Funded by Rights Equality and Citizenship (REC) programme of the European Union

EU-Project "FACT FOR MINORS. Fostering Alternative Care for Troubled minors"

Co-financed by the European Commission – Directorate General Justice and Consumers

Final Report

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1. Preface:

1.1 The “Project Context”

> “We are still asking them to fit our framework, our external setting, when we should adapt ourselves to their very limited and damaged attachment capacities.”[1]

The quote by psychotherapist Mark Dangerfield points to the challenges of providing services to delinquent youth with mental health issues. Their biographies are characterized by the discontinuity of relationships, by limited attachment capacities and risky behavior towards self and others. Many of these youth have passed through numerous help systems which, however, have not provided suitable and effective support.

An estimated 20% of all children and youth in Germany are faced with mental health problems.[2] In stationary youth welfare settings more than half of the young residents are said to have at least one ICD-10 diagnosis.[3] When it comes to the juvenile justice context, the percentage of youth with clinically relevant mental health disorders is as high as 60-90%.[4] The most prevalent psychological problems within the target group are substance abuse, dissocial behavior, personality development disorders, limited impulse control and affective disorders. However, it can be noticed that in detention psychological and psychiatric disorders often remain unidentified and unaddressed which has serious long-term effects on a young person´s mental health.[5]

The provision of appropriate services for this target group constitutes an interdisciplinary challenge for the systems involved: youth welfare services, mental health services and juvenile justice. The transnational project Fact for Minors funded by the Rights, Equality and Citizenship (REC) program of the European Union addressed this challenge and intended to foster a multi-agency approach to serving this target group in Italy, Spain, Portugal, Finland and Germany.[6]

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[1] Dangerfield, 2017: 17
[2] Ravens-Sieberer et al., 2007.
[3] Bundesverband katholischer Einrichtungen und Dienste der Erziehungshilfen e.V. (BVkE), 2010: 1.
[4] Fegert, 2010; Oschonka 2010; International Juvenile Justice Observatory (IJJO) 2009
[5] Laucht, 2001.
[6] http://www.factforminors.eu/

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1.2 The actors involved and legal framework

The complex individual needs of delinquent and mentally ill youth often require the coordination between different professions, systems and agencies, particularly, when a clear psychological diagnosis cannot be made or has not been made. In the context of Germany, the three systems involved are child and youth welfare services, mental health system and juvenile justice system. Each of these systems is rooted in their respective legal frameworks.

a.) Child and Youth Welfare System

The scope of services of the German Child and Youth Welfare System is based on the **eighth Code of Social Law SGB VIII**[7]. After a legal reform in 1990 the focus of the law shifted from an emphasis on control and intervention towards an approach of support, assistance and encouragement. The areas of responsibility of Child and Youth Services can be summarized as follows:

- To support young people in their social development and to avoid or reduce deprivation.
- To support parents or legal guardians in their educational process of child rearing.
- To protect children and youth from endangerment of their well-being
- To contribute to positive living conditions for young people and their parents and to create and sustain a children and family-friendly environment.

Apart from their pedagogical tasks Child and Youth welfare services have the responsibility of youth protection, assistance in court trials as well as custodial care (§ 42 SGB VIII) if the well-being of the youth is at risk – which includes the endangerment of self and others.

§ 36 SGB VIII stipulates the need for help plan conferences. These conferences are initiated by Child and Youth services but the young person, their families, legal guardians and other professionals are to be included.

[7] Sozialgesetzbuch (SGB) - Achtes Buch (VIII) - Kinder- und Jugendhilfe

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b.) Mental Health System and Child and Youth Psychiatry

The fifth Code of Social Law SGB V[8] and the German Civil Code BGB[9] constitute the legal framework for the scope of services of child and youth psychiatry. The SGB V includes regulations regarding the public health insurance system. It regulates the relationship between health insurances, service providers and patients. The German Civil Code BGB regulates the accommodation of a young person in a closed stationary facility including psychiatric units. This external accommodation can only be initiated upon the request by parents or legal guardians and needs to be authorized by a family court.

The tasks of the child and youth psychiatry system include the prevention, diagnosis, treatment and rehabilitation of psychological, psychosomatic and psychiatric diseases of children and youth. Precondition for an intervention by child and youth psychiatric services is the evidence for the need of treatment.[10]

c.) Juvenile Justice System

The Juvenile Court Act (JGG)[11] regulates the formal youth criminal law. According to § 19 JGG the law is applicable to young people at the age of 14 and above. Depending on their degree of maturity of the offender, the law can also be extended to young people from 18-21 years. The law stipulates that youth offences should be sanctioned primarily by educational measures. In case these measures remain ineffective, the judge takes disciplinary actions such as short-term confinement. Juvenile sentence is the highest fine the judge can impose in cases of a high severity of guilt. In cases of lack of criminal responsibility § 63 StGB[12] becomes relevant. According to this norm offenders constituting a risk to society are sentenced to a forensic hospital. While some states in Germany have designated youth forensic units, Hamburg accommodates youth in adult forensic units.

