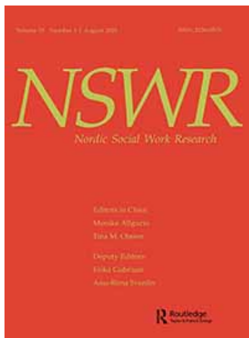

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Integrated residential childcare – facilitators and barriers for collaboration between residential care and mental health care: a systematic review

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ABSTRACT

The severe mental health problems of the many youths living in out-of-home care place demands on integrated care between the residential childcare (RCC) sector and the mental health care sector. Thus, all available resources and the professional expertise of both sectors must be coordinated to ensure adequate care. This is problematic as research highlights that reconciling the different working cultures and professional intentions of the residential childcare and mental health care sectors is perceived as difficult. As such, the purpose of this systematic review is to synthesize the evidence from studies on facilitators and barriers of integrated care practices. A literature search, limited to articles published in English between 2016 and 2022, was conducted of seven databases. Seven studies were included in the review. Information-sharing systems, structured models and joint training are suggested as bases for promoting integrated care. Interestingly, although the frontline practitioners in the residential care and mental health care sectors (social educators, nurses, care workers, etc.) play a crucial role in the implementation of integrated care, research on inter-sectoral and indeed inter-professional care is scarce. More detailed research on the factors that facilitate integrated residential care is needed. This knowledge is valuable, particularly in the Nordic high-level training system, as it reflects how we should promote inter-professional learning processes and internships to better understand and appreciate the capabilities and priorities of other professionals and service providers to ensure better outcomes for youth. This review has implications for staff standards and for residential childcare workers' professional competencies.

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Foster care; child protection; residential child care; mental health care; inter-professional

Introduction

Roughly 340,000 children are estimated to live in residential care across the EU (Lerch and Nordenmark Severinsson 2019). The mental health of these youths who are accommodated in residential facilities is often affected by experiences such as neglect, maltreatment, substance abuse, parental mental illness and other adversities. Indeed, several studies have found that children placed in out-of-home care (OoHC) are far more likely than their peers to experience mental health

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problems and psychiatric disorders (McLean et al. 2013; Sariaslan et al. 2022). Furthermore, as indicated in longitudinal studies, custody in residential care appears to be a risk factor for mental health disorders in adulthood (Seker et al. 2022). Young people in OoHC commonly experience mental illnesses such as anxiety, depression, post-traumatic stress disorder, disruptive behavioural disorders and self-harm (Tarren-Sweeney 2018; York and Jones 2017). To effectively serve the needs of these children, residential care not only has to fulfil its child protection mandate to provide a safe environment but also offers needed therapeutic services to address the complex emotional and behavioural challenges of many youths in these settings (Whittaker et al. 2023). It is self-evident that the resources and professional expertise of both the RCC and child and youth mental health care sectors must be coordinated in their care. However, studies on multiple clients in RCC and adolescent psychiatry (Armstrong et al. 2013; Kölch et al. 2019) indicate that child protection and mental health care are in fact separate services, leading to an unwanted situation where the availability of mental care services for young people living in residential care is lacking. In the Nordic countries, the outcomes of child protection have been noted to be relatively poor (Pösö, Skivenes, and Hestbæk 2014). Recently, increased marketization together with differences in the proportions of children placed in different types of residential placement has raised questions in the Nordic countries about the quality and effects of care given by residential service providers and the outcomes of RCC in general (Pålsson et al. 2024; Shanks et al. 2021; York and Jones 2017).

Integration is understood as an important goal and a means to achieve smooth care and service chains. In the RCC context, the major aim of integrated care is to enable permanent high-quality residential care and prevent placement changes (Aarons et al. 2010; Baia, Wells, and Hillemeier 2009; Collado and Levine 2007; Fawley-King and Snowden 2012). The challenge in promoting integrated care is the complexity of the service system, which brings a variety of professionals with a variety of treatment, education and therapeutic approaches together, obscuring who is the coordinator and who is in charge. Obviously, at the system level, integrated governance lays the foundation for an operating culture in which the social and health care organizations have common, shared interests and values that promote integration (Tiirinki et al. 2022; Winters et al. 2019). The main concerns when developing integrated care involve identifying both parties' responsibilities for delivering information, ensuring efficient communication to promote confidentiality and allocating resources appropriately (Darlington, Feeney, and Rixon 2005; Janssens, Peremans, and Deboutte 2010; Sloper 2004). Naturally, commonly agreed goals and an understanding of the essential elements of inter-professionalism are the keys enabling effective collaboration (Eenshuistra, Harder and Knorth 2019; Lee, Esaki, and Greene 2009; Wells and Chuang 2012). Integrated care is a multidimensional concept, with barriers and facilitators ranging from the interaction between professionals to administration, organizational structure and funding (Valentijn et al. 2013).

