


Jim Lurie

Access to Child and Adolescent Psychiatry for Users of Child Protection Services in Mid-Norway

A study of employees' experiences



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SAMMENDRAG This report presents the results of an internet-based survey of leaders and staff members from 32 municipal child protection service agencies (CPS) and 7 child and adolescent psychiatric outpatient clinics (CAPP) in Mid-Norway. The study focused on access to CAPP services for children and young people who are also users of CPS services. It was found that leaders and staff members from these two services had often quite different perceptions of how good access to CAPP is for this group of children and young people. Leaders and staff members from CAPP were more critical of the quality of referrals from CPS to CAPP, and more often reported requests for additional information from CPS. Leaders and staff members from CPS were often more critical of CPS users' access to CAPP than were their colleagues from CAPP. CPS employees were especially concerned about long waiting time for assessment of referrals, for starting necessary health services, and for receiving follow-up services after an initial consultation. CPS employees were also concerned about more difficult access to CAPP for children and young people living in an unstable family situations where the parents' ability to provide adequate care and support for the child is under evaluation. Lack of patient motivation was another factor which CPS employees saw as a barrier to good access. Respondents from CPS and CAPP agreed about two types of access problems – difficult access to inpatient mental health services, and limited access outside of CAPP's normal office hours. Respondents suggested several measures which can improve access to CAPP for CPS users. These include more resources to CAPP to reduce waiting times, better communication and coordination between CPS and CAPP, and more outreach from CAPP to families and first line agencies at the local level.			
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Preface

Research in Norway and internationally has shown that children and young people who receive help from child protection services (CPS), particularly those who are placed in foster care and institutions, have a greater prevalence of mental health problems than children and young people from the general population. Many of these children require help for these problems from child and adolescent psychiatry (CAPP), but not all receive such help in a timely fashion. This report, *Access to Child and Adolescent Psychiatry for Users of Child Protection Services in Mid-Norway – A study of employees' experiences with access*, presents new information on the important question – how good is access to CAPP services in Mid-Norway for children and young people who are also receiving help from CPS?

Information in the report is based on an internet survey which was sent by email to all municipal CPS agencies and all CAPP outpatient polyclinics in Mid-Norway (Nord-Trøndelag, Sør-Trøndelag and Møre og Romsdal). Responses were received from a total of 32 CPS agencies and 7 CAPP polyclinics.

We would like to thank our informants, the leaders or staff members from the 39 agencies and clinics who took the time to fill out the survey instrument, and for their thoughtful comments about factors that can contribute to or hinder better access to CAPP for CPS users. We would also like to thank Stiftelsen Wøyen for funding this project. This is the third project on the topic of cooperation and coordination between CPS and CAPP which the Regional Child Protection Research Unit (BUS) has carried out with financing from Stiftelsen Wøyen.

The report was written by senior researcher Jim Lurie from BUS who was also leader of the project.

We hope that this report will be useful to workers at CPS and CAPP in their efforts to ensure that CPS users with mental health problems receive the help they need from CAPP.

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Sammendrag

Forskning i Norge og andre land har vist at barn og unge som får hjelp fra barneverntjenesten, har høyere forekomst av psykiske problemer, enn barn og unge fra befolkningen generelt. Dette gjelder særlig barn og unge som er plasserte i fosterhjem eller barneverninstitusjon, men også barn som får hjelp mens de bor hjemme med familien (Kjelsberg & Nygren 2004, Iversen et al. 2008, Ford et al. 2007, Egelund & Lausten 2009). Det hevdes at barnevernbarn ofte får for dårlig tilgang til tjenester fra barne- og ungdomspsykiatrien (BUP) i Norge, og det har vært lite empirisk forskning om dette (Agleedal et al. 2006, Riedl 2008, BLD 2009, Kristofersen 2007).

Metode

Dette prosjektet har undersøkt barnevernbarns tilgang til BUP-tjenester i Midt-Norge. Informasjonen er innhentet gjennom en internettbasert spørreundersøkelse, besvart av ledere/ansatte fra den kommunale barneverntjenesten og BUP-poliklinikker i denne regionen. Undersøkelsen ble gjennomført i august og september 2010. Den ble utført ved hjelp av Questback-programmet. Deltagelsen var frivillig og informantenes anonymitet ble beskyttet.

Undersøkelsen besto av 38 spørsmål, de fleste hadde faste svaralternativer som ble krysset av. Det ble spurt om ulike sider av barnevernbarns tilgang til BUP, blant annet om henvendelser fra barnevernet, ventetid, tilgang til polikliniske- og døgntjenester, tilgang for barn med uavklart omsorgssituasjon, tilgang for barn som mangler behandlingsmotivasjon, og faktorer som fremmer og hindrer tilgang til BUP. Undersøkelsen ble besvart av 32 av 64 barneverntjenester og 7 av 12 BUP-poliklinikker. Den totale responsraten var 51 %.

Resultater

Undersøkelsen viste at informantene fra barnevernet og BUP hadde ganske ulike oppfatninger på mange av spørsmålene. Informantene fra barnevernet var stort sett mer kritiske til flere sider av barnevernbarns tilgang til BUP. Informantene fra BUP var mer kritiske til kvaliteten på henvisninger fra barnevernet til BUP.

Det var to problemer med tilgangen til BUP, som informanter fra begge tjenester var ganske enige om. De fleste informanter fra begge tjenester, mente at det var vanskelig

for barnevernbarn å få tilgang til døgn tjenester fra BUP. De fleste informanter fra BUP svarte at det var et tilstrekkelig antall BUP døgnplasser i regionen til å møte et normalt behov, men mange informanter fra barnevernet mente at kapasiteten var for liten. Mange informanter fra barnevernet mente at barnevernbarn med psykiske problemer, av og til ble plassert i barneverninstitusjoner på grunn av manglende kapasitet i BUP døgninstitusjoner, men de fleste informanter fra BUP svarte at dette sjelden var tilfellet. Bedre koordinering av døgninstitusjoner mellom Bufetat og BUP for å forbedre barnevernbarns tilgang til døgn behandling i BUP er foreslått av BLD (NOU 2009:22).

Vanskelig tilgang til BUP-poliklinikker utenom vanlig åpningstid, var det andre problemet som begge grupper var enige om. Mange BUP-poliklinikker er bare åpne fra 8:00-15:30 på hverdager. Tilgang om kvelden, i helger og i ferier er derfor ofte vanskelig for barnevernbarn og andre brukere av BUP. Kristofersen (2007) fant samme problem i en tidligere studie av tilgang til BUP.

Lang ventetider for vurdering og behandling

Informanter fra barneverntjenesten var særlig opptatte av lange ventetider for vurdering av henvisninger og for å begynne nødvendig behandling. Det er lovpålagte frister for barn og unge under 23 år med psykiske lidelser eller rusmiddelavhengighet, for vurdering av retten til nødvendig hjelp fra spesialisthelsetjenesten (inkludert BUP), og for å begynne nødvendig tjenester (Prioriteringsforskrift § 4a). Spesialisthelsetjenesten skal også fastsette en individuell frist, for når faglig forsvarlighet krever at en pasient med rett til nødvendig helsehjelp skal få denne (Pasientrettighetsloven § 2-1).

Mange informanter fra barnevernet svarte at disse rettigheter var sjelden oppfylt i praksis. Et flertall mente at total ventetid fra henvisning til oppstart av nødvendig helsehjelp var ”dårlig”. De var også kritiske til ventetiden for vurdering av henvisninger, til oppfyllelse av den individuelle fristen og også til ventetiden for oppfølging/viderebehandling etter førstegangskonsultasjonen. Informanter fra BUP var mye mer positive i forhold til alle spørsmål om ventetiden og overholdelse av frister. Statistikk fra Helsedirektoratet ser ut til å underbygge barneverninformantenes synspunkter på dette spørsmål. BUP i helseregion Midt-Norge hadde lengre ventetider og færre pasienter som ble behandlet innenfor tidsfrister enn BUP-pasienter i Norge som helhet, i perioden januar-april 2010 (Helsedirektoratet 2010b).

Dårlig tilgang for barn med en uavklart omsorgssituasjon

Mange informanter fra barneverntjenesten var også bekymret for dårlig tilgang til BUP, for barnevernbarn med en uavklart omsorgssituasjon. De mente at praksisen ikke er i samsvar med føringer i to veiledere for BUP fra Helsedirektoratet. Disse slår fast at barn og unge i familier hvor foreldres omsorgsevne er under vurdering, skal ha den samme rett til hjelp fra BUP, som andre barn og ungdom. En sårbar omsorgssituasjon som påvirker pasientens psykiske helsetilstand negativt, skal gi større rett til nødvendig helsehjelp (Veileder for poliklinikker i psykisk helsevern for barn og unge, Prioriteringsveileder psykisk helsevern for barn og unge).

Informanter fra begge tjenestene var enige i disse prinsippene, men var ikke enige i hvordan de ble praktisert. Mange informanter fra barneverntjenesten svarte at tilgang til BUP, ofte kunne bli utsatt for barn og unge med en uavklart omsorgssituasjon, i hvert fall inntil situasjonen var forbedret. Mange mente også at dette noen ganger ble brukt som begrunnelse for å avslå hjelp til disse barna.

Skal BUP vente til barn/unge og deres foreldre er motiverte for å ta i mot hjelp fra BUP?