An important support in a youth criminal case is the institution of youth court assistance services regulated in § 52 SGB VIII. Youth court service professionals assist and accompany youth throughout court proceedings, promote the application of youth criminal law and suggest youth appropriate sanctions. The youth court service

[8] SGB V. Ch. 3, para. 5
[9] Bürgerliches Gesetzbuch (BGB), paragraphs 1631 b, 1666
[10] Branik et.al., 2007: 20.
[11] Jugendgerichtsgesetz (JGG)
[12] Strafgesetzbuch (Penal code)

professional investigates details about the development and personality of the young offender, collects family data and analyzes measures that have been undertaken by youth social services. The professional keeps in touch with the youth and his family during detention and is also involved in the release process.

2. Project objectives:

How to respond to the weaknesses that characterize the multi-agency approach in working with young offenders with mental health problems

3. Capacity building and the two levels of intervention

3.1 National level: experimentation

a) Test sites and the primary actors involved

As a geographical scope for the experimentation the German partner CJD Nord chose Hamburg – with a population of about 1,8 Mio. the second largest city in Germany after Berlin. Hamburg is not only a city but equally one of Germany's 16 federal states. The combination of a large metropolitan area and administrative structures that apply on a state-wide level seemed to be an appropriate setting for experimentation. A city-wide scope was also chosen because a stronger cooperation between the mental health sector on the one hand and youth welfare services and juvenile justice on the other hand currently is an important emerging topic on the city's policy level also promoted through the Ministry for Labor, Social Affairs, Families and Integration[13] - supporting partner of the Fact for Minors project.

It is important to note that the City of Hamburg does not currently have a closed residential unit for at-risk youth. Trial projects in the past have failed and difficult to serve youth in need of a closed environment – other than jail – are sent to facilities in other German states. The controversy around the necessity of a closed facility for delinquent youth with mental health issues is a highly contested political issue in the city. Therefore, the experimentation will focus less on a closed residential facility but rather on multi-agency cooperation beyond the facility.

[13] http://www.hamburg.de/basfi/

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In an initial stage of the project, CJD Nord identified existing good practice examples of multi-agency cooperation. The project "Grenzgänger"[14] is a multi-agency approach to providing care for at-risk youth in the state of Schleswig-Holstein. Within the concept, monthly case management meetings are held between the local child and youth psychiatric clinic, youth service providers and government youth welfare services. Each party is invited to introduce cases which "fall through the cracks" and which constitute a challenge to all systems involved. The second intervention model is a cooperation between the three child and youth psychiatric hospitals of the City of Hamburg and the government provider for residential care for youth. Especially during the height of the refugee movement into Hamburg in 2015 and 2016, the state run custodial care was challenged with servicing young refugees with traumatic experiences and finding custodial solutions for a small group of highly delinquent refugee youth. Consequently, psychiatrists and psychological professionals from the three hospitals consulted both youth and staff in residential care facilities on a regular basis. The costs for regular consultation and supervision is taken over by the youth welfare system – and not financed through the system of health insurance. In preparation of the experimentation phase the CJD Nord project team further consulted the "Guidelines for Successful Cooperation between Youth Welfare Services and Mental Health Care Services" for the City of Hamburg.[15] It should be noted that the above mentioned intervention models only focus on cooperation between the youth welfare and the mental health system – the involvement of the juvenile justice system has not be targeted.

Interviews and Focus Group

Apart from reviewing intervention models and relevant literature the initial project phase included 13 individual interviews, one focus group and numerous networking events in the City of Hamburg. Individual interviews were conducted with the following professionals: former head of youth psychiatric evaluation services, professor of psychology and evaluator of the above-mentioned project "Grenzgänger", Family Intervention Team (FIT) (youth welfare services for delinquent youth), doctor at psychiatric acute station for adolescents, psychiatrist at day clinic for youth with mental health issues, head of child and youth psychiatric hospital, youth probation services, youth court services, psychologist at youth correctional facility, policy advisor at the health authority of Hamburg, head of custodial care unit of Hamburg, psychologist working for service coordination project.

[14] Groen & Jörns-Presentati, 2017.

[15] Bindt et al., 2017,

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The focus group held on July 12,2017 was constituted of operational staff from youth court services, Family Intervention Team (FIT), youth probation services, University of Applied Sciences, forensic hospital, liaison office for coordination between youth mental health and youth welfare services and government custodial and residential care for youth.

National Advisory Board

Following the scope of action of the project the CJD Nord team created a multi-agency national advisory board of professionals at managerial level from the correctional system, youth welfare services, youth probation services, youth court services, forensic clinic, Family Intervention Team (youth welfare services for delinquent youth), government custodial and residential care and the policy department for juvenile justice. In a first meeting of the national advisory board on June 26, 2017 participants discussed their expectations and needs with respect to the capacity-building phase of the project. Despite the large array of youth services in a metropolitan area such as Hamburg there remains a group of youth with multiple needs that are familiar to all systems involved but that cannot be retained by any of the services provided. Instead, a growing number of these youth are accommodated in the city's adult forensic unit – a place which participants deem as inappropriate for the target group. According to the national advisory board, the capacity-building should be geared towards identifying the "blind spots" in the care system that lead to these inadequacies. Methodologically, participants suggested detailed case discussions to analyze at which points interventions should have been different and at which points an interdisciplinary perspective would have been beneficial. Although participants agreed on the methodology they shared concerns about the confidentiality of the individual cases. In the end, participants agreed to provide anonymized cases for the capacity-building process.

b) Strengths and weaknesses of the existing model at the national level

Prior to elaborating on the actual capacity-building, the following section will outline the challenges of the care system based on the interviews with professionals and perspectives of the national advisory board.