The concept of integration has existed for years in the field of social and health care research, but defining it can often be challenging due to different interpretations (Goodwin 2016). The concept can be defined as horizontal integration, which relates to strategies that link similar levels of care, or as professional integration, which refers to the extent to which professionals coordinate services across various disciplines (Valentijn et al. 2013). Integration means promoting integrative practices between agencies and concrete interprofessional actions, which in fact creates a learning process towards understanding and appreciating the perspectives of partner professions (Ritala-Koskinen, Räsänen, and Salo 2025, 10, 317). In turn, functional service integration reflects standardization of the key actions, for example, management and information systems, that enable decision-making and coordination between different organizations and actors (Taskinen et al. 2020).

In relation to professional integration, research indicates that professionals' status differentials pose obstacles when it comes to collaborative working. In terms of collaboration between the RCC and mental health care sectors, the focus seems to be to some extent on delivering psychiatric knowledge and expertise within child protection and RCC services (Darlington and Feeney 2008; Darlington, Feeney, and Rixon 2005; Janssens, Peremans, and Deboutte 2010;

Sloper 2004). It is understandable that if one professional's knowledge and competence is appreciated more than another's, this may have an impact on expectations of co-working. When residential workers are unable to advocate for their own needs and professional interpretation, they may be unable to promote a child-centred framework and advocate effectively for children's needs (McLean 2012). In the end, it is the residential care workers' responsibility to keep educative, healing, therapeutic and rehabilitative actions on track every day and every week. A stable and well-trained residential care workforce, the inclusion of caregivers, a solid behavioural management programme for the promotion of prosocial skills and trauma-informed elements are factors affecting the positive influence of OoHC on children's mental health (James 2017; Steinkopf et al. 2022). Unfortunately, in practice not all of these factors are present. The international literature shows how the skills of residential care workers vary, with some staff having low levels of education (including paraprofessionals) and others being educators with university qualifications and approved programmes and models (Pålsson et al. 2023; Whittaker et al. 2023). This poses a challenge to our review in terms of compiling 'a general picture' of the diversity of residential care models, given the variations in implementation of co-working practices as well as the level of inter-professional competencies across different contexts.

The present review is inspired by an integrative review targeted at mental care interventions provided for residential childcare institutions (Lahti et al. 2018). We are also contributing additional knowledge to a previous review (Eenshuistra, Harder and Knorth 2019; Lee, Esaki, and Greene 2009; Wells and Chuang 2012) on the effects of training in improving competencies and promoting professionalism in residential care. The overall aim of this review is to extend previous knowledge by assessing current evidence on integrated care practices between residential childcare and youth mental health care sectors and co-working actions between professionals.

Method: a systematic literature review

Research question and eligibility criteria

A systematic literature search was conducted to synthesize an overview (Xiao and Watson 2019) of inter-sectoral collaborative practices and to provide knowledge of experiences and perceptions on the barriers and facilitators of integrated residential care. The review protocol was registered with PROSPERO (International Prospective Register of Systematic Reviews) under the registration number CRD42022330798.

The research question was 'What are the barriers and facilitators to guaranteeing integrated care for children living in residential care with mutual clientele in child protection and youth mental care services?' It was evaluated by searching for facilitators and barriers to inter-sectoral and/or inter-professional collaboration. The concept 'mental care' refers to the exploitation of child and youth mental health expertise in delivering residential care and carrying out children's care plans. The challenge of conducting an international-level analysis lies in the different terms used for different types of care, as well as the striking variation between nations in the utilization of RCC, as well as the different levels of worker expertise and training required (Whittaker et al. 2023). In this review, however, we do not focus on the complexity of RCC or the differences between service providers. Instead, the research addresses both inter-sectoral and inter-professional collaboration with the aim of finding relevant research on integrated care practices, which means that the service users' viewpoints are not included.[1]

For the purpose of this study, we use the term 'integrated residential care' as follows: it attempts to balance the structural side effects of RCC and mental care professionals working in silos, as well as to capture the interaction and coordination of the professional expertise of both sides. The concept also refers to the usual practice whereby the commissioning of RCC has increasingly

become a joint activity, in particular, the use of multidisciplinary decision-making (Holmes and McDermid 2012, Naylor et al. 2019).

The main outcomes of interest involved all inter-sectoral administration, organizational collaboration and/or inter-professional working (practice models, interventions and methods) between residential childcare and mental care. We excluded studies when there was no evidence of collaboratively implemented actions. In addition, studies on collaboration within the health care sector, e.g. primary health care and tertiary mental health care, were excluded. Extended collaboration with schools and the police were excluded as well. There was no geographical limitation for the place of study. To obtain relatively new data, the search was limited to articles published between 2016 and 2022 and written in English. Table 1 summarizes the inclusion and exclusion criteria.

Systematic search

We conducted a comprehensive search for relevant studies in the following databases: CINAHL Academic, PubMed, ERIC, Ovid MEDLINE, JIB, Cochrane Library and Academic Search Premier. A total of 388 possibly eligible citations were identified.

- The following search terms were selected to cover the RCC context and variation in residential childcare facilities: 'residential youth care' OR 'out-of-home care' OR 'foster care' OR 'group residential youth care setting' OR 'residential childcare' OR 'residential child treatment' OR 'institutionalized children' OR 'institutionalized adolescents' OR 'therapeutic residential care' OR 'state care' OR 'residential group homes' OR 'congregate care'.