Pasientenes motivasjon for hjelp fra BUP var et annet spørsmål som skilte informantene fra barnevernet og BUP. De fleste terapeuter foretrekker motiverte pasienter og mener at dette øker sjansene for gode behandlingsresultater. Barn og unge (og deres foreldre) som er henvist til BUP, er ikke bestandig motiverte for behandling i utgangspunktet, og det kan være nødvendig for BUP å bidra mer aktivt i motiveringsprosessen. Prioriteringsveileder for psykisk helsevern for barn og unge har relevante føringer på dette spørsmålet. Her står det blant annet:

”Mangelfull motivasjon for helsehjelp hos pasient og/eller dennes foresatte kan ha betydning for helsehjelpen som poliklinikker innenfor psykisk helsevern for barn og unge kan tilby... Spesialisthelsetjenesten må i slike situasjoner være oppmerksom på behovet for å samarbeide med andre tjenester, for å avklare årsakene til manglende motivasjon. Dette kan bidra til at pasienten eller familie/foresatte på en bedre måte kan nyttiggjøre seg helsehjelpen. Spesialisthelsetjenesten må kunne bidra aktivt i arbeidet med å øke motivasjon for helsehjelp dersom dette anses nødvendig” (punkt 2- Fagspesifikk innledning psykisk helsevern for barn og unge).

Informanter fra barnevernet og BUP hadde ulike synspunkter på dette tema både prinsipielt og om gjennomføring i praksis. Et flertall av BUP-informantene mente at hjelp til barnevernbarn, burde ikke være satt i gang før barn og/eller foreldre var motiverte

for hjelp fra BUP. Svært få av informantene fra barnevernet var enige i det. Mange informanter fra barnevernet mente at hjelp til umotiverte barnevernbarn ofte ble utsatt. Ingen informanter fra BUP var enige i at det skjedde ofte, men noen svarte at det skjedde av og til.

Flere informanter fra barnevernet tok opp dette spørsmålet i sine kommentarer; om hva som kan bidra til bedre tilgang til BUP for barnevernbarn. Det ble etterlyst mer innsats og mer kreativitet fra BUP, for å hjelpe barn og deres foreldre til å komme over skepsis mot å ta i mot hjelp fra BUP. Flere foreslo at BUP ikke burde være så rask, til å avslutte saker når barn ikke møtte opp til avtalt behandling.

Andre forslag til bedre tilgang til BUP for barnevernbarn

Informanter fra både barneverntjenesten og BUP, hadde mange interessante forslag til hvordan man kan forbedre tilgangen til BUP-tjenester for barnevernbarn. Blant forslagene var:

- Økte ressurser til BUP for å kunne redusere ventetid for vurdering og behandling og bidra til mer fleksible tjenestetilbud fra BUP.
- Mer innsats fra BUP på et tidligere tidspunkt til å hjelpe barn med en uavklart omsorgssituasjon.
- Bedre samarbeid og kommunikasjon mellom barnevern og BUP i forbindelse med barn med behov for hjelp fra begge tjenester.
- Mer bruk av tverretatlige team for å koordinere hjelp til enkelte barn og familier.
- Bedre avklaring på ansvar i forhold til barn, som er i kontakt med både barnevernet og BUP.
- Bedre henvisninger fra barnevern til BUP, med mer informasjon om tiltak som allerede er satt i gang i familien, og mer detaljert informasjon om barnets ferdigheter og funksjonsnivå.
- Mer oppsøkende og ambulante tjenester fra BUP til barnevernbarn, bl.a. gjennom fast kontortid i mindre kommuner som har lang avstand til poliklinikk.
- Ungdom som fyller 18 år bør få anledning til å opprettholde kontakten med BUP, i en periode, istedenfor rask henvisning til voksenpsykiatri.

Chapter 1 Introduction

Background

Many Norwegian children and young people who receive help from child protection services (CPS) have mental health problems. Some require assistance from specialty mental health services (CAPP). CAPP services are not always easily available and some CPS users do not receive needed care or must wait months before receiving help. Recent calls for better access for CPS users to CAPP services have come from the government and from private groups. This report provides new information on the topic of CPS users' access to CAPP services from the perspective of leaders and staff members from municipal CPS agencies and CAPP outpatient clinics in Mid-Norway (Nord-Trøndelag, Sør-Trøndelag and Møre og Romsdal).

Research in Norway and other countries has shown that children and young people who receive help from child protection services often have a higher prevalence of various kinds of mental health problems than children and young people from the general population. Many of these studies have focused on the mental health of children and young people placed in care by CPS, in foster homes or residential institutions (Kjelsberg & Nygren 2004, Ford et al 2007, Egelund & Lausten 2009). Norwegian children who received child welfare services while living at home with their families were also found to have a higher prevalence of mental health problems. These children had significantly greater emotional problems, hyperactivity, conduct problems, peer problems and total difficulties than their peers from the general population (Iversen et al 2008).

Several recent reports from the government and from advocacy groups have addressed this issue. One of these, from the Ministry of Health and Care Services (HOD), discussed the problem of CPS users' alleged under consumption of mental health services. The authors suggest that this is due to weak cooperative traditions between CPS and CAPP, to insufficient knowledge about each other's professional culture and methods, and to unrealistic expectations from CPS about what CAPP can contribute (Agleddal et al 2006).

A report from an advocacy organization which works to promote the mental health of children and young people in Norway discussed the need for better access to mental health services for children and young people in contact with CPS. The author argued that CPS users often receive poorer access to CAPP services than other children and young people despite a greater need for these services. This was due in part to CAPP's

freedom to prioritize who is to receive treatment according to their own discretion and financial incentives from reimbursement that does not cover the costs of interagency cooperation. The author was particularly concerned about inadequate capacity in CAPP inpatient institutions which sometimes resulted in CPS users being placed in private CPS residential care instead. These institutions are not always qualified to provide adequate mental health treatment to CPS users (Riedl 2008).

A recent report from the Ministry of Children, Equality and Social Inclusion (BLD) recommended several measures designed to improve access to inpatient mental health services for CPS users. Among these were the establishment of inpatient institutions administered jointly by CPS and CAPP which could provide inpatient treatment to children and young people with a need for help from both of these services. Another was an amendment to the mental health care act which would require regional health authorities to find necessary inpatient mental health treatment in CAPP for CPS users (BLD 2009).

CPS users' are not alone in experiencing limited access to CAPP inpatient care. The national plan for strengthening of mental health services has prioritized outpatient mental health services for children and young people rather than inpatient care. The plan for the period 1998-2008 has resulted in a rapid increase in outpatient services, but little growth in inpatient beds. Outpatient services were the dominant treatment form in 2009 with 96 % of children and young people receiving outpatient mental health care. There were only 320 beds in inpatient mental health facilities for children and young people in Norway in 2008, an increase of only 10 % since 1998. The number of children and young people receiving outpatient services from CAPP increased by over 170 % during the same period (Pedersen 2009, Helsedirektoratet 2010a).

There has been little previous research on CPS users' access to CAPP services in Norway. One study did look at cooperation between CPS and CAPP, including the issue of access to both services (Kristofersen 2007). CAPP leaders reported that access to CAPP had improved between 2002 and 2005, and that waiting time for services had generally declined. CAPP had also become better at prioritizing those in need of emergency services. CPS leaders had mixed views as to whether or not CAPP clinics had become more accessible between 2002 and 2005. Access was generally good for acute cases, but more difficult for less acute cases. Access to emergency assistance outside of normal working hours was also difficult.

CAPP patients and CPS users in central Norway in 2009

Nearly 52.000 Norwegian children and young people received specialty mental health services from CAPP in 2009. About 12 % of these (6.400) received services from CAPP in Mid-Norway. Outpatient services received by CAPP patients in central Norway included therapy/conversation (64 %), assessment/observation (11 %), and indirect services, mainly cooperation with other agencies (25 %) (Helsedirektoratet 2010a). There are no exact figures for the number of CAPP patients who also received services from CPS, but estimates from CAPP referral data for 2008 indicate that about 16 % of children and young people were in contact with both services (Helsedirektoratet 2009a). If the same proportion holds true for Mid-Norway, this would mean that about 1,000 children and young people received help from both agencies in Mid-Norway in 2009.

Legal framework – Patients’ rights and treatment deadlines

Children and young people have no unconditional right to specialty mental health services from CAPP. Children and young people are referred to CAPP by physicians or by other health and welfare providers including the leaders of CPS agencies. Admission to CAPP is then determined by the clinic administrator or by other staff members who are delegated to make this decision. Admission decisions, however, are subject to laws and regulations. Most important of these is the Patients’ Rights law (1999) which ensures that patients who are determined to be in need of necessary specialist health services shall receive these services according to the terms of the law. This right is subject to two conditions – that the patient can be expected to benefit from the health care provided, and that the costs of the care are reasonable in relationship to the expected benefits. Patients determined to be in need of specialist services (including CAPP services) shall receive these services within an individual professionally determined deadline.

These patient’s rights are specified further in regulations for prioritizing of specialist health services. The right to necessary care is also subject to a third condition related to the seriousness of the patient’s illness as measured by reduced life expectancy or quality of life if services are not received in time. The regulations also establish special deadlines for providing specialty health services to children and young people under the age of 23 with mental illness or substance dependency problems. Referrals for care must be assessed within 10 working days, and necessary care must be provided within 65 working days (Priority regulations §§ 2, 4a).

Waiting time for CAPP services in Norway and Mid-Norway

The Norwegian Directorate of Health publishes statistics three times a year on patient rights and waiting times for specialty health care services including mental health services for children and young people from CAPP. These statistics are given for the whole country and for individual health care regions, including Mid-Norway. The statistics below are for the period January-April 2010 (Helsedirektoratet 2010b).

