitute care.

Taking a child into a care placement is seen as an intervention of last resort, and, if necessary, it should be for as short a time as possible. Formally, long-term, out-of-home placements should not exist but they do. The emphasis is on reunion and contact with child's biological parents should be supported during the placement. Despite the family focused principles, Finland has more residential placements than other Nordic countries. Residential care provision in Finland is mixed, being run by

municipalities, by the state (the reform schools), by the third sector (voluntary or independent associations), and by an enlarging private sector.

Large residential establishments have been criticized for being too institutional, leading to the development of smaller, more homely units. A new development in residential care in Finland is 'professional residential homes' differing both from foster homes and residential institutions in that staff are paid but provide placement for only two or three young people. The distinction between foster and residential care is therefore not so clearly marked anymore, though there remains an argument that only larger establishments can afford to offer children individually tailored psychosocial or educational programs.

In 2009 the private sector and the third sector provided approximately 70% of residential services and state and municipalities 30%. In 2010 there were 614 private residential institutions and professional residential homes', 53 run by associations 560 run by private companies. The ideological ethos prefers foster families to residential care but, on the other hand, specialised institutions for "the most challenging and demanding" children, when residential care is the only possibility, are required. In 2011, a number of 17,409 children were accommodated outside their home of which 3,867 children were taking in care as "immediate" cases. The increase in a year was 3% and "immediate" cases were increased 13% which is a remarkable addition.

While current policy in Finland emphasizes that the child's needs should determine the form of substitute care form chosen, decisions are often influenced by economic issues and there a crowing interest in defining 'good care' in relation the economic costs. The largest Finnish towns publish annual report of the cost of substitute care and one such report found that 85% of the cost of all substitute care was spent on residential care in 2004 and that a day in residential care costs between three and five times more than a day in a foster family (Kumpulainen 2005, p. 11). The high

cost of residential care relative to foster family remains a significant factor in determining the place of residential child care in government child care strategies. It could be argued that the trend towards increasing use of family-based care may reflect a 'cost-led' approach to service development rather than a 'need-led' approach.

Given the shift to towards more family-based care for the majority of children and young people, residential care is increasingly seen as a therapeutic resource. Establishments in Finland have developed specialized treatment programmes for addressing a range of psychosocial problems, although even these programmes are seen as inadequate for dealing with the complex psychosocial problems of the children these homes cater for (Pasanen 2002; Hukkanen 2002). There is a pressure to increase psychiatric treatment facilities and care for drug and alcohol abusers and also for residential, care to meet better the different multicultural needs of children.

'Secure accommodation' does not exist as a concept in Finland. The Finnish child welfare legislation recognizes that the rights of the resident may be temporarily limited in terms of access to social contacts and free movement outside establishment but there has been a deep unwillingness to introduce close institutions. In 1998, a working group initiated by the Ministry of Social Welfare and Health concluded that closed care or 'secure accommodation' should not been introduced because of concerns about the infringement of both children's rights and the Finnish Constitution. However, they did identify a need for 'special care units', which include provision of locked rooms in the context of intensive treatment (Hujala 2004, 265–269). There are only two residential establishments providing such treatment within the child welfare system. Two psychiatric units, providing 24 beds, were introduced in 2003 to provide secure care for young people within serious behavioral and psychiatric problems. Only nine children under 18s were in custody in 2002.

Child care figures in Finland show that In 2011, there were a total of 17,409 children and young people who had been placed outside thehome. The number increased by 1.4 per cent compared with 2010. Of the children and young people placed outside the home, 34 per cent (5,840) were in foster care, 16 per cent (2,825) in professional family homes, 38 per cent (6,699) in residential care and the remaining 12 per cent (2,045) in other care. The number of children and young people in residential care grew by nearly one percentage point (0.7) on 2010. Nearly half of the children placed (in care on 31 December 2011) for longer periods of time were placed with families or relatives/friends on the basis of foster care contracts.