Within the above-mentioned legal framework only the system of child and youth welfare services is encouraged by law to foster multiagency cooperation. According to § 78 SGB VIII governmental and private youth service providers are requested to meet

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on a regular basis to coordinate and complement their services. Following the legal reform in 1990, § 35a SGB VIII stipulates that the development of a socio-educational support plan for youth who are mentally handicapped requires a psychiatric assessment.

However, cooperation across jurisdictions with the fifth Code of Social Law SGB V (health insurance), the Law on Juvenile Justice (JGG), the law on Psychiatric Care (PsychKG) and the German Civil Code (BGB) are not foreseen by law. While socio-educational staff operating under the jurisdiction of the Social Code SGB VIII has developed a practice of cooperation rooted in legal parameters, cooperation efforts by medical and psychiatric staff are not reimbursed by the Code of Health Insurance (SGB V).[16] Despite its educational mandate the juvenile justice system does not necessarily have a therapeutic mandate except when it comes to the treatment of substance abuse.

Given the different jurisdictions that apply in servicing the target group of young offenders with mental health issues experts and professionals observe a "pillarization" of services constituting a challenge to the alignment and harmonization of services. Legal norms prescribe certain limitations of responsibilities which manifest themselves particularly at the transitions between the systems leading to a so-called "revolving-door-effect". These boundaries also have an effect on the operational level of socio-educational care for the target group. Based on the desk research and the interviews conducted in the initial phase of the project these challenges can be summarized as follows: mutual language, sense of shared responsibility, transitions between systems.

Mutual Language and Systemic Knowledge

According to socio-educational and psychological professionals one of the key challenges in providing support for the target group is the lack of knowledge of the "inner logic" of the other systems involved. Particularly in cases in which a precise psychological diagnosis is not possible it often remains unclear if a medical or a socio-educational intervention is warranted. In fact, in many cases both professions are required, however legal barriers prevent the harmonization of support.

> "On our acute station we often have this problem with patients where we would say this is not an exclusive socio-educational problem, where we say these patients need both socio-educational and psychological support, but not

[16] Kölch et al., 2015, S. 9.

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acutely…first it is the responsibility of youth welfare services to find adequate housing. Once you find housing we can talk about longer-term in-patient treatment. Youth welfare services often do not understand why we don't take the patient immediately. We reject the patient, and they can't place the patient in residential care because the facilities require for the young person to be in therapeutic care. This becomes somewhat of a vicious circle…So I believe the idea of a common language is very important and to know about the scope of work and the responsibilities of the other system are extremely important. One could save a lot of frustration and energy if the youth welfare system could assess from the start if a patient is appropriate for an acute station or not."[17]

In addition there is a difference in professional self-conception. While the medical field can rely on the tool of psychological diagnoses, social workers only receive limited medical training during their education. The complexity of the role of a youth welfare worker at the intersection of examination, negotiation and decision making, often prevents the degree of precision that can be observed in the medical field:

"I find that we often lack the language of what social workers do. The psychologists have their diagnoses that are coherent, they provide precision. The field of social work doesn't have that (…) amongst social workers there is a self-esteem issue. They hesitate to present their work or to stress that they are doing important work. Instead, it's psychologists, doctors and lawyers who dominate the field."[18]

A "self-devalorization"[19] of the youth welfare system could be countered through effective cooperation. The above-mentioned cooperation project between LEB and the psychiatric hospitals of Hamburg demonstrated that the initial assessment of a social worker oftentimes was confirmed by the cooperating psychiatrists which led to more self-confidence and a more cohesive treatment approach for the young person.

"We explained to the social workers that we also don't have the ´magic cure´ (…). The two-way dialogue has relativizes expectations towards each other – that's a good thing!"[20]

Sense of Shared Responsibility

[17] Interview with psychiatrist at psychiatric unit for adolescents
[18] Excerpt from multi-disciplinary focus group on July 12, 2017
[19] Quote by Prof. Dr. Holger Ziegler during a conference on "Kooperation im Grenzgängerbereich – Ergebnisse und Ausblicke" in Glückstadt.
[20] Bindt et al., 2017: 14.

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One of the characteristics of the target group of delinquent youth with mental health issues is their prevalent rejection of outside help. The resistance of the young persons and their families often leads to a feeling of helplessness amongst professionals:

> "Sometimes we need to admit that we just cannot get any further with some clients. In these cases it happens that the professional groups involved attack each other because they just cannot bear the helplessness anymore. And sometimes there is a sense of relief when the young person ends up in jails."[21]

Closely related to this sense of helplessness is the high level of responsibility that professionals face under the pressure of finding appropriate residential care for highly aggressive youth with risky behavior. Private-run residential units do no supply sufficient capacities for this target group and can choose who they accept into their units. State-run facilities on the other hand are mandated to take all youth into custody leading to a concentration of highly vulnerable and at risk youth in these units. According to the professionals involved a sense of shared responsibility is often lacking:

> "Fear is not a good consultant. There need to be possibilities to alleviate the burden, that the high level of responsibility and the risk that one takes become bearable."[22]

An emerging sense of disempowerment leads to a delegation of responsibility between professionals of different systems:

> "There are youth that are placed in psychiatric care that nobody wants because they constitute too high of a risk through self-damaging behavior. So, the person is declared as suicidal and we as youth welfare services are released from responsibility. The psychiatry could perform the tire change, and afterwards we will pick him up again."[23]

<u>Transitions between Systems</u>

Communication and transitions between systems always entail a number of unclarified issues: what is the mandate of each system? What are the respective responsibilities? Who takes over the costs? These transitions between residential facility, jail, and

[21] Excerpt from multi-disciplinary focus group on July 12, 2017
[22] Excerpt from multi-disciplinary focus group on July 12, 2017
[23] Excerpt from multi-disciplinary focus group on July 12, 2017

psychiatric in-patient care need to be further streamlined and harmonized. On the one hand there is a need for increased formal communication between systems to prevent – as an example - that youth are released from a psychiatric unit without follow-up psychological support.

Along with the need for a stronger formalization of cooperation between systems multi-disciplinary cooperation also needs time, longevity and consistency. Professionals have stated that positive cooperation only works through repeated concrete human encounters. In support of this statement the above mentioned evaluation project of the cooperation between youth mental health and residential care services has found that socio-educational and psychiatric staff considered the level of cooperation as positive only after at least 7 actual face-to-face encounters.

c) Experimentation of Strategies and Practices within the Identified Setting: Series of three Capacity-Building Workshops

Based on the above mentioned intervention models, interview findings and input from the advisory board, the CJD Nord team developed and conducted a series of 3 workshops between October 6, 2017 and December 1, 2017. Participants for the workshops were recruited with the assistance of the National Advisory Board which also met three times until December 2017. Participating agencies in the capacity-building workshops were: youth social services, residential care services, youth court services, probation services, juvenile justice, mental health services, youth psychiatric unit and school administration. Amongst the professional qualifications represented were social workers (with psycho-therapeutic qualifications), psychologists, probation officers and criminologists. During the acquisition phase, the CJD Nord team faced the largest challenge in recruiting medical staff from the system of child and youth psychiatry who declined their participation due to limited time resources.

Workshop I

The first capacity workshop was held on October 6, 2017 with a group of 16 participants. In an initial phase of the workshop participants introduced themselves and voiced their expectations of the workshop series which can be summarized in the following categories: getting to know each other, professional exchange, cooperation, improvement of case analyses, knowledge transfer between systems.
The anonymized case of "Hans" for the first workshop was introduced by the Family Intervention Team. A psychologist and a social worker in the team had been authorized by their director to invest time in developing a highly detailed chronology

of the case. Prior to the workshop the FIT team distributed the chronology of social service support since birth, the police record as well as the psychiatric evaluation of the young person to all participants. The case presentation by the FIT was followed by a group discussion.

According to the participants, the detailed case chronology demonstrated clearly the "revolving door effect" between systems where many interventions had been "experimented with". Decisions on interventions in retrospect highlighted a sense of powerlessness and resignation. Why was the young person repeatedly sent back to his mother's house which was a source of severe conflict? What was the source for adhoc transfers into the child and youth psychiatric clinic when it was clear that an in-patient accommodation could not be justified by the young person's diagnosis? Participants asked themselves: why were all these ruptures and transitions supported when in fact they were clearly not addressing the needs of the young person? In the group discussion participants came to the conclusion that it was not the lack of support services that led to an inadequate support scheme but rather systemic boundaries and a lack of a common understanding of the case. In line with this conclusion, the group agreed to devote the second workshop to the question of how different systems and their respective institutions could developed a shared understanding of the case. A representative of the clinic of child and youth psychiatry in cooperation with a psychologist of FIT agreed to introduce the case for the second workshop – a highly prominent case familiar to all systems.

Workshop II

> "I, a fragmented adolescent with my fragmented family, have to integrate what you all have not successfully integrated in many years…"[24]

This perspective of a young person demonstrates that a commonly shared understanding of a case requires both a multi-systemic and a client-centered approach. After the introduction of the second case of "Max" – a young person with amok fantasies - participants in the second workshop was therefore divided into two groups. One group focused on the various parallel legal systems that are of relevance for developing an adequate approach to care. Even participants with an extensive professional experience stated their desire for an increased knowledge of the workings of other relevant systems. According to them the professional routine is often dominated by inner-systemic processes which limits the development of multi-systemic intervention approaches.

[24] Dangerfield, 2017: 20.