- The following search terms were selected to cover all residential co-workers with variation in training backgrounds: 'residential youth worker' OR 'social care worker' OR 'residential childcare worker' OR 'social educator' OR 'educator' OR 'social worker' OR 'counsel' OR 'youth worker' OR 'group youth worker'.

- The following search terms were selected to cover the variety of collaboratively implemented actions with mental care, as mental care is assumed to be the main associate actor for delivering residential care: 'inter-professional' OR 'multiagency' OR 'working together' OR 'multidisciplinary team' OR collaboration OR 'co-working' OR 'teamwork' OR 'integrated work' OR 'multi-professional' OR 'multisectoral'.

In the next stage, the titles and abstracts were shared among reviewers to assess whether the studies focused on integrated care, i.e. inter-sectoral and inter-professional collaboration between

Table 1. Inclusion and exclusion criteria.

Inclusion criteria:
1. Phenomenon of interest: Inter-sectoral and inter-professional collaboration between residential childcare and youth mental care 2. Outcomes: All inter-sectoral collaboration and inter-professional practices between residential care and youth mental care, delivered in interaction 3. Data range: 2016–December 2022 (when the main search was executed) 4. Language: English only 5. Study design: Qualitative, quantitative and mixed methods peer reviewed studies 6.Place of study: No geographical limitation 7. Evaluation: Facilitators and barriers for inter-sectoral and/or inter-professional collaboration
Exclusion criteria:
1. Not collaboration aspect: All studies on professional practice models, interventions and methods between residential childcare and youth mental care when there were no collaboratively implemented actions. 2. Inadequate inter-sectoral collaboration: collaboration between primary health care and tertiary mental care within the health care sector 3. Other than child protection and mental care integration, e.g. collaboration with school and police

residential childcare and mental care. In order to be selected, abstracts had to clearly identify the collaboratively applied practice. After screening the titles and abstracts, 21 potentially relevant full-text articles were read comprehensively by the corresponding author and one reviewer author.

From 21 potentially relevant studies, 14 were excluded for the following reasons: study design ($n = 2$), project reports ($n = 2$), not in English ($n = 1$), no collaborative characteristic ($n = 6$), published before 2016 ($n = 3$). The final sample consisted of seven articles. The final screening based on a full-text reading according to the SPIDER tool resulted in five studies: Jennings and Evans 2020, Johansson et al. 2021, Monson et al. 2021, Timonen-Kallio et al. 2016, and Timonen-Kallio 2019. Of all the seven studies included, Greiner et al. (2019) did not fully meet the standards of the research design but was included because of the important knowledge of prototyping a hospital-driven information system towards a wider inter-sectoral usage promoting integrated care. In addition, the study by Hamilton and Maslen (2021) did not focus directly on collaboration between sectors but gave a complementary societal angle for our review. All included studies were qualitative, although the search was not limited to qualitative studies.

For quality appraisal in qualitative evidence syntheses, we used the Critical Appraisal Programme (CASP) checklist tool for the seven included papers to assess the methodological rigour and possible indicators of poorer quality (Long, French, and Brooks 2020). The ethical and reliability aspects of the literature review have been taken into account by having several researchers in the research team jointly define the inclusion criteria and read, evaluate and select the studies to be included in the review. Throughout the review process, we remained reflexive about how our own subjective positioning is influencing, and is being influenced, by the review findings. The selection of studies for inclusion is presented as transparently as possible. In reporting, we aim to present the results in a way that respects the original authors (Suri 2020).

Description of the studies

Figure 1 provides a PRISMA flowchart for the systematic review selection procedure (see prisma-statements.org).

All included studies were qualitative, although the search was not limited to qualitative studies. Three studies applied semi-structured in-depth interviews (Hamilton and Maslen 2021, Jennings & Evans 2020, Johansson et al. 2021), but one also used focus groups (Jennings & Evans 2020) and three used only focus groups (Monson et al. 2021, Timonen-Kallio et al. 2016, Timonen-Kallio 2019). One study did not meet the strict standards of research and could also be considered a development process (Greiner et al. 2019). Altogether, there were 203 respondents from the health and mental care, social work and RCC fields involved in the selected studies. The study design of Monson et al. (2021) used focus groups with practitioners across child welfare and mental health services ($n = 43$). Jennings and Evans (2020) conducted semi-structured individual interviews and focus groups with residential carers ($n = 15$) and foster carers ($n = 15$). In the study design of Greiner et al. (2019), a structured brainstorming session with stakeholders, interviews with child protection staff ($n = 18$) and health care personnel ($n = 9$), and pilot testing were used. Johansson et al. (2021) conducted phone interviews for social workers ($n = 7$) recruited using the snowballing sample technique. Hamilton and Maslen (2021) conducted 15 interviews; the interviewees included chief executive officers, senior managers, service delivery coordinators and support workers. The study by Timonen-Kallio et al. (2016) used two separate focus group sessions, with both including four mixed focus group interviews taking place every other week. The professionals were from three areas of expertise: seven from residential care, seven from the mental health care sector and three from social work ($n = 17$). In the international comparative study design, individual interviews, focus group interviews and joined focus group interviews complemented by secondary data from national documents and statistics on the residential context were used (Timonen-Kallio et al. 2019).