Germany has established the legal framework of youth welfare in the German Code of Social Law containing the two main types of residential care, the foster family and children homes. Children with severe and ongoing mental health problems also have the right for special assistance in integration and rehabilitation and therapy, even parallel to other forms of educational assistance. Usually before a family gets further, systematic help of the youth welfare system, especially residential care, there has to be a certain process of counseling and exchange of information between the parents or legal guardians, the child and different professionals of the youth welfare service); specific needs, aims and measures are mutually defined (and have to be controlled during the course of the measure).

The most important institutions in the youth welfare system are the municipal youth welfare offices, which are part of the municipal administration. There are 590 municipal youth welfare offices in Germany. They are responsible for the youth welfare in the specific region.

Out of home placement residential care usually takes place at the request of the legal guardians or as a mean of protection by the welfare offices, if the best interest and welfare of a child are severely endangered (also against the wishes of the

parents). According to the principle of subsidiary most of the children's homes services are conducted by non-public organizations: 67% of institutions (61% of places). Most of them are non-profit making welfare organizations and 1.5% of the organizations (2.8% of places) are privately run as free commercial enterprises.

In 2011, there were 65,367 children, adolescents and young adults in care in residential homes or other forms of supported housing; 61,894 were in full-time care in another family. So that the use of residential care and foster care is quit balanced. The most common causes in 2011 for residential care were the (possible) endangering of best interest and welfare of a child (in 20 % of cases), limited education competences of parents (16%), and the limited care and support in family. In 2006 there were 31,687 full-time professionals working in residential care), mainly child care workers, social workers and social pedagogues.

In **Lithuania**, the Law on Fundamentals of Protection of the Rights of the Child came into force in 1996 (last amendment on 2006). According to the Lithuanian legislation alternative care of a child may be: temporal/permanent guardianship in a foster family, social family or a child care institution; temporal guardianship under the request of parents**;** and adoption (national or international). Guardianship is established for children under the age of 14; curatorship is established for children older than 14.

The purpose of temporary child guardianship/curatorship is to return the child into the child's natural family. A child is placed under temporal guardianship by the decision of the Director of the Administration of the Municipality under the recommendation of the regional Child Rights Protection Institution. Permanent child guardianship/curatorship shall be established for children deprived of parental care who, under the existing conditions, are unable to return into their natural family, and their care, upbringing, representation and protection of their rights and

legitimate interests are entrusted to another family, social family or guardianship/curatorship institution. A child is placed under permanent guardianship by the decision of the court under the application of the regional Child Rights Protection Institution.

A number of 4,119 children were in child care institutions in 2011 (1,335 in temporary guardianship and 2,784 in permanent guardianship), the vast majority in residential care 91% (mostly municipal children's homes but also state and NGO residential care exists) and the rest in family foster care. A number of 1,412 of them (34.3%) needed medical aid for MH disorders. In the same year 175 children were adopted.

The Government of the Republic of Lithuania approved the Plan of Transfer of the Functions of the Founder of State Child Care Institutions to Municipalities and the Plan of the Optimisation of the Network of Child Care Institutions, both in 2007. The Plan of the Optimisation of the Network of Child Care Institutions establishes two stages of optimisation: the first stage in 2008–2010 – transfer of the functions of the founder of state child care institutions to municipalities; the second stage in 2011–2015 – reduction of the number of places in child care institutions and optimisation of the organisation of the activities of child care. It was stated that as of 2010, the number of places in child care institutions should not exceed 60; the founder of child care institutions should be municipalities or non-governmental organisations; and work with children in these institutions should be organised on a family basis.

The Plan of Implementing Measures of the Strategy envisages specific measures aimed at increasing the level of referrals of children deprived of parental care to guardian (foster carer) families and reducing the number of children placed in child care institutions through the system of prevention, intervention and integration measures.

There are two types of specific institution for children and youth: "social care homes" for children and young people with disabilities and "special schools and/or special education centres".

Child care in **Scotland** had a watershed in the Kilbrandon Report of 1964 when concluding that similarities in the underlying situation of juvenile offenders and children in need of care and protection 'far outweigh the differences' and that the true distinguishing factor was their need for special measures of education and training, the normal up-bringing processes having, for whatever reason, fallen short. The concern, then, was to try to meet children's needs through a welfare model rather than address their needs through a criminal/juvenile justice one. In reaching these conclusions the Committee was picking up on the existing educational tradition in Scotland. It also looked to Europe and primarily Scandinavia rather than America or England for its ideas.