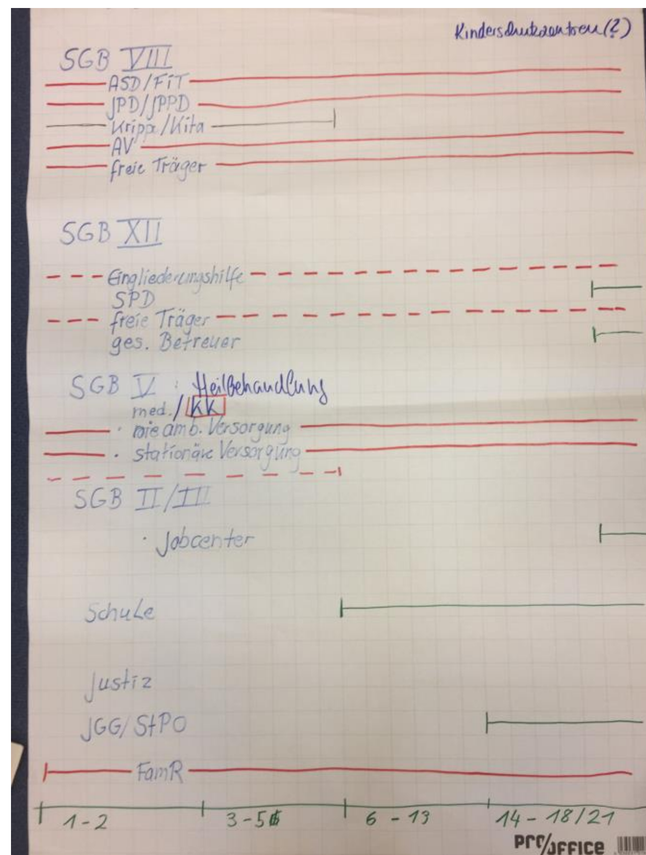

Illustration 1: Group activity in workshop II – parallel legal systems involved in care of youth with multiple needs

The second group reflected on the case development from a client-centered perspective. With the task of “I am Max and I feel that…” participants were asked to relate to the case of “Max” at various age levels since childhood. This exercise corresponds with the above-mentioned quote by highlighting the complexities of relationships and responsibilities that the young person is confronted with. The group visualized the complex network of family and professional stakeholders and placed “Max” at the center of this network to highlight the burden that he carries.

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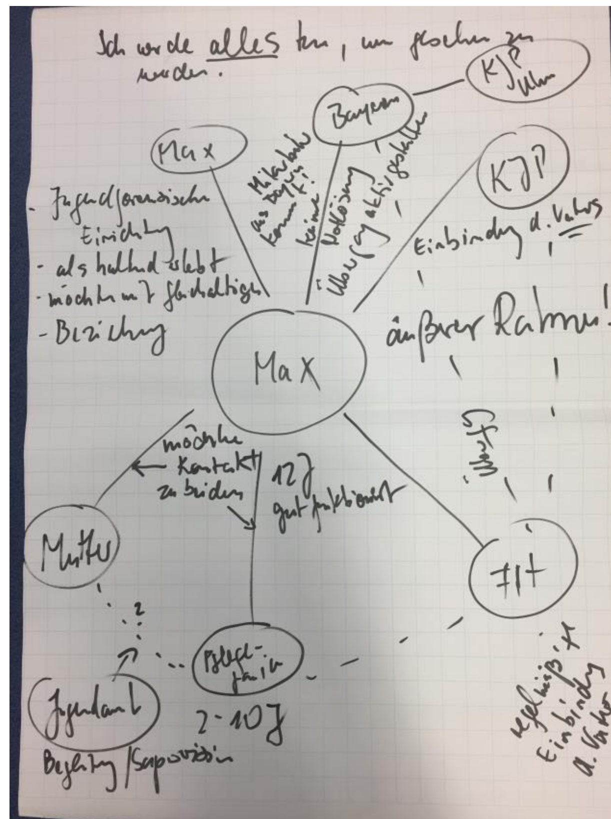

Illustration 2: Group activity in workshop II – "Max" at the center of a complex network of relationships.

The illustration not only highlights the complexities of relationships but also the gaps in the provision of services and the lack of cooperation at important junctures. The exercise further accentuated certain reoccurring patterns – professionals recognized that "Max" repeatedly felt rejected by his mother, by his foster family, by care professionals, by psychiatric hospitals – rejected into unfamiliar settings. It can be noted that the client-centered perspective evoked a new sense of empathy for "Max". The participant introducing the case had previously reached his professional limits in the difficult task of protecting his hospital staff from the threats of violence and amok fantasies of "Max". Brainstorming with other professionals who were unfamiliar with the case and "feeling" like Max led to a different understanding not guided by fear and anger.

During the final phase of the workshop both groups presented their findings. The first group emphasized that the "systemic exercise" demonstrated the multitude of stakeholders and institutions that are involved in the care system from school age on. However, the exercise also demonstrated the "pillarization" of systems. Participants

observed that “a fragmented system only deals with fragments of the problem”. Also, the exercise demonstrated that the care system is geared towards the treatment of symptoms rather than the promotion of prevention which would require a stronger financial commitment from the health insurance system.

The second group considered the client centered “changing of perspectives” as very beneficial. While the case-introducing participant initially considered the approach as “esoteric” it turned out that the perspectives, hypotheses and recommendations from professionals from other systems without familiarity of the case were helpful. The participants from the second workshop concluded that not the young person needs to be adapted to the system but the care system needs to adjust to the youth.