We used a table (Table 2) to gather the descriptive overview of the authors, study year, sample and design of the included studies. In addition, the table includes the integration category as well as

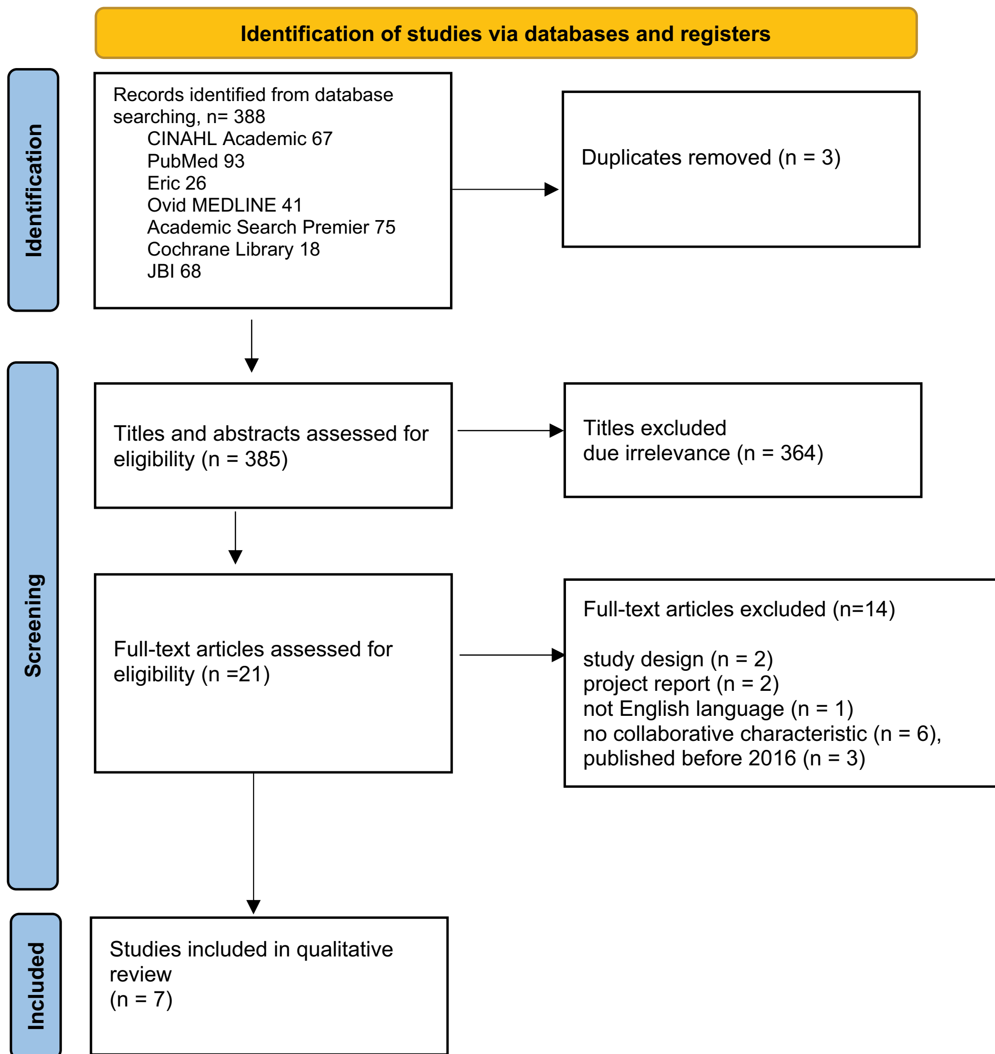

Figure 1. PRISMA flowchart for the systematic review selection procedure.

initial analysis of the facilitators and barriers to integrated care. Further analysis and final findings were extracted from this table.

Findings

When looking at the barriers and facilitators for integrated care, there are factors that are simultaneously facilitating and hindering. For instance, there are structured models and efforts to systemize collaborative work but at the same time, the models are too time-consuming with optimistic assessments of the available human resources (Johansson et al. 2021). The need for collaboration is genuine. It is indicated that OoHC children have worse health status in part because of poor information sharing between health care and child welfare agencies (Greiner et al. 2019). The fragmented welfare system and the overlapping of services hinders multi-agency collaboration between social work, residential care and mental care (Timonen-Kallio et al. 2016). As previously

Table 2. An overview of evidence of barriers and facilitators as well as the key factors promoting integrated care.