Percentage of referrals receiving right to necessary mental health care from CAPP

Mid-Norway	84 %	Norway	87 %
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Percentage of referrals assessed within deadline (10 working days)

Mid- Norway	87 %	Norway	89 %
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Average waiting time from referral to start of treatment by CAPP

Mid-Norway	77 days	Norway	67 days
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Percentage of children with right to necessary health care receiving help from CAPP within maximum general deadline (65 working days)

Mid-Norway	83 %	Norway	87 %
------------	------	--------	------

Percentage of children with right to necessary health care receiving help from CAPP within individual professionally-determined deadlines

Mid-Norway	61 %	Norway	79 %
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These statistics show that CAPP in Mid-Norway had poorer results than the country as a whole on all measures of waiting time and right to necessary care. Total waiting time from referral to start of treatment was 10 days longer on average for CAPP patients in Mid-Norway than for those in the country as a whole. Mid-Norway had also considerably more difficulty in meeting the individual deadline for care. As seen above, only 61 % of children and young people in Mid-Norway received care within this deadline (as compared to 79 % in the whole country).

CAPP guidelines and CPS users

The Patient's Rights law and the Priority regulations apply to all children and young people and do not specifically mention CPS users who may be in need of specialist

health services. CPS users are, however, discussed in two guidelines from the Directorate of Health for CAPP outpatient clinics and for prioritizing of mental health treatment to children and young people with various specific mental health conditions or diagnoses.

The guidelines for CAPP outpatient clinics state that CPS users should be referred, assessed and admitted to CAPP polyclinics in the same way as other children and young people. Children and young people living in unstable family situations with parents whose ability to care for their children is under evaluation shall also have the same right to treatment from CAPP. The CAPP polyclinic is expected to establish close cooperation with CPS in their community and to assist CPS directly and indirectly with cases involving children with mental health problems (Helsedirektoratet 2008).

Children and young people with a difficult family situation which can negatively affect their mental health are to receive higher priority when it comes to the right to necessary care, because this can increase the seriousness of their health care problem. The priority guidelines also state that children and young people who have mental health problems which are caused by conditions in their living environment can need from assistance from CAPP. This help should be adapted to the child's situation and should be provided in coordination with other helping agencies including CPS, local health services and schools or nursery schools (Helsedirektoratet 2009b).

Research initiative on child welfare and mental health

This project is part of a broader research initiative at the Regional Child Protection Research Unit (BUS) on the topic of child welfare and mental health. BUS has collaborated with the Regional Centre for Child and Adolescent Mental Health in Mid-Norway (RBUP) at NTNU on this initiative, and the two centers are currently working together on a research project focused on the mental health of young people in CPS residential care institutions.

BUS has received financing from the Wøyen foundation (Stiftelsen Wøyen) for three projects within this policy area. The first project was a literature review of current knowledge on cooperation and coordination between CPS and CAPP in Norway over the past 20 years. The project provided information about current and previous efforts to improve cooperation between these two services at different levels of government and using a range of different methods (Lurie & Tjelflaat 2009). The second project was an interview study of young people and their parents in Trøndelag who had re-

ceived help from both CPS and CAPP. The report discussed the families' interaction with both of these agencies, and their views on cooperation between the families and the two agencies (Lurie & Ulset 2010). It was found that children and young people often had a closer relationship to therapists at CAPP, while parents and foster parents often were in closer contact with CPS. This report on CPS users' access to CAPP services in Mid-Norway is the third in the series which has been financed by Stiftelsen Wøyen.

Chapter 2 Method

The aim of this study has been to find out about access to CAPP services for children and young people who also receive help from CPS. This question has been examined from the perspective of leaders and employees from the two services, CPS and CAPP, in Mid-Norway.

Study design

The study had the following research questions:

1. How do leaders and staff from CPS and CAPP perceive access to CAPP services for CPS users?
2. Do children and young people have adequate access to different kinds of CAPP services including outpatient and inpatient treatment?
3. How are waiting times for assessment and treatment in CAPP?
4. How are referrals from CPS to CAPP?
5. How is access for CPS users in unstable family situations who are living with parents who may not provide them with adequate care?
6. How is access for CPS users who lack motivation for treatment or whose parents are not motivated for help from CAPP?
7. What can contribute to better access to CAPP for CPS users?
8. What can hinder access to CAPP for CPS users?

The survey instrument

Data for this study has been collected using an internet-based survey questionnaire. The survey was designed and carried out using the Questback-program. The survey consisted of 38 questions which took about 15 minutes to answer. These included 35 closed questions with multiple choice answers and 3 open questions which the respondents could answer in their own words. The questionnaire covered the following topics: background, referrals from CPS to CAPP, waiting time, access to CAPP, access

to inpatient care, access for children living in unstable family situations, access for children lacking motivation for treatment, costs and benefits of care, cooperation between CPS and CAPP, and factors which can contribute to or hinder access to care.

Participation in the survey was voluntary. Information about the survey and a link to the survey for those willing to participate was sent by email to all potential respondents. The respondents answered the survey anonymously, with hidden identity, which prevents the researchers from linking survey responses to the email addresses of the respondents. Respondents were not asked to provide information that could identify them as individuals or the municipalities or agencies where they were employed. The survey was carried out during the period from August 16 to September 24, 2010. Those who did not respond to the initial invitation received three automatic reminders to participate. The study was approved by the Norwegian Social Science Data Services (NSD), which is the privacy ombudsman for research in Norway. The NSD has responsibility under the Personal Data Act for ensuring that research is conducted in accordance with ethical standards, including those protecting the anonymity of research informants.

Respondents

The survey was sent to the leaders of all municipal CPS agencies and all CAPP outpatient/polyclinics in Mid-Norway. This region includes the 3 counties Nord-Trøndelag, Sør-Trøndelag, and Møre og Romsdal. Invitations were sent to a total of 76 agencies including 64 municipal CPS agencies and 12 CAPP outpatient clinics. Leaders were invited to respond to the survey themselves or to delegate this task to other employees who were knowledgeable about this topic.

Most of the CPS agencies in these three counties serve a single municipality. Some CPS agencies, however (particularly in Nord-Trøndelag) are intermunicipal agencies which serve more than one community. CPS services in Trondheim, the largest city in the region, are provided by four district offices. Survey invitations were sent to each of the four district offices.

CAPP services in Norway are provided by specialist mental health services which are part of regional health authorities. Health region Mid-Norway contains five such health authorities located in Sør-Trøndelag (Trondheim), Nord-Trøndelag (Levanger and Namsos), and Møre og Romsdal (Sunnmøre and Nordmøre og Romsdal). These five authorities have responsibility for the 12 outpatient CAPP clinics in Mid-Norway which were all invited to participate in the survey.

Survey response and missing data

The overall survey response rate was 51 %. This included responses from 39 of the 76 respondents who received invitations to participate. Half of the 64 CAPP agencies participated, as did 7 of 12 CAPP outpatient clinics. The initial response was only 29 %. Non-respondents received automatic (anonymous) reminders at regular intervals. Three reminders were sent out, resulting in a final rate of 51 %.

A 51 % response may be considered to be a reasonably good response for a survey of this kind administered by email. Babbie (1979) considers a survey response of 50 % to be adequate for purposes of analysis, with rates of 60 % as good, and 70 % as very good. These classifications were based on traditional postal surveys. Several studies of response rates for electronic surveys have found that these often have lower response rates than traditional surveys administered by mail, with average rates in the 35-40 % range (Sheehan 2001, Cook et al. 2000).

Caution must, nonetheless, be exercised in attempting to generalize the results of this survey to a broader population. This is because of the danger of non-response bias, which can occur if those responding to a survey differ from non-responders in ways which systematically affect their answers to the survey. A high response rate reduces the risk of non-response bias. Follow-up studies of non-respondents are sometimes conducted to determine if they differ significantly from respondents. This was not possible in this case because we do not know which CPS agencies or clinics responded to the survey.

There was relatively little missing data on this survey, particularly on the 35 closed multiple choice answer questions. Most respondents answered all multiple choice questions or had at most one or two missing answers. 31 respondents also provided comments about factors that can contribute to access, and 26 provided information about barriers to access.

Chapter 3 Results

Introduction

The results of the survey are presented in this chapter. As described in the previous chapter, the data consists of responses from leaders/coworkers from 32 municipal CPS agencies and 7 CAPP outpatient polyclinics. This chapter includes the results from the 35 closed format multiple choice questions on the survey. Respondents answered these questions by selecting one of the predefined answer alternatives (for instance poor, acceptable and good). Respondents also answered two open-ended questions at the end of the survey in their own words about factors which can contribute to and factors which hinder CPS users' access to CAPP. The results from those two questions will be presented in the concluding chapter of the report.

The two agencies have different roles and responsibilities with regard to CPS users' access to CAPP, and these may be expected to influence their views on the access question. CPS has responsibility for referring children in need of mental health services to CAPP, while CAPP has responsibility for assessing the children's need and for providing adequate care where this is required. The results show that the two groups had different views on many of the survey questions. The results are, therefore, presented separately for each of these two services. CPS respondents make up over 80 % of all respondents, so results presented for respondents as a whole would largely reflect the views of the CPS respondents.

Because of the relatively small number of respondents, we have chosen to present the findings descriptively rather than through a statistical analysis. The descriptions of main tendencies in the two groups are supplemented with tables which provide the frequency and percentage of responses in each category for both groups and for the respondents as a whole.