Workshop III

The objective of the third and last workshop was to evaluate the findings of the previous meetings and to suggest steps towards a stronger multi-agency approach to alternative care. Methodologically the third workshop continued the dual approach of a systemic and a client-centered perspective by creating two thematic working groups. The second workshop had highlighted the complex network of stakeholders that surround a vulnerable youth like “Max”. Participants argued that due to this complexity and the multitude of parallel and often uncoordinated actions, professionals loose the client-focused view and do not recognize his or her actual needs. During the second workshop they expressed the need for centralization and bundling of the institutions and services. Therefore, one working group reviewed the concept of a “key worker” or “multimodal worker” who would relieve the youth by replacing him or her at the center of this network and who would take the role of coordinating these multiple interests.

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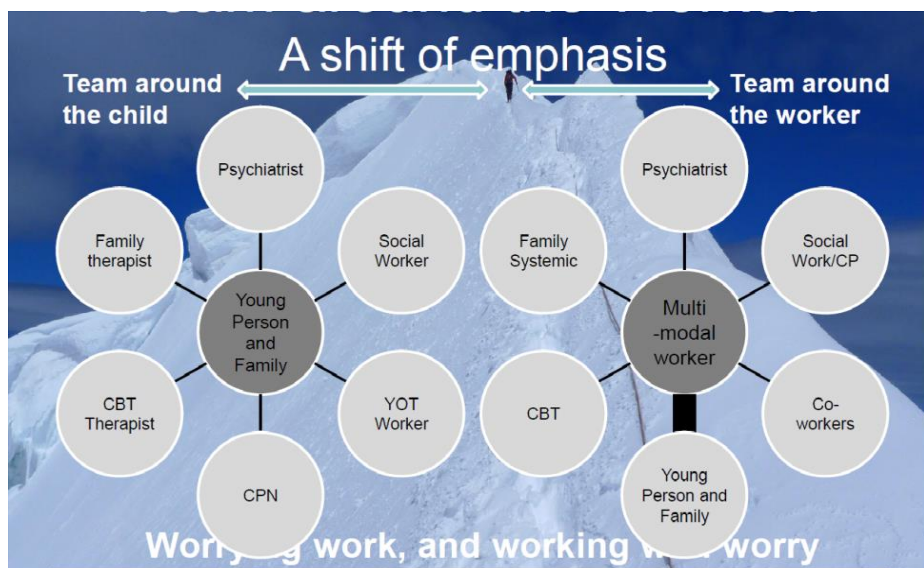

Illustration 3: Basis of discussion for workshop III. The multi-modal worker replaces the young person at the center of the network. Dickon Bevington and Peter Fuggle, Anna Freud National Center for Children and Families in London, in: Dangerfield, 2017.

In the illustration above the multi-model-worker is presented as the only professional in the institutional team with direct contact to the young person and his family. Other involved professionals have to liaise with the multi-model worker. The model was introduced to Fact for Minors partners and the transnational advisory board by Marc Dangerfield during the second steering group meeting in Barcelona. The model has been developed by Dickon Bevington and Peter Fuggle from the Anna Freud National Center for Children and Families in London. As the German care system does not include such an actor, this model generated particular attention.

After introducing the concept of the multi-modal worker the group was given the task to transfer this concept to the national context by creating a new professional who works explicitly with the young target group. A second graphic of Mark Dangerfield´s presentation was translated and used as a basis for the participants´ discussion on qualification and scope of responsibility of an imaginary key worker who pursued a working method of "mentalizing".

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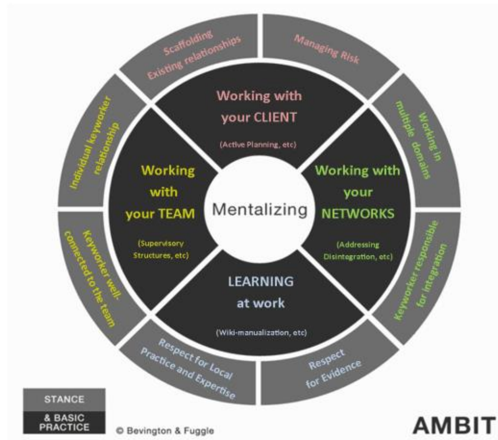

Illustration 4: Participants translated the concept of mentalizing to a German professional setting to improve services for the target group

Participants' attitude and thinking changed noticeably in the course of that task. In the beginning most were convinced that such an imaginary key worker was a regular case manager in the existing youth social services system. With a deeper discussion on the key worker's qualifications, his tasks and the multi-disciplinary and multi-professional network around him, participants concluded that a multi-modal worker is a different professional – he or she is rather a social worker with additional psycho-therapeutic qualification, with special competences related to the target group, a close relationship of trust with the young person and equally important with a multi-institutional team that supports him or her which shares the burden of responsibility.

The second working group in the workshop addressed the question of how a multi-agency approach on a systemic level could be fostered in a large metropolitan setting. Initiating the discussion the moderator challenged the group with the question of the "added value" of cooperation. Does cooperation potentially represent an agreement on a least common denominator curtailing professional decision-making?[25] This perspective was rejected by the majority of the group which stated that the workshop series has accentuated the value and benefits of cooperation in servicing the difficult target group. They expressed their dedication to further promote the idea of a multi-agency approach – however to reach this goal certain parameters and procedures of cooperation need to be defined. For one, a new forum of multi-agency cooperation

[25] Reference to a presentation by Prof. Dr. Holger Ziegler on November 29, 2017 at the conference "Kooperation im Grenzgängerbereich – Ergebnisse und Ausblicke" in Glückstadt.