One of the innovative changes to flow from the 1968 Act was the creation of a system of children's hearings to address the problems faced by children who offend and those deemed to be in need of care and protection, the underlying needs of both groups being considered largely similar. The key player in the children's hearings system is the Reporter to the Children's Panel or Children's Reporter. The Reporter may come from a variety of professional backgrounds (although mostly and increasingly, law) and her/his role is both as the initial gatekeeper to the system and the person who ensures its proceedings comply with the law. Children and young people can be referred to the Reporter from a number of sources, including police, social work, education and health. A hearing consists of three lay panel members who are part-time volunteers, thus emphasising a community responsibility for children in trouble. Panels receive background reports prepared by social workers but the child and her/his family are included as key participants in the decision-

making process. Following a full discussion of the circumstances of a case, panel members can decide to take no further action, suggest voluntary measures of support or impose a supervision requirement, which may involve a child remaining at home subject to social work supervision or could include particular conditions, such as the requirement to live in a foster home or residential care. Decisions are made in the best interests of the child rather than on the basis of abstract legal principles.

The Children (Scotland) Act (1995) replaced the child care provisions of the Social Work (Scotland) Act (1968). It marked a shift in policy away from a welfare base and towards a more justice-oriented approach to child care decision-making, in which legal principles were uppermost. Terminology changed away from being 'in care' t being 'looked after'. Children in the care of the local authority now became 'looked after' whether living in residential accommodation or foster care.

The current overarching policy framework for children's services is *Getting it Right for Every Child* (GIRFEC), (2004). The thrust of GIRFEC is to provide adequate levels of support for all children and for considering the needs of children with additional support needs within a universal framework of children's needs. GIRFEC identifies a number of wellbeing indicators for children, specifying that they ought to be: Safe, Healthy, Active, Nurtured, Achieving, Respected and Responsible and Included. The GIRFEC practice model offers three main tools to guide practitioners' assessments and interventions with children and their families: the My World Triangle, the Wellbeing Wheel and the Resilience Matrix. The GIRFEC agenda dovetails with the main educational development in recent years, the implementation of *Curriculum for Excellence* (2004). This identifies the aspiration of the Scottish education system to seek to promote a wide and flexible conception of education. It aims to develop four capacities in children that they might become: successful learners; confident individuals; responsible citizens and effective contributors.

The Children's Hearings (Scotland) Act (2011), is a recent legal piece that maintains the basic principles of the children's hearings system, but modernising it through instituting a new national body, Children's Hearings Scotland, under a Chief Executive, in place of locally based children's panels. This body sets standards and ensures consistency across Scotland.

Residential child care is provided, primarily, in children's homes, and residential schools. Children's homes are generally small, catering for, on average, around four or five children. Schools are larger but, within these, children usually live in smaller, more homely accommodation. The overall pattern in the use of residential child care is one of significant decline. In England, placements fell from over 25,000 to fewer than 2000 between 1981 and the present. Proportionately, a similar fall was evident in Scotland. Foster care (or increasingly kinship care) is the option of choice.

On 31st July 2011 there were 16,171 children looked after by local authorities, an increase of 2 per cent since 31st July 2010. The number of children looked after has increased every year since 2001, and is at its highest since 1981. Thirty four per cent of children looked after were looked after at home with parents and 24 per cent were looked after by friends or relatives. Such kinship care arrangements have grown substantially over the past decade. The proportion of children looked after in residential care is only nine per cent nationally, and is now at its lowest since data has been available. The actual numbers of children in residential care has been fairly static between 2000 and 2007, but has started to show a decline since 2007.