Results will be presented on the following topics:

- Respondent background
- Referrals from CPS to CAPP
- Waiting time
- Access to CAPP
- Quality and sufficiency of care

- Access to inpatient services
- Access for children in unstable family situations
- Access for children lacking motivation for help
- Access and resource use for CPS users
- Cooperation between CPS and CAPP

Respondent background

Respondents were asked to provide limited background information on their employment status, including type of agency, type of position, and how long they had worked in the agency. They were not asked the name of the municipality where they were employed or the location of the CAPP inpatient clinic, in order to protect the respondents' anonymity.

The survey was answered by 32 CPS respondents and 7 CAPP respondents. 82 % of all respondents were from CPS.

The survey was sent by email to leaders of CPS agencies and CAPP polyclinics with instructions to answer the survey themselves or delegate this task to other employees. Most leaders chose to answer the survey themselves. 79 % of the responses were from leaders, including 24 from CPS and 6 from CAPP.

Most of the respondents (74 %) had been employed at their agencies for 5 years or more, which was the highest category. 21 % had been employed for 3-5 years. Only 2 respondents (both from CPS) had less than 3 years of experience at their agency.

Referrals from CPS to CAPP

Physicians and the leaders of CPS and social welfare agencies are the groups with formal authority to refer children to CAPP. The majority of referrals are made by physicians. 11 % of referrals to CAPP in 2007 were made by CPS or child welfare agencies (Sosial- og helsedirektoratet 2008).

Respondents answered several questions about the quality of referrals from CPS to CAPP and about requests for additional information from CPS. As shown below, CPS respondents as a group had a more favorable impression of referrals from CPS to CAPP than did CAPP respondents. Nearly half of CPS respondents (46 %) believed that referral quality was good, but nearly all CAPP respondents found them to be ac-

ceptable. One CAPP respondent rated CPS referrals as poor. As discussed in the next chapter, several CAPP respondents also had specific suggestions for improving the quality of referrals from CPS to CAPP.

The two groups had more similar views about how often CPS is able to refer the “right” children to CAPP. “Right” meaning children with a real need for help from CAPP. A majority of both groups answered that CPS “often” referred the right children while the rest of the respondents replied that they sometimes managed to do this.

CAPP respondents more frequently reported requests from CAPP to CPS for additional information to supplement the original referral. A majority of CAPP respondents reported that CAPP “often” requested additional information from CPS, while nearly half of CPS respondents said this happened only “sometimes”.

Table 1 - How good are referrals from CPS to CAPP?

	CPS	CAPP	Total
Poor	0 (-)	1 (14 %)	1 (3 %)
Acceptable	15 (54 %)	6 (86 %)	21 (60 %)
Good	13 (46 %)	0 (-)	13 (37 %)
N	28	7	35

Table 2 - How often does CPS refer the “right” children to CAPP?

	CPS	CAPP	Total
Seldom	0 (-)	0 (-)	0 (-)
Sometimes	10 (36 %)	3 (43 %)	13 (37 %)
Often	18 (64 %)	4 (57 %)	22 (63 %)
N	28	7	35

Table 3 - How often does CAPP request additional information from CPS?

	CPS	CAPP	Total
Seldom	9 (31 %)	0 (-)	9 (25 %)
Sometimes	14 (48 %)	3 (43 %)	17 (47 %)
Often	6 (21 %)	4 (57 %)	10 (28 %)
N	29	7	36

Waiting time

As discussed in chapter 1, children and young people under the age of 23 years with mental health or substance abuse problems have the right to assessment of their need for necessary specialized mental health services from CAPP and to start receiving necessary services within specific legal deadlines. CPS respondents were generally more critical of waiting times for assessment and treatment, and of CAPP's failure to meet these deadlines than were respondents from CAPP.

All but one CAPP respondents reported that total waiting time from referral to CAPP to start of necessary treatment was "acceptable". A majority of CPS respondents (56 %) replied that the total waiting time for CPS users in CAPP was "poor". Very few respondents answered that total waiting time was "good".

CPS respondents were also more critical about how often CAPP was able to meet the deadlines for assessment of need and for starting necessary care within individual (professionally determined) deadlines. CAPP respondents were nearly unanimous in reporting that both of these deadlines were "often" met, while CPS respondents were more divided on these questions. Only about 1/3 of CPS respondents answered that these deadlines were "often" met, with the others reporting that the deadlines were met only "sometimes" or "seldom". 29 % of CPS respondents reported that CAPP "seldom" met the individual treatment deadlines.

There are no legal deadlines for follow-up treatment from CAPP and some critics (Riedl 2008) have argued that CPS users must often wait quite long for follow-up care after receiving an initial consultation or treatment from CAPP. CPS respondents reported much more frequent waits for follow-up care than their colleagues from CAPP. Over 2/3 of CPS respondents replied that CPS users had to wait too long for follow-up care. Only one of the CAPP respondents shared this viewpoint.

Table 4 - How is the total waiting time for CPS users from referral to start of treatment in CAPP.

	CPS	CAPP	Total
Poor	18 (56 %)	0 (- 0 -)	18 (47 %)
Acceptable	13 (41 %)	5 (86 %)	18 (47 %)
Good	1 (3 %)	1 (14 %)	2 (6 %)
N	32	6	38

Table 5 - How often is need assessed within 10 working days?

	CPS	CAPP	Total
Seldom	6 (19 %)	0 (-)	6 (15 %)
Sometimes	15 (47 %)	0 (-)	15 (39 %)
Often	11 (34 %)	7 (100 %)	18 (46 %)
N	32	7	39

Table 6 - How often is treatment started within individual deadline for CPS users?

	CPS	CAPP	Total
Seldom	9 (29 %)	0 (-)	9 (24 %)
Sometimes	11 (36 %)	1 (14 %)	12 (32 %)
Often	11 (36 %)	6 (86 %)	17 (45 %)
N	31	7	39

Table 7 - CPS users must often wait too long for follow-up treatment

	CPS	CAPP	Total
Disagree	10 (32 %)	6 (86 %)	16 (42 %)
Agree	21 (68 %)	1 (14 %)	22 (58 %)
N	31	7	38

Access to CAPP

Respondents provided information about various access questions including overall access quality, access outside of regular office hours, and changes in access over time. As in the case of waiting time for assessment and treatment, CPS users tended to be more critical about most measures of CPS users' access to CAPP than were respondents from CAPP.

Though most respondents from both groups rated CPS users overall access to CAPP as "acceptable", it is important to note that only 2 respondents rated access as "good". A sizable group of CPS respondents (34 %) rated overall access as "poor". CAPP respondents were also more optimistic about changes in access which had taken place over the past 5 years. While most CAPP respondents (5 of 7) reported improved access for CPS users, less than half of CPS respondents agreed (45 %). Nearly half of CPS respondents (48 %) believed that access for CPS users was the same as 5 years earlier, and 2 from this group reported worse access than in the past.

One access problem that most respondents from both groups agreed about was access to CAPP services outside of regular office hours. Many CAPP outpatient clinics in Norway are open only on weekdays during regular working hours (for instance 8:00 – 15:30). It is therefore difficult to gain access to these clinics evenings, weekends and holidays. All but one respondent from CAPP and over $\frac{3}{4}$ of those from CPS replied that it is not easy to gain access to CAPP outside of regular working hours. Kristofersen (2007) found similar problems during the period 2002-2005.

Respondents also rated access to CAPP services for CPS users living in three different situations – at home with their parents, in foster care, and in CPS residential institutions. As in the case of overall access, most respondents from both groups rated access as "acceptable", regardless of where the child was living. There were some exceptions to this general pattern. Some CPS respondents believed that children living at home had worse access than those placed in foster homes or institutions. Nearly 40 % of CPS respondents replied that children living at home had "poor" access to CAPP. Relatively few of the CPS users had "good" access to CAPP, but a slightly higher proportion of children in foster care (23 %) were reported to have "good" access to CAPP.

Table 8 - How good is access to CAPP for CPS users?

	CPS	CAPP	Total
Poor	11 (34 %)	1 (14 %)	12 (31 %)
Acceptable	19 (59 %)	6 (86 %)	25 (64 %)
Good	2 (6 %)	0 (0 %)	2 (5 %)
N	32	7	39

Table 9 - Access to CAPP for CPS users as compared to 5 years earlier.

	CPS	CAPP	Total
Worse	2 (7 %)	0 (-)	2 (5 %)
The same	15 (48 %)	2 (29 %)	17 (45 %)
Better	14 (45 %)	5 (71 %)	19 (50 %)
N	31	7	38

Table 10 - Access to CAPP outpatient services outside of regular working hours.

	CPS	CAPP	Total
Very easy	2 (7 %)	0 (-)	2 (6 %)
Easy	5 (17 %)	1 (14 %)	6 (17 %)
Not easy	22 (76 %)	6 (86 %)	28 (78 %)
N	29	7	36

Table 11 - How good is access for CPS users living at home?

	CPS	CAPP	Total
Poor	10 (39 %)	0 (-)	10 (30 %)
Acceptable	12 (46 %)	6 (86 %)	18 (55 %)
Good	4 (15 %)	1 (14 %)	5 (15 %)
N	26	7	33

Table 12 - How good is access for CPS users living in foster care?

	CPS	CAPP	Total
Poor	3 (9 %)	1 (14 %)	4 (10 %)
Acceptable	22 (69 %)	4 (57 %)	26 (67 %)
Good	7 (22 %)	2 (29 %)	9 (23 %)
N	32	7	39

Table 13 - How good is access for CPS users living in CPS institutions?