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should not create parallel structures to already existing committees and working groups. Regarding procedural matters involved in creating a new forum of cooperation the following questions need to be addressed:

- Constitution of participants: management level or operational level? Professionals familiar or unfamiliar with the case?
- Geographical scope: community level or city-wide?
- Administration of the forum: regular meetings or on-demand? Length and frequency of the meetings?
- Introduction of cases: Who introduces case and which cases are brought in? When is a case “severe” enough?
- Commitment: who is responsible for follow-up? Are the decisions made binding?
- Coordination: external or internal?

In the following group discussion participants addressed these questions and developed a geographical scope, possible stakeholders and parameters of administration. Instead of putting forth obstacles and challenges participants voiced the desire to “finally get started on a small scale with open-minded youth service administrations”.

d) The national advisory board and actor network: To what end?

The national advisory board was a multi-disciplinary group of management level professionals representing youth social services, youth probation services, youth court assistance, juvenile justice policy department, a juvenile correctional facility and a forensic hospital unit. Over the course of their 3 meetings the national advisory board contributed as follows:

- Identification of existing structural weaknesses, formulation of institutional needs and expectations of the project
- Assistance in designing the capacity-building => case analysis on an operational staff level
- Authorization to introduce anonymized cases for workshop series
- Supply of professionals for the workshop series
- Provision of time resources to allow for in-depth case preparation by staff
- Review and analysis of findings made during the workshop series
- Dissemination of the project results on policy and ministerial leve

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3.2. Transnational level:

a) International meetings: A comparison of procedures, practices and experiences: how it have helped to implement the new models of intervention

Transnational meetings gave an insight into other countries' procedures and practices and the mutual challenges of finding adequate custodial and care taking solutions for young delinquents with mental health disorders. The transnational exchange informed partners about different legal parameters and political strategies to better service this target group. During the transnational meeting it became evident that some systems are less punitive than others - e.g. instead of juvenile jails the Finish system has Reform Schools with semi-open structures accommodating delinquent youth and providing socio-educational services. Despite these differences in legal frameworks professionals – both frontline and management level – seem to be confronted with very similar difficulties in servicing the young target group.

Although different legal frameworks prevented direct transnational analogies, it was beneficial to focus on selective points from partner countries' practices and their potential transferability into one's own national context. One such impulse was given by the presentation Mark Dangerfield, clinical psychologist, psychotherapist and psychoanalyst of Anna Freud National Centre for Children and Families in London. During the second Steering Group meeting in Barcelona in May 2017 he presented the method of AMBIT (Adaptive Mentalization Based Integrative Treatment) including the concept of a *Multi-modal-worker* developed by Dickon Bevington and Peter Fuggle. The concept which is being practiced in Spain has served as the basis for the second capacity-workshop described above.

Another significant effect of the transnational level was the possibility to bring experts and professionals to the transnational meetings. The German stakeholders greatly appreciated this networking opportunity. They exchanged ideas with their international colleagues and were encouraged to further disseminate the European aspect into the local national context. In addition, working relationships and cooperation between national professionals intensified as a result of joining the transnational meetings.

4. Results

a) National capacity building results: What did we learn from the experimentation?

At the end of the three workshops the CJD Nord team conducted a round of reflection and a written evaluation. Furthermore, an additional meeting was held which brought together both workshop participants as well as members of the national advisory board to discuss findings and possibilities of transfer beyond the duration of the project. Based on these rounds of feedback a number of "lessons learned" for next steps were be generated:

- The workshops were initiated, planed, coordinated and moderated by the CJD Nord as a **neutral and independent stakeholder**. Although the process was guided by a European research agenda, no direct institutional interests mitigated the process. Through this approach it was clear that the expertise and professional competencies were with the participants.

- The participants appreciated the **nuanced and diverse composition of the group**. Some participants had previously heard of each other but never met in person. Initial skepticism amongst some participants developed into openness, the willingness to engage in the process and new networking contacts. However, these positive effects could mainly be observed amongst those participants who attended all three workshops. It was stated that the development of trust - as a key condition of cooperation – will take a more long-term process of familiarization with one another. Fluctuation in group participation constitutes a mitigating factor in cooperation.

- The agenda of the three workshops was developed in a **participatory process** with members of the national advisory board and workshop participants. While most participants appreciated this approach others considered the participatory approach as too time-consuming and would have wished more pre-conceptual guidance.

- Participants evaluated the **in-depth case preparations prior to the workshops** as positive. Already in the preparation of the cases new constellations of professionals came together and experienced the beneficial effects of multi-disciplinary case analyses. Participants stated that in their daily routine the time is often lacking for an intensive mutual case reflection. Instead, parallel

diagnoses are developed that are not being properly channeled due to either limited time resources or data protection rules.

- Another positive aspect mentioned by participants were the **two strands** pursued throughout the workshops – a focus on fostering a multi-agency approach on a **systemic level** on the one hand and a focus on the promotion of a **client-centered perspective** requiring multiple disciplines and agencies "to think outside of the box."