Author(s), year	Location	Description of the integration category	Sample and design	Facilitators for integrated care	Barriers for integrated care	Key factors to promote integrated care for foster children
1. Hamilton and Maslen (2021)	Australia	Structural injustice of inter-organizational child protection system as presenting barriers to accessing and utilizing resources from child protection authorities, legal system and other community actors.	Interviews ($n = 15$) with community and child protection workers in four organizations	– Even balance of power – Impartial facilitators of case conferences - Transparent provision of information to all actors, including judges, community workers and parents – Independent mechanisms that allow the decisions and actions of child protection to be challenged	- Legal arena as an uneven playing field where practices and norms of child protection departments create cases that are 'unwinnable' - No information, support or advice available on how to change the decision of the court – Disbelief between community workers and child protection staff – Unawareness of procedures - Arbitrary decision-making processes – Marginal position of community organizations	- Inter-organizational respect and collaboration to shift the institutional power imbalance between community organizations and child protection - Advocating parental rights and responsibilities in institutional system: • Supporting families to navigate complex and multi-faceted system • Combatting stigmas of 'bad' parenting, avoiding blaming the parents and anxiety-provoking practices - Finding public consensus over 'good enough' parenting for locating child removal thresholds

(*Continued*)

Table 2. (Continued).

Author(s), year	Location	Description of the integration category	Sample and design	Facilitators for integrated care	Barriers for integrated care	Key factors to promote integrated care for foster children
2. Johansson et al. (2021)	Sweden	A medical home model (Hälsofam) to provide multi-professional coordinated consultation and trauma-aware care situated at a university hospital. Offers multi-disciplinary assessment when a child enters child protection services.	Semi-structured pers. comm., social workers ($n = 10$)	- Model offers efficient contact point for consultation and networking, bridging the 'silos' between two sectors - Enables multidisciplinary assessments and extended understanding to the context around the child, – Frames and coordinates different responsibilities – Positive effects on youth when seeing that sectors work together for them - Holistic approach in work: child or adolescent is both sectors' 'common' client – Mental health provides a deeper understanding of the child protection possibilities for support	- Requires actively participating social workers: high workload and time consuming - Challenges uptake and understand the benefits of multi-professional consultation and care - Challenges 'obeyance' of the strict structure and process of the model – Social workers avoiding meetings in person – Lack of appropriate information and stigma	Hälsöfam model has offered social workers a way to utilize the expertise of health care sector. Personal attitude of the social workers and the heavy workload situation create limitations for applying the model efficiently and providing care for *every* child with congruent procedures. Applying the model needs new routines and structures for proper use of the model. Model demands ability, competence to work inter-professionally, and to perceive the collaborative nature of child protection work.
3. Greiner et al. (2019)	USA	An information-sharing system between child welfare and health care to improve the flow of knowledge about children and ensure their safety, as well as to measure the effectiveness of the programmes.	Interviews (53) with child protection staff ($n = 18$), health care personnel ($n = 9$)	- Information-sharing platform is a centralized, secure and accessible technical solution via automated data linkage for information sharing between partners – Streamline communication.	– Platform is costly - Discrete elements of data, how to protect privacy – Identifies who should have access to what information and when - Getting data sharing agreement in place is time-consuming – Low user uptake with a new system	To be effective and beneficial for both sectors, information-sharing platform needs to link, merge and display information from two data sets: medical data with statement of paediatricians to be shared with the child protection system and child protection data to share with health care system, including mental health.

(*Continued*)

Table 2. (Continued).

Author(s), year	Location	Description of the integration category	Sample and design	Facilitators for integrated care	Barriers for integrated care	Key factors to promote integrated care for foster children
4. Jennings and Evans (2020)	Wales, UK	Interprofessional practices, relationships at the professional interface and tensions in co-working between social care (foster and residential carers) and health care professionals.	Semi-structured individual interviews and focus groups, residential carers (n = 15) and foster carers ($n = 15$)	– Interprofessional attitude to utilize different forms of expertise – Values the plurality of knowledge - Engages all parties with valuable information in multi-agency team meetings	– Foster and residential carers' inadequate professionalization processes, lack of professional qualifications - Foster and residential carers positioning themselves outside any expert identity, simultaneously endorsing other discipline dominance, - Power imbalance: carers' sense of disempowerment, marginalization of information	Training and accreditation for social care professionals to reduce contestations of expertise. Moving beyond duality of propositional (clinicians) and tacit, experiential (carers) knowledge.
5. Monson et al. (2021)	Australia	Inter-agency and interprofessional collaboration as service level intervention and practitioner-to-practitioner level collaboration.	Mixed sector focus group composition (5), practitioners across child protection, alcohol and other drug therapeutic services and (youth) mental health services, ($n = 43$)	– Shared understanding of the history and context of problems of young person - Interagency conversations to reduce anxiety, to increase role clarity and improve consistency of care – Shared understanding operationalized into skills and strategies - Self-awareness via reflective practice of all actors on their role to promote support-seeking from wider care team	– Trivial practice recommendation for care workers – Care workers feeling unsuccessful in efforts of collaboration – Different organizational mandates and legislative frameworks - Lack of professional self-awareness – No involvement of foster carers in mental health care planning	Mental health practitioners delivering psychoeducation to foster carers. Specific skills training for both sectors.

(*Continued*)

Table 2. (Continued).