	CPS	CAPP	Total
Poor	6 (21 %)	1 (14 %)	7 (19 %)
Acceptable	20 (69 %)	4 (57 %)	24 (67 %)
Good	3 (10 %)	2 (29 %)	5 (14 %)
N	29	7	36

Quality and sufficiency of care

Two other important measures of access to mental health services in CAPP are quality of care and sufficiency of care. It is not enough for CPS users to receive some access to CAPP if the care they receive is of inferior quality or if they do not receive enough care to meet their treatment needs. CAPP respondents were generally positive about both of these questions, while many CPS respondents questioned the sufficiency of care received by CPS users.

Most respondents from both groups (70 %) rated quality of mental health services as “acceptable” and 9 respondents (including 7 from CPS) rated quality as “good”. A majority of CAPP respondents (4 of 7) replied that CPS users “often” receive sufficient help from CAPP, but most CPS respondents (84 %) believed that CPS users only “sometimes” receive sufficient help from CAPP.

Table 14 - How good is the quality of mental health services for CPS users?

	CPS	CAPP	Total
Poor	2 (7 %)	0 (0 %)	2 (5 %)
Acceptable	21(70) %	5 (71 %)	26 (70 %)
Good	7 (23 %)	2 (29) %	9 (24 %)
N	30	7	37

Table 15 - How often do CPS users receive sufficient help from CAPP?

	CPS	CAPP	Total
Seldom	3 (10 %)	0 (0 %)	3 (8 %)
Sometimes	26 (84 %)	3 (43 %)	29 (76 %)
Often	2 (7 %)	4 (57 %)	6 (16 %)
N	31	7	38

Access to inpatient services

As discussed in chapter one, most children and young people who receive help from CAPP receive outpatient services (96 % in 2009, Helsedirektoratet 2010a). There are relatively few inpatients CAPP beds in Norway (320 in 2008) and there has been little increase in inpatient capacity during the past decade (Pedersen 2009).

Most respondents in this study reported that it is “not easy” for CPS users to gain access to inpatient treatment from CAPP in Mid-Norway. 90 % of CPS respondents and 4 of 6 CAPP respondents gave this answer.

Respondents from CPS and CAPP had different views on CAPP inpatient capacity in Mid-Norway in general. Most CPS respondents (78 %) replied that there are not enough beds in CAPP inpatient facilities to meet normal demand, but only 2 of 4 CAPP respondents agreed. This would seem to indicate that CAPP respondents believe that it is more difficult for CPS users to gain access to CAPP inpatient care than it is for other children and young people.

Respondents from the two groups also had different perceptions about the consequences of limited CAPP inpatient access for CPS users. A majority of CPS respond-

ents (58 %) replied that CPS users are “sometimes” placed in CPS institutions because of insufficient capacity in CAPP institutions. Several CAPP respondents agreed that this took place “sometimes”, but half of the CAPP respondents replied that this was “seldom” done. Riedl (2008) has criticized this practice because he argues that many CPS residential institutions are not qualified to provide adequate care to children and young people with serious mental health problems.

Table 16 - How easy is it for CPS users to be admitted to a CAPP inpatient facility?

	CPS	CAPP	Total
Very easy	0 (-)	0 (-)	0 (-)
Easy	3 (10 %)	2 (33 %)	5 (14 %)
Not easy	28 (90 %)	4 (67 %)	32 (87 %)
N	31	6	37

Table 17 - Are there enough beds in CAPP inpatient facilities to meet normal demand in the region?

	CPS	CAPP	Total
Yes	7 (22 %)	4 (67 %)	11 (29 %)
No	25 (78 %)	2 (33 %)	27 (71 %)
N	32	6	38

Table 18 - How often are CPS users placed in CPS institutions because of insufficient capacity in CAPP institutions?

	CPS	CAPP	Total
Never	3 (10 %)	1 (17 %)	4 (11 %)
Seldom	6 (19 %)	3 (50 %)	9 (24 %)
Sometimes	18 (58 %)	2 (33 %)	20 (54 %)
Often	4 (13 %)	0 (-)	4 (11 %)
N	31	6	37

Access for children in unstable family situations

Riedl (2008) has argued that CAPP is sometimes reluctant to treat children and young people living in unstable family situations where the parents' ability to provide adequate care is being evaluated by CPS, and where placement of the child outside the home is being considered. This practice is, however, contrary to recent guidelines for CAPP outpatient clinics which state that children and young people in contact with CPS, including those living in this type of unstable family situation, shall have the same access to CAPP as other children and young people (Helsedirektoratet, 2008).

Respondents in this study were in total agreement with the recommendations of the guidelines on this issue. Only one of the 39 respondents did not agree that children living in unstable family situations should have comparable access to CAPP as other children and young people.

Respondents from CPS and CAPP had somewhat different perceptions, however, about how well this principle was followed up in practice. Respondents from CPS more frequently reported delays in care until the family situation was resolved, and in some cases children who did not receive care at all. CAPP respondents reported less frequent delays and refusals. 59 % of CPS respondents reported that care to children in these situations was "often" delayed. Only 1 CAPP respondent agreed that care was "often" delayed, but the majority replied that this "sometimes" took place. 47 % of CPS respondents replied that care was "often" refused to children in this situation; 3 CPS respondents reported that care was "sometimes" refused. Many CPS respondents also wrote about this problem in their comments on obstacles to access (see next chapter).

Table 19 - Children in families where parents ability to care for their children is under evaluation should have comparable access to CAPP as other children?

	CPS	CAPP	Total
Disagree	1 (3 %)	0 (-)	1 (3 %)
Agree	31 (97 %)	7 (100 %)	38 (97 %)
N	32	7	39

Table 20 - How often is help from CAPP to children and young people delayed until the issue of parental capacity has been resolved?

	CPS	CAPP	Total
Never	0 (-)	0 (-)	0 (-)
Seldom	3 (9 %)	2 (29 %)	13 %
Sometimes	10 (31 %)	4 (57 %)	36 %
Often	19 (59 %)	1 (14 %)	51 %
N	32	7	39

Table 21 - How often are children and young people refused help from CAPP because the issue of parental capacity is being evaluated?

	CPS	CAPP	Total
Never	0 (-)	2 (29 %)	2 (5 %)
Seldom	2 (6 %)	2 (29 %)	4 (10 %)
Sometimes	15 (47 %)	3 (43 %)	18 (46 %)
Often	15 (47 %)	0 (-)	15 (39 %)
N	32	7	39

Access for children lacking motivation for help

Riedl (2008) has argued that CAPP is sometimes reluctant to provide help to children and young people if they are not motivated for mental health treatment or if their parents/guardians lack motivation. CAPP guidelines for prioritizing of mental health services do not provide clear instructions on this issue. They acknowledge that lack of patient motivation can have consequences for the kind of help which CAPP can offer to families, but also recommend that CAPP work actively to increase patient motivation where this is required (Helsedirektoratet 2009b).

Respondents in this study had differing views on this issue. Most CPS respondents (84 %) did not believe that CAPP should wait until children and parents were motivated for treatment before initiating contact with the child. CAPP respondents were more divided on this question with 4 of 7 replying that CAPP should wait until the family was motivated for care.

The respondents also had different perceptions about practice in these situations. 45 % of CPS respondents replied that care was “often” postponed to children in families which were not motivated for treatment. No CAPP respondents reported “often” postponed care, but 5 from this group replied that care was “sometimes” postponed until motivation was present. This issue was also discussed by respondents from both CPS and CAPP in their comments to the open questions (see next chapter).

Table 22 - Treatment from CAPP for CPS users should not be initiated until children and/or parents are motivated.

	CPS	CAPP	Total
Disagree	26 (84 %)	3 (43 %)	29 (76 %)
Agree	5 (16 %)	4 (57 %)	9 (24 %)
N	31	7	38

Table 23 - How often has care from CAPP to children/young people who are CPS users been postponed until they and/or their parents are motivated?

	CPS	CAPP	Total
Never	2 (7 %)	0 (-)	2 (5 %)
Seldom	4 (13 %)	2 (29 %)	6 (16 %)
Sometimes	11 (36 %)	5 (71 %)	16 (42 %)
Often	14 (45 %)	0 (-)	14 (37 %)
N	31	7	38

Access and resource use for CPS users

Riedl (2008) has argued that CAPP’s financial incentives can also help to limit access to CAPP for CPS users. This is because CPS users sometimes have more complicated problems which can require extra resources to treat. Reimbursement to CAPP for time spent on meetings and telephone calls with other agencies is quite low compared to reimbursement for providing direct patient services.

Respondents in this study agreed that CPS users can often require more resources from CAPP than other children and young people. All CAPP respondents and 75 % of CPS respondents agreed with this statement. As with many of the other questions on the

survey, there was greater disagreement as to the consequences this could have for CPS users. 6 of the 7 CAPP respondents believed that CPS users were refused care or received reduced care because they were seen as requiring too many resources from CAPP. Most CPS respondents agreed that this is not a frequent problem, but they did reply that it could sometimes limit access for CPS users. 28 % of CPS respondents answered that CPS users were “sometimes” refused care or received reduced care in these situations; 41 % from this group answered that this “seldom” took place.

Table 24 - CPS users can often require more resources from CAPP than other children and young people.

	CPS	CAPP	Total
Disagree	8 (25 %)	0 (-)	8 (21 %)
Agree	24 (75 %)	7 (100 %)	31 (80 %)
N	32	7	39

Table 25 - How often have CPS users been refused care or received less care from CAPP because they were seen as requiring too many resources?