Of the 1,475 places in residential care, 87 of these were in secure accommodation across six units. The secure units vary in size from 4 beds to 21. Children are only placed in secure accommodation if they meet the following legal criteria:

1) They have a history of absconding and are likely to abscond from other types of accommodation and

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

Until the latter decades of the 20th century the Church of Scotland and the Catholic Church were significant providers. Nowadays, the Church of Scotland maintains a toehold in residential care provision but the Catholic Church no longer has a presence. The past ten years has seen a significant growth in private provision and a worrying trend (more apparent in England at the moment) is the involvement of large private equity companies who see residential care as a potential source of profit. Relative numbers of public/private providers is hard to come by but the balance is shifting rapidly towards more private provision.

With the professionalization of social work, following the 1968, Social Work (Scotland) Act, the intention was for residential care worker to become professionally qualified in social work. Despite a number of initiatives, the aspiration for workers to become qualified in social work was never realised and the residential child care workforce has remained under-qualified and undervalued. To address difficulties in residential workers becoming professionally qualified, a competency-based approach to the assessment of practice, Scottish Vocational Qualifications, was introduced. However, even this reduced level of qualification did not lead to substantially improved qualification rates.

A National Residential Child Care Initiative (NRCCI) (2009), initiated by the Scottish Government recommended that a new Level 9 (Bachelor's degree) qualification specifically in residential child care should be introduced. Work is currently being undertaken to develop this qualification.

In **Spain**, after 40 years of dictatorship with charity organisations and a heavy history of institutionalisation, child care system started to be modernised in 1987 when a new law reforming the Civil Code established the priority for family intervention and introduced foster care for first time. Afterwards, the Constitutional Child Protection Law in 1996 created the national legal framework, enhancing all aspects of children's rights and treating children as citizens. It also established different types of foster care and introduced an important concept into child care practice: considering the interests of the child as paramount in all decisions taken with regard to his/her welfare. In addition to the above, each Autonomous Community has developed its own social services laws and its own child protection laws.

Child care system consists of two different levels:

1) Community social services: run by Municipalities and based on the community model. The types of services offered to children and families include prevention programmes and the identification of risk situations, family support programmes (multiprofessional intervention at homes) and social integration programmes aimed at individuals who are socially excluded.

2) Specialised social services: responsibility for these services lies with the Autonomous Community administration. Specialised services in the field of child protection include: residential child care: both for welfare and judicial reasons; foster care and adoption services; and coordination and support for community programmes.

Therefore, a key issue in the Spanish system is the coordination between the two levels and the good harmonization between them as very often is very controversial.

Statistics are a serious problem in Spain as Autonomous Communities don't have a common system to collect data and they send on a voluntary basis data to the Ministry of Health and Social Policy that produces a yearly bulletin. This publication has a lot of gaps with some communities despite the effort that the Ministry has made in last years. According to this system there were 34,569 children in out of home care placements on 31st December 2010, 40% in residential care and 60% in foster care. Although those figures seem to mean that Spain has overcome the past of institutionalisation in favour of foster care placements, it is important to notice that foster care is mostly (75-80%) kinship care. Then, very few foster care placements are due to voluntary families fostering children without a previous relationship. The role of grandparents as kinship carers is a characteristic very distinctive of Spain and there is an enormous need of voluntary families to raise figures of foster care (with non-relatives).

Typologies in residential care comprise children's homes for children 0-3 years old, emergency shelter homes, children's homes for varied ages (particularly useful for sibling groups), supervised homes for adolescent in order to be prepared for independent living, homes for adolescents with severe behavioural and emotional disorders and residential homes for unaccompanied asylum-seeking young people. Both, residential care for adolescents with behavioural disorders and asylum seekers were notably growing in the last decade and nowadays residential care in Spain is a measure really specialized in adolescents with this kind of problems.

Residential workers in residential care are social educators who must have a university grade, similar to nurses or teachers. Many of the children's homes (particularly the biggest ones) have a multiprofessional team with psychologists, social workers or pedagogues to support the socio-educative work. In the case of

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

Interaction between MH and child care systems, special groups and good practices

No data from **Denmark**.

No data from **Finland**.

