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**How can mental health practitioners collaborate with child welfare practitioners to improve mental health for young people in Out of Home Care?**

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**Background:** Young people who grow up in out of home care (OoHC) have higher risk of poor mental health outcomes than peers who grow up with their family-of-origin. Interagency collaboration is an important service-level intervention to improve access to mental healthcare. However, few descriptions of collaboration provide guidance about collaboration between individual practitioners.

**Aim:** This substudy aimed to contribute to a larger study – the Ripple project - through exploring the experiences of practitioners working across child welfare and mental health services regarding collaboration in the care of young people; and to identify practices that might enhance collaborative work and improve mental health outcomes.

**Method:** Practitioners from across child welfare and mental health services were purposively sampled and participated in focus groups. Recordings and transcriptions of focus groups were analysed to identify themes within and between groups. A cross-sector expert advisory group was involved in this work.

**Results:** Focus groups were convened with 43 practitioners. We identified four themes during analysis, these were: shared understanding of the history and context of problems; specific skills and practices; self-awareness of workers and carers; and involving and supporting carers.

**Conclusions:** A number of practices were identified that might lead to enhanced collaboration between agencies and across interdisciplinary care teams. Supporting mental health practitioners to adopt these might assist interagency and interdisciplinary working.

Crossover youth; Early intervention; Looked-after-children; youth mental health;

## 1. Introduction

Young people who grow up in out of home care (OoHC) have a high risk of poor mental health, and experience limited access to mental health services. OoHC refers to the range of care settings outside of the family-of-origin for children and young people in need of protection. In Victoria, these include foster care, in the private home of a substitute family receiving payment; kinship care, with a family member or approved custodian; and residential care, in a house with up to three other young people supported by paid staff (Cummins, Scott & Scales 2012).

Young people who experience OoHC have typically experienced risk factors for the development of mental ill-health, such as exposure to physical abuse, sexual abuse and neglect (Salazar et al., 2013; Kerker et al. 2015). They experience poorer mental health outcomes than peers who grow up within a family of origin (Ford, Vostanis, Meltzer & Goodman, 2007; Milburn, Lynch & Jackson, 2008; Rahamim & Mendes, 2015). They commonly experience substance use problems, suicidal ideation, self-harm, and offending behaviours (Cashmore & Paxman, 2006; Osborn & Bromfield, 2007; Wise & Egger, 2007). Meta-analysis suggests a threefold risk of suicide attempts (Evans, White, Turley et al., 2017).

These young people also experience particular barriers to accessing mental healthcare. Their carers might not routinely detect mental health problems (Bonfield et al., 2010; Winsor & Mclean, 2016), might lack knowledge of how to access mental health services, and often feel disregarded when they seek help (York & Jones, 2017). When young people do access mental healthcare, available evidence provides limited guidance for treating their complex problems (Tarren-Sweeney 2010; Leve et al., 2012; Luke et al., 2014; Vojt, Skivington, Sweeting et al., 2018). They may experience less positive treatment outcomes (Jones, Godzikovskaya, Zhao et al., 2019).

Calls for better mental health service provision for children and young people in OoHC have come from both child welfare (Tarren-Sweeney, 2010) and youth mental health (Hughes et al., 2018). Both sectors identify that interagency collaboration is critical. System-level activities including information-sharing protocols, and timely

screening, assessment and referral procedures have been recommended (Bai, Wells & Hillemeier, 2009; He, Lim, Lecklitner, Olson & Traube 2015; Cooper, Evans & Pybis, 2016; Smith, Fluke, Fallon et al., 2017). Where implemented, these activities appear to increase access to mental healthcare (He, Lim, Lecklitner, Olson & Traube, 2015). There is not yet evidence that these activities increase access to evidence-based treatments, or improve outcomes (He et al., 2017; Winters, Collins-Camargo, Antle & Verbis, 2020). Where formalised partnerships do not exist, individual mental health practitioners may still be influential in promoting and supporting interagency working. Collaboration between individual practitioners may influence the extent to which therapeutic intervention is integrated into the care of a young person (Bunger, Cao, Girth et al., 2016; Darlington, Feeney & Rixon, 2005). Positive experiences of case-focused collaboration can enhance other opportunities for partnership and collaboration (Van den Steene et al., 2018). This paper explores how individual practitioners from different settings can collaborate in the care of an individual young person.

## **2. Aim**

This study aims to explore:

- (a) the experiences and perceptions of child welfare and mental health practitioners regarding interagency and interprofessional collaboration to meet the mental health needs of young people living in OoHC; and
- (b) what mental health practitioners might do, to promote collaboration to meet the mental health needs of young people in OoHC.