	CPS	CAPP	Total
Never	10 (31 %)	6 (86 %)	16 (41 %)
Seldom	13 (41 %)	0 (-)	13 (33 %)
Sometimes	9 (28 %)	1 (14 %)	10 (26 %)
Often	0 (-)	0 (-)	0 (-)
N	32	7	39

Cooperation between CPS and CAPP

Better cooperation between CPS and CAPP in Norway has been a government priority for many years. Lurie & Tjelflaat (2009) have summarized some of the earlier initiatives in this area. A report from the Ministry of Children, Equality and Social Inclusion has recommended new measures to improve coordination between CPS and CAPP, with emphasis on inpatient services.

Respondents in this study answered several questions about cooperation between CPS and CAPP as related to CPS users’ access to CAPP. Most respondents, including all of

those from CAPP, reported that cooperation with regard to children referred from CPS to CAPP was “acceptable”. 72 % of CPS respondents also gave this rating.

One form of cooperation between CAPP and CPS in relation to children referred from CPS is guidance from CAPP personnel to CPS personnel rather than direct help to the child from CAPP. Respondents had varying views about how often this form of cooperation was used. A majority of respondents from CAPP (4) and half of those from CPS reported that this type of cooperation was “sometimes” used. Several respondents from both groups answered that this occurred “often”.

Another question about interagency cooperation concerns the timing of intervention by the two services. Should CAPP wait with its help to children and young people until after CPS has completed its work with the family? The respondents in this study all replied that help by the two agencies should be given at the same time, rather than CAPP waiting until CPS was finished with its intervention.

Table 26 - How good is cooperation between CPS and CAPP with regard to children referred from CPS to CAPP?

	CPS	CAPP	Total
Poor	4 (13 %)	0 (-)	4 (10 %)
Acceptable	23 (72 %)	7 (100 %)	30 (77 %)
Good	5 (15 %)	0 (-)	5 (13%)
N	32	7	39

Table 27 - How often does CAPP give mainly advice or guidance to CPS staff rather than direct services to CPS users?

	CPS	CAPP	Total
Never	1 (3 %)	0 (-)	1 (3 %)
Seldom	11 (34 %)	1 (14 %)	12 (31 %)
Sometimes	16 (50 %)	4 (57 %)	20 (51 %)
Often	4 (13 %)	2 (29 %)	6 (15 %)
N	32	7	39

Table 28 - CAPP should not begin its work with children or young people until CPS has completed its work with the family.

	CPS	CAPP	Total
Disagree	32 (100 %)	7 (100 %)	39 (100 %)
Agree	0 (- 0 -)	0 (- 0 -)	0 (- 0 -)
N	32	7	39

Chapter 4 Discussion and Conclusion

This study is about access to CAPP for children and young people who have also received help from CPS. The views of leaders and staff members from 32 municipal CPS agencies and 7 CAPP polyclinics in Mid-Norway have been presented.

Most respondents replied that CPS users' access to CAPP was acceptable, but only 2 respondents believed that access for these children and young people was good. Some CPS respondents were more critical; over one-third of this group believed that CPS users' access to CAPP was poor. CAPP respondents were also more positive about changes in access for CPS users which had taken place over the previous five years. Most CAPP respondents reported that access has improved over this period, but only half of their colleagues from CPS agreed, and several CPS respondents believed that access was worse now than it was five years ago.

Respondents from CPS and CAPP had similar views on some of the survey questions, but CPS respondents were generally more critical than their colleagues from CAPP on a number of important access issues. CAPP respondents were more critical of the quality of CPS referrals to CAPP. We will summarize and discuss some of the important differences between the two groups in this concluding chapter. Suggestions from the respondents about ways to improve access to CAPP for CPS users will also be presented, together with their comments about factors that can hinder access.

Respondents from CPS were more critical about some access problems

CPS respondents were more critical than their colleagues from CAPP about a number of access problems for CPS users. These include waiting time, access for children living in unstable family situations, access for children who are unmotivated for treatment, and whether or not CPS users receive sufficient help from CAPP.

Long waiting time for assessment and treatment was one of the access problems which CPS respondents were more critical about than their colleagues from CAPP. As discussed in chapter one, children and young people under the age of 23 years with mental health or substance abuse problems have legally mandated deadlines for assessment of the right to necessary care and to start receiving care which is determined to be necessary. They also have the right to professionally determined individual deadlines.

Many CPS respondents reported longer total waiting time from referral to the start of necessary care, and less frequently met legal deadlines for assessment and for starting care as compared to their colleagues from CAPP. Though there are no legal deadlines for follow-up care from CAPP after an initial consultation, it is nonetheless important that follow-up care be provided without long delays. CPS respondents more often reported longer waiting time for follow-up treatment for CPS users.

As shown in chapter one, CPS users are not the only CAPP patients in Mid-Norway with long waiting time for assessment of need and for treatment. CAPP patients in health region Mid-Norway had longer average waiting times from referral to start of treatment (10 days longer) and less frequently received care within individual deadlines (61 % vs. 78 %) than CAPP patients in the country as a whole during the period January – April 2010 (Helsedirektoratet 2010b).

CPS respondents were also more critical of access to CAPP services for CPS users living in unstable family situations. This is a situation where the parents' ability to provide adequate care for the child is being evaluated and alternate placement of the child is under consideration by CPS. Most respondents from both CPS and CAPP agreed in principle that children in this type of situation should receive the same access to CAPP as other children and young people. This is also recommended by the Directorate of Health in the guidelines for CAPP outpatient clinics (Helsedirektoratet 2008). The two groups disagreed, however, about how well these guidelines were followed in practice. Many CPS respondents believed that CPS users were often denied care from CAPP under these circumstances or had care delayed until the child's placement situation had been resolved.

Respondents from CPS and CAPP also had different views about treatment for CPS users who were unmotivated to receive help from CAPP. The groups had different views in this case both in theory and in practice. Motivation for mental health treatment on the part of both children/young people and their parents is often seen as a prerequisite for effective care. Guidelines for prioritization of CAPP services from the Directorate of Health state that lack of patient motivation can have consequences for the type of care which CAPP can provide, but they also recommend that CAPP play an active role in the effort to increase patient motivation where this is required (Helsedirektoratet 2009b). A majority of CAPP respondents believed that treatment should not be initiated for CPS users until the child and/or his parents were motivated. Very few of the CPS respondents (16 %) shared this view. Nearly half of CPS respondents believed that CAPP often postponed care for CPS users until they and their parents were motivated for treatment. CAPP respondents did not agree that care was

often delayed until CPS users were motivated, but most acknowledged that such delays sometimes occurred.

CPS respondents were also more critical about another important access measure, how often CPS users receive sufficient help from CAPP with their mental health problems. A majority of CAPP respondents believed that CPS users often receive sufficient help from CAPP, but most CPS respondents reported that this was only sometimes achieved.

Respondents from CPS and CAPP had similar views about two access problems

CAPP respondents though generally more positive about the quality of CPS users' access to CAPP had similar views as CPS respondents about two access problems. These were access to CAPP services outside of regular office hours and access to inpatient services. Both of these problems have also been discussed in earlier research and reports.

Most CAPP outpatient clinics are open weekdays (Monday to Friday) during regular working hours but are closed evenings, weekends and holidays. CPS leaders in an earlier study reported difficult access to CAPP outpatient services outside of regular working hours during the period 2002-2005. This was especially a problem for children and young people in need of acute services, for instance because of acute psychosis or suicidal behavior Kristofersen (2007). The results of our study show that this continues to be a problem for CPS users in Mid-Norway in 2010. Most of our respondents, including all but one of those from CAPP, reported that access to CAPP outpatient services outside of regular working hours was not easy.

Access to CAPP inpatient services was the other access problem that both CAPP and CPS respondents agreed about. As previously discussed, most children and young people who receive help from CAPP receive outpatient services, (96 % in 2009). There are relatively few CAPP inpatient beds in Norway (about 320 in 2008) and few new beds have been added during the last decade. It is therefore not surprising that most of our respondents including 4 of 6 CAPP respondents reported that it is not easy for CPS users to be admitted to a CAPP inpatient facility.

This problem has been discussed in several recent reports. A government committee which studied ways of improving interagency cooperation for children and young peo-

ple at risk made several proposals aimed at improving access to CAPP inpatient care for CPS users. One suggestion called for the establishment of residential care facilities which could provide help to CPS users with mental health problems in cooperation between CPS and CAPP (BLD 2009). Another report from a private mental health advocacy group (Voksne for Barn) raised the issue of CPS users with mental health problems who were placed in private CPS residential facilities because of a shortage of available CAPP beds. The author argued that these private CPS institutions were often not well qualified to provide help with mental health problems (Riedl 2008). Our respondents had differing views about how often this type of placement occurred due to a lack of CAPP inpatient capacity. CPS respondents reported more frequent placements of this kind, with a majority replying that these sometimes occurred. Most CAPP respondents believed that this was a more seldom practice.

CAPP respondents were more critical of referrals from CPS to CAPP

As previously discussed, CPS respondents were generally more critical about various aspects of access to CAPP for CPS users particularly waiting time and access for children in unstable family situations. The reverse was found with respect to the quality of referrals from CPS to CAPP. Most CAPP respondents reported that referrals from CPS to CAPP were acceptable and one rated them as poor. Nearly half of CPS respondents believed the referrals were good. CAPP respondents also reported more frequent requests for additional information from CPS to supplement the information in the original referral. Most CAPP respondents replied that they often requested additional information, but most CPS respondents believed that such requests were sometimes received. Some CAPP respondents also offered specific suggestions for improving the quality of referrals from CPS. These will be discussed later in this chapter.