Author(s), year	Location	Description of the integration category	Sample and design	Facilitators for integrated care	Barriers for integrated care	Key factors to promote integrated care for foster children
6. Timonen-Kallio et al. (2016)	Finland	Interprofessional collaboration between social work, residential care workers and mental health care practitioners.	Mixed sector focus groups from three areas of expertise: seven from residential care, seven from mental health care sector and three from social work (n = 17).	- Regular multi-agency meetings without client issues – Child's care worker in care plan meetings - Proactive mental health care, including visits and meetings in residential settings – 1–2-week intervention at psychiatric ward to stop escalation of situation in residential facility – Concrete models and written guidance from mental care sector – Availability of immediate psychiatry consultancy for residential foster care – Social workers as mediators between two sectors – Accurate shared interprofessional decisions	– Fragmented system and overlapping services - Medical-therapeutic language 'excludes' foster care to consider different care options - Poorly prepared, one-sided decisions and changes in care, e.g. hasty moves back and forth between residential facilities and inpatient psychiatry care – Unclear division of responsibilities between social work and residential care work – Mental care sector relies too much on the facilities and resources they assume there are in residential facilities	Unrealistic expectations and perceptions of the 'other' professional grouping and its facilities to support and help children. A shared understanding of professional intentions and comprehensive framework for residential care. Social workers as mediators between two sectors to strengthen the status of residential care work and promote carers' confidence and readiness for multi-agency collaboration.
7. Timonen-Kallio (2019)	Finland Denmark Spain Lithuania UK Germany	General European characteristics on multi-agency collaboration practices between child protection and mental care sectors.	Focus groups in six countries, practitioners across child protection and mental health service ($n = 61$).	– Written detailed guidelines for collaboration practices - Clearing services in child protection with youth psychiatry competences to find the right help, to adjust and match different forms of assistance and to clear responsibilities - Avoid *intraprofessional* jargon – Social workers as mediators between the sectors	– Limited perspective on other's orientations and working conditions - Lack of information, ownership of information is within one sector – Incidental contacts and unplanned meetings threaten the continuum of residential care	Initiatives, needs for collaboration come almost without exception from foster care. Pedagogical interventions match well with psychiatric diagnosis and treatments and support collaborative work. Special clearing services in child protection with child psychiatry competences help to clear responsibility and case management. 'Everydayness and parental skills' discourse struggle with 'specialized' mental health treatment and medication.

mentioned, it is challenging to achieve consensus when there is an imbalance between sectors, differently valued knowledge and status of competencies.

The findings and facilitating and hindering factors are initially discussed in terms of sectoral and professional integration, and after that the main observations for respective systems are presented.

Facilitators for integrated care at the system level

In collaboration between these two sectors, a shared information system, a platform as a technical solution via automated data linkage, supports updated and actual data sharing and documentation, and as such is a vehicle towards integrative care and service paths for service users. To be effective and beneficial for both sectors, the information sharing platform needs to link, merge and display information from two data sets: medical data with statements of health care (paediatricians) to be shared with the child protection sector, and child protection data to be shared with the health care sector, including mental health (Greiner et al. 2019). Hamilton and Maslen (2021) indicate that structural injustice in inter-organizational child protection as well as lack of awareness of procedures and arbitrary decision-making processes themselves present barriers to utilizing the resources of child protection, legal system and other community actors. Integrated residential chilcare is indeed challenging when child protection is heavily affected by lawyers and judges, who are not fully aware of how their judgements are in fact implemented by child protection authorities. The authors are concerned about disbelief between different authorities, which changes the support system itself into an obstacle for efficient multi-sectoral collaboration. Interestingly, on the other hand, the authors call for intensive work with parents to combat the stigma of 'bad' parenting and, on the other hand, defend the rights and responsibilities of parents. This will facilitate the image of residential care and has a positive impact on collaboration with all parties. Again, intensive inter-sectoral working with parents requires the transparent provision of information and agreeable knowledge between authorities. Sectoral collaboration and information sharing is seen to similarly support impactful working with children while showing that the different sectors work together for them in the best interests of the child (Johansson et al. 2021).

An information sharing platform is one opportunity to create trust and space for further collaboration – building mutual understanding of the key aspects and determining a shareable information component for collaboration (Greiner et al. 2019). The importance of building trust and sharing awareness about the resources of both parties is supported by the findings of unrealistic expectations for the 'other' provider to help and care (Timonen-Kallio, 2019).

Professional collaboration in the residential context

One barrier for inter-professional collaboration was reported to be the limited perspective on other professionals' orientations and working conditions – medical care professionals do not know what kind of working environment an RCC setting is and vice versa, residential care workers are not aware of mental care therapeutic treatments. As indicated in this review, the contestation in distinct expertise leads to a sense of professional disempowerment and marginalization, which inhibits residential carers' eagerness towards integrated care and working together with mental care practitioners (Timonen-Kallio et al. 2016; Timonen-Kallio 2019; Jennings & Evans 2020; Monson et al. 2021).