This study comprised one component of formative evaluation for the Ripple study of implementing a complex mental health intervention for carers of young people in OoHC in Victoria, Australia (Herrman et al. 2016). It complements interview studies conducted with foster carers and kinship carers (Fergeus, Humphreys, Harvey & Herrman 2019) and with young people in OoHC (Monson, Moeller-Saxone, Humphreys, Harvey & Herrman, 2019).

## **3. Method**

This project took place in Melbourne, Australia, and was overseen by a project advisory group (Advisory Group) with representatives from all sectors.

We believe individuals' knowledge, attitudes and behaviours are influenced and produced by the physical, social and legal environments within which they exist (Bronfenbrenner, 1977). Focus groups were uniquely suited to our study aims. Unlike other qualitative methods (e.g: questionnaire, in-depth interview), the social milieu of groups reproduces aspects of participants' context (Wilkinson, 1999). Participants negotiate their individual experiences and opinions with their professional roles, their group memberships, and the ways in which these relate to others.

The Advisory Group developed a semi-structured focus group schedule aimed at eliciting discussion amongst participants (see Appendix 1). Five focus groups were convened with practitioners from relevant sectors:

- specialist child and adolescent, and youth mental health services (CAMHS/YMHS), alcohol and other drug (AOD), and specialist OoHC-focused therapeutic services who provide trauma-informed consultation and trauma treatment in OoHC ('therapeutic services'); and
- community sector organisations (CSOs) contracted to provide OoHC casework and placement services and;
- statutory Child Protection services including direct-care staff, team leaders and program managers tasked with overseeing statutory aspects of OoHC.

### ***3.1 Ethics***

This study received Melbourne Health Human Research Ethics Committee approval. Additional approval was sought from the Department of Health and Human Services Research Coordinating Committee, and relevant committees at participating health and human services.

### ***3.2 Data collection***

Participants were recruited purposively through the Advisory Group. A sampling matrix was developed to ensure internal heterogeneity of the sample. Focus groups

were conducted in inner-urban locations convenient to participants, over three weeks in August and September 2013.

Four of five focus groups were convened by an experienced facilitator with an investigator role on the project. Author 4 convened another, because of familiarity with participant context. Another investigator was always present for observation and note-taking.

### **3.3 Data analysis.**

We followed phases of thematic analysis outlined by Braun and Clarke (2006). Authors 1 and 3 listened to each audio recording at least once to familiarise themselves with the data in context, and then discussed their experiences of the data. Author 1 is a mental health practitioner with professional and personal experience interacting with the OoHC system. Author 3 is a mental health promotion researcher. Audio recordings of focus groups were transcribed by a professional transcription service. On reading transcripts, Authors 1 and 3 deductively identified codes. Codes were recorded through hand annotation of transcripts. Initial codes were discussed with the author group for validation and identification of possible gaps. Author 1 began exploring relationships amongst codes that were pertinent to the key research questions. Emergent themes were presented to the Advisory Group for validation, including whether data included in each theme were seen as relevant to the code; and whether the theme was broad enough to be rich and narrow enough to be meaningful (Braun & Clarke, 2020).

## **4. Results**

Five focus groups were convened, with 43 participants.

Professions represented included social work, occupational therapy, clinical psychology, psychiatry, psychotherapy, psychiatric nursing, community services and youth work. Participants described they had been employed in their sector for between 3 and “more than 20” years.

Table 1: Focus group composition

[TABLE]

Focus groups lasted between 90-minutes and 180-minutes, with a break.

All participants in all groups contributed verbally. It was not uncommon for participants to overtly build on one-another's examples through interpreting and clarifying aspects, for example, in focus group 3, one participant shared a story of interagency collaboration and consultation to a care team. Others then contributed:

*"(it sounds like it was about) tolerating ambiguity"* [CAMHS/YMHS participant]

*"Sitting with not knowing"* [therapeutic services participant]

*"Yeah tolerating that we might not have all the answers"* [CAMHS/YMHS participant]

In mixed sector groups, there were occasions of overt acknowledgement of differences in practices and paradigms, for example participants inviting others contributions:

*"I should probably let mental health services comment"* [therapeutic services participant]

In groups 1, 2 and 4, identifying promising practices was prominent, with focus on what participants would like to see more of. In groups 3 and 5, there was more emphasis on threats to positive outcomes. Some participants in the Child Protection practitioner group described historical efforts at collaboration as "the biggest fattest waste of time", although the same participants perceived one example of collaboration very favourably.