In **Germany** some studies conclude that 59.9% have a mental disorder with a predominance of Conduct Disorders, but also ADHD, depression, substance abuse or Enuresis are frequent; there is also a high rate of comorbidity. MH problems in residential care often contribute to moving through different institutions, dropouts and aborts of youth welfare interventions and in general to less effectiveness of interventions and special care. There is a clear concern about the need for a closed cooperation between MH and welfare systems that need for changes in legal, financial and political structures.

As good examples of cooperation: some regions have written guidelines for cooperation as a result of mutual discussions; case conferences, committees and taskforces with professionals from both systems; increasing numbers of specialized residential homes for young people with severe MH problems where there is a better supply of therapeutic services; also specialized complementary services for residential homes like so called liaison-services increase in number; in some cities there are special clearing services in youth welfare with child psychiatry competences to find out the right help, to adjust and match different forms of assistance and to clear responsibility and case management.

With respect to special groups, there is still a high need of better concepts and more specialized residential homes for different groups of children and adolescents. These are children with certain experiences and problems (e.g. traumatized children, violent,

delinquent adolescents, sexual offenders or refugees). For instance the concept of "trauma pedagogic" is getting more popular and is quite promising. It is also necessary to improve help for under age, minor refugees, especially those who come to Germany without parental or any other official guidance. Their number in Germany is estimated to 10,000.

There is an ongoing controversial discussion about closed residential homes for delinquent and/or very aggressive adolescents and juvenile offenders. These special placements can be an "ultima ratio" in very severe cases and on court order. There are less than 20 of these institutions in Germany

In **Lithuania** there is a lack of statistics about children in care receiving MH services. In this country foster homes social worker is the initiator who provides support for a child and who uses help not only from the institution but also from other concerned institution specialists.

In **Scotland** several studies (on UK) on leaving care indicates poor educational qualifications with only 1% going to University (36% in their peers), being ten times more likely to be excluded than other children. MH problems are also more frequent than in children cared for at home. A Scottish study shows a 52% of prevalence in children in care compared to an estimated 8% in general population. The disorders evident were conduct disorder, hyperactivity and emotional disorders of anxiety and depression.

Poor outcomes for those leaving care prompted a political focus on how children and young people leaving care might be best supported. The Children (Scotland) Act 1995 provides the legislative basis for work with children and young people in care and leaving care, setting out powers and duties that fall on local authorities to support throughcare and aftercare arrangements.

In **Spain**, as mentioned above, there is a serious problem of statics, not only in child welfare but also (and even more serious) in MH services. There are no national epidemiological data for general population or for children in care. Only a recent study in the Autonomous Community of Extremadura allows having some data. Results show that 26% of children in residential care were receiving therapeutic services, but diagnoses were very scarce and non-specific. Suicide threatens and attempts were remarkable (9%) and also intellectual disability (17%) was a significant problem. Almost half of children and young people with

intellectual disability were receiving MH therapy due to other emotional or behavioural problems. The most frequent resource was public MH services (70%), usually attended by psychiatrists but 60% received psychological treatment (half of them shared with psychiatry services).

As a part of this study, that can be considered a good practice, a Guide of Mental Health of Children in Residential Care was published, including theoretical contents about child psychopathology; a proposal for detection, assessment and referral process; and some theoretical and practical training about resilience, attachment and conflict managing to help social educators in their work.

Other good practices in Spain comprise specific therapeutic programs for children in care, like in the Autonomous Community of Murcia, where a hospital unit has a specific program based on virtual therapy for abused or neglected children (most of them in residential care). Also in the region of Guipúzcoa (Basque Country) there is an agreement between child care services and the Psychologist Association to have a list of specialised psychologists to attend children in residential care. Social educators can use this service freely referring children with suspicion of behavioural or emotional disorders.

With respect to special groups the most important issue in the last decade was the massive arrival of young people coming form North Africa as unaccompanied asylum seekers (on a estimation of 2,000 per year since 2002 to 2009). All of them were attended in residential care, so many new units had to be created specifically for them. Although this group doesn't have the same high need for MH treatment than our local young people, they posed a lot of challenges in terms of cultural adaptation, language, religion, educational level, etc.