Different typologies of residential care facilities with a variety of professional competencies challenge the realistic expectations of handling the behavioural and mental health needs of OoHC children (Timonen-Kallio et al. 2016; Timonen-Kallio 2019). Sometimes the mental care sector relies too much on the facilities and resources they assume are available in the residential facilities. This is why visits to residential settings are desired to give mental care practitioners a better understanding of the working conditions of carers and the living environments of the children (Timonen-Kallio et al. 2016). Mental care practitioners should act more as 'insiders' in children's

residential care and be better informed of RCC procedures to promote realistic support-seeking from the wider care team (Monson et al. 2021). Residential carers occasionally position themselves outside of any expert identity, simultaneously endorsing medical dominance which in turn contributes to their sense of disempowerment and professional marginalization (Jennings and Evans 2020; Monson et al. 2021).

Inter-professional co-working can benefit from mutually approved and shared working methods. As Johansson et al. (2021) indicate, the structured models for co-working may prove to have high workloads, which affect to what extent professionals are able to implement the model and care process in every case in the same coherent way. This is supported by Greiner et al'.s (2019) reporting that only 61% of practitioners regularly use the information platform as a method for guaranteeing the transparency of information between the health care and child protection sectors. In this situation, practitioners might question the original objectives of the model and do not 'obey' the model's process and working requirements. Due to lack of resources, the benefits of the new models remain half-hearted and, in the end, depend on the mindset and attitude of the individual practitioner.

Key factors promoting integrated residential care

In the sample, there was only one article dealing with the concrete practical and shared working model. Hälsofam, a medical home model from Sweden, provides interprofessional consultation and care to child protection services by coordinating the child's health plan and matching the placement and multi-agency quality assurance at the child level (Johansson et al. 2021). This single hit is puzzling because structured models are highly recommended with many beneficiaries: they offer an efficient contact point for consultation and networking, bridge the 'silos' between two sectors, enable multidisciplinary assessments and extended understanding of the context around the child, as well as frame and coordinate different responsibilities (Johansson et al. 2021). Simultaneously, both parties get a deeper understanding of others' possibilities for support and help in common cases. In addition, inter-agency conversations reduce anxiety, increase role clarity and improve consistency in care, by sticking to regulations and providing care for every child with congruent procedures. As the authors underline, the application of new models needs new routines and structures to support the proper usage of the model. More importantly, developing novel information sharing systems or taking new collaborative models into use demand the competence to work inter-professionally and to perceive the collaborative nature of the RCC work (Greiner et al. 2019; Johansson et al. 2021). Regular multi-agency meetings without client issues are suggested as a forum for reflecting and developing professional self-awareness, which clarifies the division of responsibilities within RCC services (social workers and residential childcare workers) and between RCC and mental health care (Timonen-Kallio 2019).

The relationships between a variety of professionals were characterized with discord and dissent hindering the development of mutual professional goals. Joint training facilitates the learning process to understand the complimentary factors of 'everydayness and professional parental skills' discourse and 'specialized' mental health treatment and medication. After all, the key is to value the plurality of knowledge (Jennings and Evans 2020). Sharing everyday life with children can allow access to observe and obtain valuable information for care planning. The role of professional expertise is to conceptualize, share and develop this information further in multi-agency care plan meetings. It is suggested that social workers as the responsible child protection authority should act as the competent mediator between the two sectors across child protection contexts (Timonen-Kallio et al. 2019).

The coordination of the professional expertise of both sectors with a shared inter-professional vision is crucial for executing integrated care plans. Developed cooperation refers to mutually agreed forms of help and support for children, as well as shared professional responsibilities with written detailed instructions (Timonen-Kallio, 2019). When better informed about work

orientations, it has been proven that educational interventions in fact match well with mental care treatments – as a matter of fact, the mutual methods concretize a collaborative practice (Timonen-Kallio 2019). To avoid mental health practitioners delivering one-way psychoeducation to residential carers, specific joint training is suggested (Monson et al. 2021). This is supported by Jennings and Evans (2020) who underline joint training as a forum to reduce contestations of expertise and to move beyond the duality of propositional (clinicians) and tacit, experiential (carers') knowledge.

Discussion

Our main objective in this review was to provide an overview of the research on current practices in integrated residential care, i.e. inter-sectoral and inter-professional collaboration between RCC and mental health care. Comprehensive international analysis is challenging because there appears to be striking variability between nations in the utilization of residential care for children in out-of-home placements. Comparative research covering 16 countries found that the many different terms for residential care, the imprecise descriptions of residential care and, more importantly, the remarkable differences in the requirements and qualifications for residential care workers are directly related to the quality of services (Whittaker et al. 2023). Being aware of this difficulty in compiling a comprehensive analysis of integrated residential care, we wished to take a broad approach in order to contribute to the ability of organizations and stakeholders to take the initiative and implement improvements. A previous literature review (Lahti et al. 2018) also indicated that the multidisciplinary collaboration between residential workers and mental health practitioners in everyday co-working has received scant exploration. This search yielded just seven studies that relate to *integrated* residential care. An information sharing system, structured models and joint training are suggested as basis for integrated care. Tackling the problems and facilitating common agency ownership were suggested as long as a decade ago (Kerns et al. 2014; Lee, Esaki, and Greene 2009; Sloper 2004), but only limited evidence of related efforts was found in the present review. It seems that the evidence gap remains. Research is scarce on inter-sectoral collaborative care practices between the RCC and youth mental health care sectors, especially inter-professional actions extended in the everyday residential care context.