- The **key-worker or multi-modal worker** was considered as an innovative approach for servicing the target group. Operational staff that has participated in the workshop series had reviewed that concept and developed a first draft for transferal into the Hamburg system.

- Choosing **interdisciplinary cases analyses** as a methodology was evaluated as positive. Participants became familiar not only with the working methods but also with the limitations faced by other institutions based on two concrete cases. In the process, there was also room for uncertainties, doubts and misinterpretations. However, instead of drawing boundaries participants experienced the process as both enriching as well as a relief to their common pressure of responsibility. Due to the pilot character of the workshops, participants were not confronted with the immediate pressure of decision-making and could approach the case reflection in an open and creative manner. The fact that only parts of the group were familiar with the case proved to be fruitful and allow participants "to experience together more than just helplessness".[26]

b) Multi-actor and multi-agency work: Limits and capacity

After completion of the workshop series participants and the national advisory board inquired on the next steps implementation. The interests in a continuation of the process can be evaluated as a project success. However, it was also recognized that the next steps of sustainability fall into the responsibility of political decision-makers. Financial considerations, the avoidance of "parallel structures" and the added value are relevant questions when institutionalizing a model of multi-agency cooperation. Efforts to foster multi-agency cooperation will initially require additional resources

[26] Presentation of workshop participant from child and youth psychiatry at Steering Group Meeting Fact for Minors in Porto, January 17, 2018.

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which would need to be "shouldered" by all systems involved. Professionals would need to be provided with sufficient time and funding to mutually develop client-centered solutions – which in the long run would be both time-and cost-effective. Participants of the capacity building therefore voiced their desire for a "Hamburg alliance" in pursuing this goal.

Cooperation should not be an end in itself – it must be worthwhile.[27] The professionals involved in cooperation need to benefit by experiencing a relief from their fears and pressure of responsibility. The workshops highlighted that reaching this objective will need time, commitment, maintenance and nurturing of relationships. Cooperation cannot be achieved "on the side", it needs to be well prepared, documented and fully incorporated into operational proceedings.[28] Professionals representing different institutions need to realize that their single contribution in promoting the well-being of the young person is limited if it is not part of a holistic solution supported by all agencies involved.[29] A cooperative approach requires an attitudinal change and taking a dedicated stance towards overcoming boundaries not only by professionals but also by the management level.

The creation of "parallel structures" is a legitimate concern in a metropolitan context. However, with the decrease in funding for in-patient treatment, the fragility of family support resources and an increasing shift from somatic towards mental health problems a growing need of treatment and care for the target group can be expected.[30] The workshop series has highlighted the desire of professionals for a designated multi-agency forum for highly challenging cases touching all three systems. However, apart from the need for space and time for generating creative solutions, there is a need for developing quality standards of cooperation ensuring that it goes beyond the above mentioned lowest common denominator and instead allows for client-centered, custom-made solutions for young people, the strengthening of professionals and for making the pressure "more bearable".

[27] See Groen & Jörns-Presentati, 2017
[28] Interview, also see Groen & Jörns-Presentati, 2017: 15.
[29] Presentation of workshop participant from child and youth psychiatry at Steering Group Meeting Fact for Minors in Porto, January 17, 2018.
[30] Beck & Kellerhaus, 2010.

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5. Prospects for the future

The project Fact for Minors has been met with great interest by local stakeholders in Hamburg. However, it needs to be mentioned that the greatest dedication was initially shown by the youth welfare system – the system traditionally encouraged to cooperate. The commitment by the mental health sector and the juvenile justice system was less prevalent. As mentioned above, some of the reasons for the reluctance of participation were limited time resources, a rejection of responsibility for cases with an ambiguous diagnosis, legal and financial parameters that prevent psychological treatment in jails, etc. Despite these reservations, the project succeeded in bringing all three systems to the table. After the completion of the capacity-building process a number of dissemination events emerged. On April 12, 2018 the CJD Nord was invited to present their findings at the monthly meeting of the interagency policy group on youth violence in Hamburg coordinated by the Ministry of Labor, Social Affairs, Families and Integration.

On June 19, 2018 the CJD Nord is invited to present at the kick off meeting initiated by the Wilhelmstift, a hospital of child and youth psychiatry which was actively involved in the capacity building and the transnational advisory board. Based on the findings of the project the clinic is planning to start a multi-agency cooperation process with youth welfare services in their immediate community.

On June 21, 2018 CJD Nord will present their findings at a multi-disciplinary city-wide conference entitled: “Beyond the order. Challenges of providing care for youth between offenders services, psychiatry and youth welfare services.” The theme emerged as a result of the project bringing together participants from all three systems.

In retrospect, it was challenging to choose a city-wide scope for experimentation. However, given that stronger forms of cooperation between mental health services, youth welfare services and juvenile justice are currently high on the city’s political agenda the empirical field work and the actual capacity-building with professionals of the project was an important contribution in supporting these policy efforts. The Fact for Minors project with its strong focus on multi-agency cooperation provided an impulse for creative thinking beyond the pure focus on a closed facility. Instead, the various interviews and inputs during the capacity building process “gave a voice” to the professionals – their concerns, fears and support needs to work with the challenging target group. By incorporating the level of the national advisory board in the project design these concerns and needs could be reported back to the management level with decision-making competencies.

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