Analysis derived four main themes:

1. A shared understanding of the history and context of problems
2. Specific skills and practices
3. Self-awareness of workers and carers
4. Involving and supporting carers

Each theme captures participants' experiences and perceptions of how interprofessional collaboration might promote improved mental health outcomes. Description of these themes forms the rest of this section.

#### ***4.1 A shared understanding between mental health and child welfare practitioners, and carers, of the history and context of the young person's situation and difficulties***

Participants in all groups highlighted the importance of developing an understanding of the young person's situation and difficulties, and the events likely to have shaped these. They described that vitally, this understanding should be shared amongst mental health and child welfare practitioners, and carers. Carers included employed carers, such as residential carers; and voluntary foster carers and kinship carers. A shared understanding was seen to be useful to help all involved to be empathic towards a young person, to identify their strengths not only their challenges.

Participants described how "shared understanding" [CAMHS/YMHS participant] might allow care teams to:

*"support one another...because it's a big thing to contain emotionally, because...it's a lot of risk involved, and for people to be able to handle that risk [they need to have] a safety net."* [CAMHS/YMHS participant]

When practitioners across sectors had different understandings, this could lead to incoherence in the care team, which in turn could impact placement stability.

*"You get (professionals) with opposing views and they're sort of going at each other and you get the dynamic of the Department must do this, and the Department saying we can't or we won't"* [Child Protection participant]

Whilst differences in understanding of the young person's difficulties might be driven by "silos" services operate in [CSO participant], more commonly they were sustained by "umpteenth multiple services...not talking to each other" [CSO participant].

Disjointedness was less likely when mental health assessment, formulation and treatment planning occurred in close collaboration with other practitioners, and carers.

*"Jointly formulate what's going on for the young person based on their understanding of their life story and their circumstances"* [AOD participant]

Mental health practitioners' use of excessively technical language was seen as a barrier to developing shared understanding.

*“Like you read some treatment plans and you're looking at it and going what the hell are they talking about?”* [CSO participant]

Collaborating to develop a shared understanding typically involved considering the young person's development, understanding the impact of specific traumas and understanding attachment behaviours.

*“Steer away from some of that [diagnostic] language, just to sort of ... create a space to unpack what's actually going on for the child in terms of their development...draw on the developmental history and particularly trauma history to gain a sense of how they're travelling”* [therapeutic services participant]

CSO staff drew on experiences of secondary consultation and care team consultation to describe how shared understanding might reduce anxiety, increase role clarity, and lead to improved consistency in care. Interagency conversations were seen as one way to keep the young person's story and experiences “in heart and mind” [CSO participant], and “coordinate silos” [CSO participant].

#### ***4.2 A shared understanding of specific skills and practices likely to be helpful***

Participants in all groups described that ideally, a shared understanding should be operationalized into skills and strategies that might be used by practitioners and carers.

*“Diagnosis is only helpful if it helps you understand what to do.”* [therapeutic services participant]

*“Acknowledging where the behaviour's coming from and acknowledging the trauma and the complex issues that these young people have been through and are going through, but also trying to kind of find some practical approach about how you can manage that.”* [CSO participant]

*“Giving us feedback on what's happening for this young person, what we should be doing – those sort of tips are really important, and they work”* [Child Protection participant].

A shared understanding of difficulties could provide a shared rationale, thereby overcoming resistance or reluctance to try new strategies.

*“Once you...sit with a group of people who are tearing their hair out and then get a shared understanding of what’s happening...and suddenly you see it moves, things start moving, the care starts moving, [the care team’s] behaviours start changing”.* [therapeutic service participant]

Child Protection participants described some practice recommendations felt trivial - “just keep going, you’re doing great work” [Child Protection participant]. They suggested credible and acceptable recommendations were those that were “highly informed and highly individualised”.

Participants in all groups except the CSO group emphasised the importance of the credibility of practitioners providing practice recommendations. Some suggested this was improved if the mental health practitioner was an ‘insider’ in the young person’s care.

*“someone...who’s happy to get in there on the floor”* [Child Protection participant]

*“there’s a lot to be said about actually being there, being in the unit”* [CAMHS/YMHS participant]

CSO participants felt that ‘outsiders’ could equally be credible and provide meaningful recommendations if they had an opportunity to work with members of the care team to develop a shared understanding.

*“Looking at the assessments...not making the assumption that everyone in the care team knew how to put all that work and all that knowledge into practice... [collaborating to develop a] structured outline of what the intervention for this young person needed to look like.”* [CSO participant]

Importantly, strategies had to “work within the parameters of (the OoHC) system” [CSO participant], and recognize the different roles and responsibilities of different care team members.