One possible explanation for the respondents' differing views on access to CAPP for CPS users and on the quality of CPS referrals to CAPP has to do with the different roles and responsibilities of the two agencies. CPS is responsible for referring children and young people with mental health problems to CAPP (along with physicians and other professionals), while CAPP is responsible for evaluating the needs of the referred children and for deciding who shall be admitted for treatment. It is undoubtedly easier for the two groups of respondents to criticize each other's performance than it is for them to point out weaknesses in the performance of their own agency.

Factors that can improve or hinder access to CAPP for CPS users

Most of the questions on the survey were closed format questions which respondents answered by choosing from predefined answer alternatives (for instance, poor, acceptable, good). The respondents also provided more detailed answers in their own words to two open-ended questions about factors which can improve access to CAPP for CPS users and factors which hinder such access.

Improving access

Most of the respondents from CAPP suggested better referrals from CPS to CAPP as a means of improving access to CAPP for CPS users. Specific recommendations on this topic included the need for better descriptions of the help already received by the child and the family prior to being referred to CAPP, and about how well these interventions had worked. More specific information about the child and his or her functioning level was also suggested.

Some CAPP respondents suggested early intervention, including earlier contact between the child and his primary care physician. Another suggested better support and guidance from CAPP to CPS staff. Several recommended the need for better competence on the part of workers in both agencies. Several suggested improved cooperation and coordination between the two agencies including better communication and regular interagency meetings. Another suggested increased use of ambulatory outreach services by CAPP.

CPS respondents had many suggestions for improving access to CAPP for CPS users. Many of these involved improved interagency cooperation and coordination between CPS and CAPP. Several suggested establishing interagency teams with representation from CPS, CAPP and other agencies such as municipal health services. Team meetings could be used to discuss both individual patients and more general policy. One emphasized the need for cooperation based on greater equality between the two agencies; where CAPP recognized CPS's primary responsibility for making decisions about placement of children in foster care or residential institutions. Better information about each other's roles and responsibilities and more clarity about division of responsibility were also recommended.

Another frequent suggestion was for more resources for CAPP, in order to reduce waiting time for assessment and treatment, and to enable CAPP to provide more flexible treatment alternatives. One emphasized the importance of shorter waiting time for

treatment in order to increase the chance of reaching the child while they are motivated for help. Several suggested the need for better access to inpatient treatment. One suggested the creation of an inpatient facility administered by both CPS and CAPP which could be used by CPS for short-term placements children and young people in emergency situations.

Increased outreach activity on the part of CAPP was another suggestion from several CPS respondents. Suggestions in this area included an ambulatory team which could make visits to children and young people at home, and regular office hours for CAPP in smaller communities where children and families could meet with CAPP locally.

Obstacles to access

Respondents from CAPP and CPS also identified important barriers to access to CAPP for CPS users. Lack of motivation for treatment from CAPP on the part of both children and their parents was one obstacle described by several respondents from CAPP. One emphasized the fact that help from CAPP should be a voluntary service, and that lack of motivation for help on the part of children and their parents reduces the chances for successful treatment. Another respondent wrote about parents who sabotage their child's interaction with CAPP, because they perceive CAPP as an extension of CPS with the agenda of controlling the family. One CAPP respondent raised the problem of unnecessary referrals from CPS to CAPP of children who could have been helped at the local level if there was better cooperation between CPS and other municipal agencies such as local health services. Another CAPP respondent wrote about the problem insufficient inpatient capacity in CAPP for CPS users, particularly for children and young people who have violent and aggressive behavior.

Many CPS respondents identified CAPP's reluctance to provide help to children living in unstable family situations with parents whose ability to provide adequate care is being evaluated by CPS as the biggest obstacle to access for CPS users. One added that this is based on CAPP's belief that their help will not benefit the child if they are living in a very difficult family environment. Another wrote that many children and young people in contact with CPS are living in unstable family situations, and that they should not need to wait until this situation is resolved before receiving help from CAPP.

Another obstacle identified by a number of CPS respondents was the problem of children, young people and their parents who are not motivated to receive help from CAPP. As noted above, this problem was also raised by several respondents from

CAPP. This problem was described somewhat differently however by the two groups of respondents. CAPP respondents appear to place responsibility for motivation on the children themselves, and particularly on the parents who do not appreciate the help they are being offered. Several CPS respondents emphasized CAPP's responsibility to help in motivating the family. One wrote that CAPP needs to be more offensive and proactive in their interaction with young people who are reluctant to receive mental health treatment. CAPP should not be so quick to discharge children and young people when they do not keep their appointments. They should use more time and effort in motivating the child and the parents, and should focus on the needs of the whole family and not just the child.

Several CPS respondents also mentioned the problem of too long waiting time for assessment and treatment from CAPP. Others mentioned the problem of poor communication and poor cooperation between CPS and CAPP on cases involving CPS users. One attributed this to differences in professional perspectives between the two services. Another wrote that CAPP was unwilling to communicate with CPS on a professional level. Another suggested the need for better coordination of services to individual children, rather than each agency waiting for the other to take the initiative. One recommended better dialogue between the two agencies about their strengths and limitations.

Other obstacles identified by CPS respondents included the abrupt transition from mental health services for children and young people to adult psychiatry at the age of 18. Another problem identified was CAPP's failure to provide follow-up care to children and young people after they were moved out of the family and placed in a foster home or a CPS institution.

Concluding comments

This study has shown that CPS users in Mid-Norway faced many barriers to access when they were referred to CAPP for assessment and treatment. Though most respondents rated overall access for this group as acceptable, they also identified a number of serious access problems. These included too long waiting time for assessment, initial treatment and follow-up care. Children and young people sometimes received some help from CAPP, but not enough help to meet their needs. Access to inpatient services and to outpatient services outside of regular working hours was also difficult. Children and young people living in unstable family situations and families lacking

motivation for treatment often experienced delays in access until these problems were resolved.

CAPP respondents agreed about some access problems, but CPS respondents were often more critical about many of these issues. CAPP respondents were more critical of the quality of CPS referrals to CAPP. We do not have definite explanations as to why respondents from CPS and CAPP tended to have such different views on many of the survey questions. One obvious explanation is that it is easier for workers from the two agencies to criticize each other's performance than to criticize their own agencies. CPS is responsible for referring children and young people with mental health problems to CAPP, and CAPP is responsible for assessing these children and for providing adequate care to those it determines to be in need. Our study shows that neither of the two groups of respondents was particularly satisfied with the efforts of the other agency, at least in certain situations.

The relatively low response rate on this survey (51 %) may also help to explain some of the differences between the two groups. Each CAPP polyclinic covers a region which includes more than one CPS municipal agency. In order to protect their anonymity, respondents were not asked to identify the municipality where they worked or the specific agency. This means that we are unable to match the responding CPS agencies with the responding CAPP polyclinics geographically. Some of the responding CPS agencies may be in the catchment area of one of the 5 CAPP polyclinics that chose not to participate in the survey and vice versa.

Finally, the information presented in this study is based on the opinions and attitudes of the leaders and coworkers from CPS and CAPP who responded to the survey. They have provided interesting and valuable information about the question of access to CAPP for CPS users, but more research on this topic is needed. More detailed information about the children and young people referred to CAPP, about CAPP's decisions in individual cases, and about the specific care provided by CAPP to CPS users would be useful. This type of information can be obtained by studying the written patient records of CPS users who have been referred to CAPP to see how their cases were handled by CAPP, whether they were determined to have the right to necessary care, how long they had to wait for assessment and treatment, and what services they received from CAPP.

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Public documents

Forskrift om prioritering av helsetjenester, rett til nødvendig helsehjelp fra spesialisthelsetjenesten, rett til behandling i utlandet og om klagenemnd (prioriteringsforskriften) av 1. desember 2000 nr. 1208.

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 **NTNU**
Samfunnsforskning AS**Barnevernbarns tilgang til psykisk helsevern****Forespørsel om å delta i et forskningsprosjekt - spørreundersøkelse for kommunale barneverntjenester og BUP poliklinikker i Midt-Norge**

Ved Barnevernets utviklingscenter i Midt-Norge (BUS), NTNU Samfunnsforskning AS gjennomfører vi en undersøkelse om "Barnevernbarns tilgang til psykisk helsevern". Undersøkelsen skal kartlegge holdninger og erfaringer til ansatte i kommunale barneverntjenester og BUP poliklinikker i Midt-Norge om dagens praksis i forhold til tilgang til BUP tjenester for barn og unge med psykiske problemer som har vært i kontakt med barneverntjenesten. Det skal undersøkes praksis og holdninger knyttet til henvisninger, inntak, beslutninger om rett til nødvendig/prioritert helsehjelp, ventetid og samarbeid mellom barnevernet og BUP i denne forbindelse. Målsettingen er å identifisere eventuelle barrierer som begrenser tilgang til BUP for denne pasientgruppen og bidra til bedre praksis på dette området.

Data skal innhentes gjennom vedlagt elektronisk spørreskjema som besvares av deg som leder innen kommunale barneverntjenester/BUP poliklinikker, eller av en medarbeider (valgt av leder) med god kunnskap om henvisnings- og inntaksprosessen og barnevernbarns tilgang til BUP. Deltagelse i prosjektet er frivillig. Spørreskjemaet består av 38 spørsmål (35 med faste svaralternativer) som tar ca. 10-15 minutter å besvare. Skjemaene sendes ut til lederens epostadresse og besvares via link med skjult identitet.