Our results support the findings of previous research on the prerequisites for organizational collaboration and agencies' abilities and readiness to change (Kerns et al. 2014; Matscheck and Piuva 2023; Winters et al. 2019). The differences in competencies (level of training) between professional groups can lead to a situation where residential agencies try to satisfy external demands for evidence-based treatments without the resources, ability or required commitment (James 2017). Previous studies (Gharabaghi 2019; Smith, Fulcher, and Doran 2013; Storø 2013) have noted that residential workers' professional duality, in terms of being both a 'professional' and a 'parent' when working with severely behaviourally troubled children and youth, has an impact on the development of integrated care. Limited training is no doubt a hindrance to perceiving the collaborative nature of residential care work and is surely an obstacle to building shared professional intentions, particularly considering it has been shown that countries with high education and training requirements for residential staff have higher utilization of residential care (Whittaker et al. 2023). In our interpretation, 'higher utilisation' refers to the effective use of RCC as a positive and integral part of a continuum of child welfare services in order to address the complexity of the needs of children who cannot live with their families of origin (Anglin and Henderson 2023; Francis, Kendrick, and Pösö 2007; Gharabaghi 2019).

Delivering integrated RCC is extremely challenging, and as such the included studies represent an important attempt to address the above-mentioned evidence gap. We strongly recommend improving accreditation of residential care workers and joint continuing training to widen the limited perspective on *other* professionals' orientations and working conditions and, furthermore, to equalize the power status between partner professionals. Indeed, joint training helps professionals to understand the goals, resources, terminology and processes of other agencies, as well as to

understand what is essential in the realization of inter-professionalism (Eershuistra et al. 2019; Wells and Chuang 2012). In addition, advanced integrated residential care requires continued efforts to support the reframing and conceptualization of the care and education delivered in residential settings (James et al. 2021; McLean 2012). Joint training might possibly strengthen intentional co-working as a required competence for negotiated care plans and for offering different care options in inter-sectoral meetings. A mutual learning process is important; thus, new kinds of relational forms of expertise are built *in relations* (Edwards 2010). Moreover, facilitating integrated care in everyday practice requires frequent and effective information exchange and structured models with written guidelines. The practical implementation of the integration requires, naturally, investments in the development and management of service entities and service chains, and in clarifying the roles and division of work of various actors (Tynkkynen et al. 2025). However, it is crucial to perceive the integrated nature of RCC, all the way from sectoral-level interventions to the practitioner-to-practitioner co-working level.

Limitations

There are a number of limitations to this review. The included studies examine different service systems and working practices in different countries, so no precise analysis has been reached. Instead, we raise general-level findings for further discussion that are not too context-bound. The limited number of studies meeting our inclusion criteria is likely related to the strict inclusion criteria, which were targeted at identifying studies on inter-sectoral services and co-working between residential childcare workers and mental health care practitioners. While we limited the search to the period 2016–2022, we partially lost the ability to reach wider studies for analysis. This is why McLean (2012), Kerns et al. (2014) and Besier, Fegert, and Goldbeck (2009) were not included. Furthermore, the focus on studies written in English may have prevented us from gaining complete knowledge and perspectives of integrated foster care (e.g. Müller-Luzi and Schmid 2017). One limitation is that there were only two studies from the Nordic countries meeting the inclusion criteria. This is a bit surprising because Nordic comprehensive mental health care and child protection, with its spectrum of services, expertise and developed practices provide a particular context for developing integrated residential childcare.

Conclusion

We agree with previous studies (Holmes and McDermid 2012; Mack et al. 2017; Morgan et al. 2019Naylor et al. 2019) which indicate that further research is needed on the factors that facilitate integrated residential care in order to incorporate the limited resources. Four of the seven studies were focused on professional co-working extended in the everyday residential context. Some potentially good practices were identified and suggested as sectoral facilitators for the development of integrated care. Interestingly, though frontline practitioners in RCC and mental care play a crucial role in the implementation of integrated care objectives, the inter-sectoral and indeed collaboratively applied care between these professionals is not of interest to researchers. There is a lack of research into how structured practitioner-to-practitioner co-working and enabling mutual decision-making, for example, between social educators and nurses, is executed in daily care routines.

This knowledge is valuable, particularly in the Nordic high-level training system, as it reflects how we should promote integrative practices within inter-professional learning processes and internships to better understand and appreciate the capabilities and priorities of other professionals and service providers in complex situations. RCC targeted at children with diverse needs is demanding and requires continued efforts to strengthen the integrated approach between frontline professionals and to reform the organizational structures and horizontal collaboration between the RCC and mental health care sectors.

Note

1. Service users' experiences and views are studied in other articles.

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