*“It needs to be about the whole system and the whole context.”* [Child Protection participant]

### ***4.3 Self-awareness of practitioners and carers***

Participants described young peoples' behavior could be worrying or frustrating for carers and practitioners. This sometimes led to reactive and unhelpful responses. Self-awareness was seen by all groups as invaluable for reducing reactivity.

*“Helping [workers and/or carers] plot out what patterns they get drawn into, and then how actually, why they're unhelpful in the first place, where they've come from, what might they be enacting in that and then how to step out and try something different”* [CAMHS/YMHS participant].

Self-awareness was equally important for carers as for professionals, central to guiding reflection on their role, and promoting support-seeking from the wider care team. Without self-awareness, “people end up acting in very stilted ways that actually exacerbate the problems” [therapeutic services participant]. All groups except Child Protection described reflective practice as an important practice framework for self-awareness. Reflective practice – together with a shared understanding - was seen to assist people to be self-aware, and to reduce reactivity.

### ***4.4 Involving and supporting carers***

All previous themes are inclusive of carers, not only practitioner-to-practitioner collaboration. In addition, all groups highlighted the importance of providing direct, tailored support to carers. Participants believed that carers and young people benefit from support to repair relationship ruptures and enhance placement stability.

Carer burden was acknowledged, including carers' worry that they will be criticized or blamed for challenges in the placement.

*“They often feel really undervalued in the work they do, and they often feel they're blamed when things are going wrong, that they've got this big brother watching over everything they do”* [therapeutic services participant]

Including carers in care team meetings was seen as one way to reduce the risk of carers feeling criticised or blamed. Showing empathy, and validating carers was regarded as vital.

*“(Carers) love the kind of knowing that someone's on their side and someone to understand what they're up against”.* [therapeutic services participant]

## 5. Discussion

We aimed to explore experiences of interagency and interprofessional collaboration amongst practitioners across CAMHS/YMHS, AOD, therapeutic services, CSOs and Child Protection. We wanted to understand what mental health practitioners might do to promote collaboration. Participants in all groups from all sectors endorsed that collaboration was important to improve mental health outcomes for young people in OoHC. Participants across sectors described positive experiences of working collaboratively to understand a young person's difficulties and to respond in helpful ways. Child Protection participants identified some efforts they felt were unsuccessful, highlighting barriers to collaboration.

Participants described that developing a shared understanding of a young person's difficulties extends beyond a diagnostic label, towards acknowledging the individual's idiosyncratic experience, context and meanings (Macneil, Hasty, Conus & Berk, 2012). Whilst participants did not mention specific treatments, psychoeducation is a prominent component of most promising treatment models (Luke et al., 2014). Mental health practitioners delivering psychoeducation in OoHC should focus not only on 'symptoms' (Tarren-Sweeney, 2010) but on constructs such as attachment, and impacts of trauma (Luke et al., 2014). Ideally, psychoeducation should include the young person and others involved in their care (Lucksted, McFarlane, Downing & Dixon 2012).

Kerns et al. (2014) found child welfare practitioners may lack confidence to translate assessment into case planning and intervention. Mental health practitioners can use shared understanding to work towards collaborative planning that focuses on reducing vulnerability, and increasing protective factors (Zabern & Bouteyre, 2018). Most participants highlighted the importance of workers developing specific skills to support the young person. Skills training is identified as a core component of successful foster carer and kinship carer interventions for children (Luke et al. 2014, Kemmis-Riggers, Dickes & McAllon 2018), and is a component of some therapeutic care models (Cameron & Das, 2019). Participants here suggested that skills training might be beneficial beyond the *in-locis-parentis*, to anyone with a role in the system of care. Emotional attunement, emotion validation and establishing boundaries are

specific skills that young people in care, and carers themselves have identified can be useful (Brown et al., 2019, Monson et al., 2019). Further, these are components of promising interventions (Luke et al., 2014).

Self-awareness via reflective practice was described by participants across most sectors as vital. Elsewhere, it has been identified as a critical component of effective therapeutic residential care (McLean, Price-Robertson & Robinson, 2011). Current intervention research focuses on developing reflective skills in foster carers (Bammens et al., 2015). Whilst participants in this study did not seek mental health practitioner input into developing reflective practice, this finding may act as a prompt to mental health practitioners to promote the value of reflective practice in the wider care team.

Participants occasionally referred to different organizational mandates and legislative frameworks as important context for collaboration. This challenge is described in detail elsewhere (e.g: Morgan, Pullon et al., 2019) and deserves ongoing attention. Interventions are likely to be strengthened if mental health practitioners are familiar with OoHC legislative and practice contexts. Self awareness therefore includes awareness of ones' own roles, responsibilities and mandates, and awareness of others' contexts (Morely & Myhill, 2018).

In contrast to the perceptions of foster and kinship carers (Fergeus et al., 2019), practitioners across all sectors readily identified the importance of caregiver wellbeing to young people's mental health outcomes. Involving caregivers of young people in OoHC is likely to increase young people's retention in treatment (Dorsey et al., 2014). Furthermore, it may enhance placement stability, identified as critical to their mental health (Rice et al., 2017). Participants did not identify particular barriers to caregiver involvement in mental health assessment and treatment planning. However, given continued challenges implementing family involvement in mental health services (Selick et al., 2017), OoHC caregiver involvement may require special attention.

Given a diverse array of scenarios discussed in these focus groups, future qualitative studies may focus on narrative accounts that explore in greater detail multiple

perspectives of the same collaboration. Longitudinal accounts that consider outcomes for young people will be particularly valuable (Baidawi, Mendes & Snow, 2014).

### **5.1 Limitations**

Earlier stakeholder engagement activities through the Ripple project (Herrman et al, 2016) may have increased participants' receptiveness to ideas of collaboration, consequently reducing the likelihood of eliciting barriers to collaboration found in other studies. Though not found here, we acknowledge practitioner concerns about information-sharing and privacy can inhibit collaboration (Hwang, Mollen, Kellom, Dougherty & Noonan 2017). Efforts to act on these findings should address this issue.

Heterogenous group composition (i.e: mixed groups of mental health, child protection and community sector practitioners) may have led to contextualised interactions that would enable identification of other implementation opportunities and challenges.

This study did not seek young people's or carers' views on collaboration, nor the views of families-of-origin. Their perspectives are crucial to ensuring that mental healthcare is provided in a person-centred and family-inclusive way. We acknowledge the importance of young people in OoHC as central to decision-making about their own treatment and care (Davies & Wright, 2008). We have described elsewhere our initiatives to include young people (Herrman et al, 2016; Monson et al, 2019; Rafeld et al., 2019) and carers (Fergeus et al., 2019).

### **6. Conclusions**

Participants saw interagency and interprofessional relationships between child welfare and mental health as critical to improving young people's mental health outcomes. They described that carers must be involved, too. This complements the understanding from other research of the central role of young people and carers in effective care and support systems.

Outcomes may be improved through young people, carers, mental health and child welfare practitioners, and others involved in the young person's care jointly formulating the impact of past experiences on the young person's current difficulties.

Mental health practitioners need to acknowledge the context of different contributors to a young person's care, and develop tailored responses. This may lead to improved quality of care. As with young people living with their families of origin, young people in OoHC are likely to benefit from service provision that focuses on involving and supporting their caregivers in their mental healthcare.

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**Data availability:**

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to containing information that could compromise the privacy of research participants.

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Table 1: Focus group participants

Focus Group	Composition	Participant Details
1.	Mental health, AOD and therapeutic services	7 participants <ul style="list-style-type: none"> <li>• 4 participants from CAMHS/YMHS</li> <li>• 1 participant from AOD</li> <li>• 2 participants from therapeutic services</li> </ul>
2.	Mental health, AOD and therapeutic services	7 participants <ul style="list-style-type: none"> <li>• 5 participants from CAMHS/YMHS</li> <li>• 1 participant from AOD</li> <li>• 1 participant from therapeutic services</li> </ul>
3.	Mental health, AOD and therapeutic services	8 participants <ul style="list-style-type: none"> <li>• 5 participants from therapeutic services</li> <li>• 3 participants from CAMHS/YMHS</li> </ul>
4.	Community Sector Organisations	9 participants <ul style="list-style-type: none"> <li>• 2 participants from CSO-A</li> <li>• 4 participants from CSO-B</li> <li>• 3 participants from CSO-C</li> </ul> (Various management and team leader roles, across home-based care and residential care)
5.	Child Protection	12 participants <ul style="list-style-type: none"> <li>• 5 participants identified as 'practice leaders'</li> <li>• 4 participants identified as 'case managers'</li> <li>• 3 participants identified as team or area managers</li> </ul>

## **Appendix 1. Example focus group questions.**

How do you define mental health, and social and emotional wellbeing? What do these terms mean to you?

What are the top three priority mental health and wellbeing issues amongst young people in Out of Home Care, from your perspective?

What structures and mechanisms enable collaborative work to improve the mental health of young people in Out of Home Care?

What are some of the strengths in the system at present?

What are the top three priority activities that could strengthen practitioners' responses in the area of mental health?

What skills do mental health professionals need to have, if they are working towards improving the capacity of child welfare practitioners to respond to young people's mental ill health?