Questback er databehandler. Svar på spørreskjema går via link med skjult identitet, til Questback, som videreformidler data til forskerne. Dette innebærer at det kun er Questback som vil ha en kobling mellom direkte personidentifiserende opplysninger (epostadresse) og selve data materialet. Alle opplysninger behandles konfidensielt. Det spørres ikke om privatopplysning som navn, personnummer, adresse, arbeidsplass eller lignende. Data skal presenteres i anonymisert form i sluttrapporten for å sikre at ingen enkeltindivider eller organisasjoner kan gjenkjennes. Undersøkelsen skal gjennomføres i løpet av august/september 2010 med rapportering høsten 2010. Innsamlet informasjon skal slettes når prosjektet avsluttes 15. desember 2010.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Dersom du ønsker å delta i prosjektet, er det bare å besvare spørreskjema som du har mottatt gjennom eposten og sende det tilbake via linken som opprettes med skjult identitet.

Har du spørsmål i forbindelse med denne henvendelsen kan du gjerne ta kontakt med meg på email eller telefon.
Epost: jim.lurie@samfunn.ntnu.no eller telefon 73596271.

Trondheim, august 2010

Med vennlig hilsen

NTNU Samfunnsforskning AS
Barnevernets utviklingscenter i Midt-Norge
Jim Lurie
Prosjektleder/seniorforsker
Din identitet vil holdes skjult
Les om retningslinjer for personvern. (Åpnes i nytt vindu)

1) Bakgrunn

2) 1) Hvor er du ansatt?

- Barneverntjenesten
 - BUP poliklinikk
-

3) 2) Hvilken stilling har du?

- Leder
 - Medarbeider
-

4) 3) Hvor lenge har du arbeidet i denne tjenesten?

- Under 1 år
 - 1-2 år
 - 3-5 år
 - Mer enn 5 år
-



5) Henvisninger fra barneverntjenesten til BUP

6) 4) Hvor god er henvisningene fra barneverntjenesten til BUP?

- Dårlig
 - Akseptabelt
 - Bra
-

7) 5) Hvor ofte henviser barneverntjenesten rette barn og unge til BUP (barn og unge med behov for psykisk helsehjelp) ?

- Sjelden
 - Av og til
 - Ofte
-

8) 6) Hvor ofte tar BUP kontakt med barneverntjenesten for å få mer opplysning om barn og unge som barneverntjenesten har henvist til BUP?

- Sjelden
- Av og til
- Ofte



9) Ventetid

10) 7) Hvordan er den totale ventetiden fra henvisning til oppstart av helsehjelp for barn og unge ved BUP som har vært i kontakt med barneverntjenesten?

- Dårlig
 - Akseptabelt
 - Bra
-

11) 8) Hvor ofte vurderes henvisninger av barn og unge som er i kontakt med barneverntjenesten innenfor fristen (10 virkedager fra mottatt henvisning)?

- Sjelden
 - Av og til
 - Ofte
-

12) 9) Hvor ofte iverksettes nødvendig helsehjelp til barn og unge som er i kontakt med barneverntjenesten innenfor deres individuelle (faglig forsvarlig) frist?

- Sjelden
 - Av og til
 - Ofte
-

13) Hva mener du om følgende utsagn?

14) 10) Barn og unge som er i kontakt med barneverntjenesten må ofte vente for lenge etter førstegangskonsultasjonen for eventuelt oppfølging eller videre behandling.

- Uenig
- Enig

15) Hva mener du om følgende utsagn?

16) 11) Barn og unge som er i kontakt med barneverntjenesten må ofte vente lengre for å få psykisk helsehjelp enn andre barn og unge med sammenlignbar psykisk helse og psykiske problemer.

- Uenig
 Enig



17) Tilgang til psykisk helsehjelp

18) 12) Hvordan er tilgang til psykisk helsehjelp for barn og unge som har vært i kontakt med barneverntjenesten?

- Dårlig
 Akseptabelt
 Bra
-

19) 13) Hvordan er tilgangen til psykisk helsehjelp for barn og unge som har vært i kontakt med barneverntjenesten sammenlignet med andre barn og unge med sammenlignbar psykiske helse?

- Dårligere
 Tilsvarende
 Bedre
-

20) 14) Hvordan er kvaliteten på psykisk helsehjelp for barn og unge som har vært i kontakt med barneverntjenesten?

- Dårlig
 Akseptabelt
 Bra
-

21) 15) Hvor ofte får barn og unge som har vært i kontakt med barneverntjenesten tilstrekkelig hjelp med sine psykiske problemer?

- Sjelden
 Av og til
 Ofte

22) 16) Hvordan er tilgangen til psykisk helsehjelp for hjemmeboende barn og unge som får hjelp fra barneverntjenesten?

- Dårlig
- Akseptabelt
- Bra

23) 17) Hvordan er tilgangen til psykisk helsehjelp for barn og unge som er plasserte i fosterhjem?

- Dårlig
- Akseptabelt
- Bra

24) 18) Hvordan er tilgangen til psykisk helsehjelp for barn og unge som er plassert i barneverninstitusjon?

- Dårlig
- Akseptabelt
- Bra

25) 19) Hvor lett er det å få psykisk helsehjelp fra BUP poliklinikken utenom vanlig arbeidstid (kveld, helg og ferie)?

- Svært lett
- Lett
- Ikke lett

26) 20) Hvordan er tilgangen til psykisk helsehjelp for barn og unge som er i kontakt med barneverntjenesten i dag, sammenlignet med situasjonen for 5 år siden?

- Dårligere
- Tilsvarende
- Bedre



27) Døgnbehandling ved BUP

28) 21) Finnes det nok døgnplasser i BUP institusjoner til å møte vanlig behov i regionen din?

- Ja
 Nei
-

29) 22) Hvor lett er det å få tilgang til døgnplasser i BUP institusjoner for barn og unge som har vært i kontakt med barneverntjenesten?

- Svært lett
 Lett
 Ikke lett
-

30) 23) Hvor ofte må barn og unge med psykiske problemer, som er i kontakt med barneverntjenesten, plasseres i barneverninstitusjon på grunn av manglende kapasitet på BUP sine døgninstitusjoner?

- Aldri
 Sjelden
 Av og til
 Ofte



31) Barn og unge med uavklart omsorgssituasjon

32) Hva mener du om følgende utsagn?

33) 24) Barn og unge med en uavklart omsorgssituasjon bør få tilgang til psykisk helsehjelp fra BUP på lik linje med andre barn og unge.

- Uenig
 Enig
-

34) 25) Hvor ofte har du opplevd at barn og unge med en uavklart omsorgssituasjon har fått avslag på psykisk helsehjelp fra BUP?

- Aldri
 Sjelden
 Av og til
 Ofte
-

35) 26) Hvor ofte har du opplevd at psykisk helsehjelp til barn og unge med en uavklart omsorgssituasjon har blitt utsatt inntil situasjonen ble avklart?

- Aldri
 Sjelden
 Av og til
 Ofte



36) Motivasjon for psykisk helsehjelp

37) Hva mener du om følgende utsagn?

38) 27) Det bør ikke settes i gang psykisk helsehjelp til barn og unge som er i kontakt med barneverntjeneste før de og/eller deres foreldre/foresatte er motiverte for å ta i mot hjelpen.

- Uenig
 Enig
-

39) 28) Hvor ofte har du opplevd at psykisk helsehjelp har blitt utsatt til barn eller ungdom inntil de og/eller deres foreldre var motivert for å ta i mot hjelp?

- Aldri
 Sjelden
 Av og til
 Ofte
-

40) Kostnader og utbytte

41) Hva mener du om følgende utsagn?

42) 29) Barn og unge som er i kontakt med barneverntjenesten kan ofte være mer ressurskrevende for BUP å behandle enn andre barn og unge.

- Uenig
 Enig
-

43) 30) Hvor ofte har du opplevd at barn og unge i kontakt med barneverntjenesten har fått avslag eller redusert hjelpetilbud fra BUP, fordi saken ble vurdert som for ressurskrevende?

- Aldri
 - Sjelden
 - Av og til
 - Ofte
-

44) Hva mener du om følgende utsagn?

45) 31) Det er viktig at forventede kostnader og utbytte til psykisk helsehjelp fra BUP, står i rimelig forhold til hverandre.

- Uenig
 - Enig
-

46) Hva mener du om følgende utsagn?

47) 32) Det er ikke lønnsomt for BUP å gi helsehjelp til barn og unge som er i kontakt med barneverntjenesten, fordi takster for møter og samarbeid med barnevernet er for lave.

- Uenig
- Enig



48) Samarbeid mellom barneverntjenesten og BUP

49) 33) Hvordan opplever du samarbeidet mellom barneverntjenesten og BUP, i forhold til barn og unge som henvises fra barneverntjenesten til BUP?

- Dårlig
 - Akseptabelt
 - Bra
-

50) 34) Hvor ofte gir BUP primært råd eller veiledning til barneverntjenesten, fremfor direkte hjelp til barnet i saker som gjelder barn og unge i kontakt med barneverntjenesten?

- Aldri
- Sjelden
- Av og til
- Ofte

51) Hva mener du om følgende utsagn?

52) 35) BUP bør ikke begynne sitt arbeid med barn eller unge før barneverntjenesten er ferdig med sitt arbeid med barnet og familien.

- Uenig
- Enig



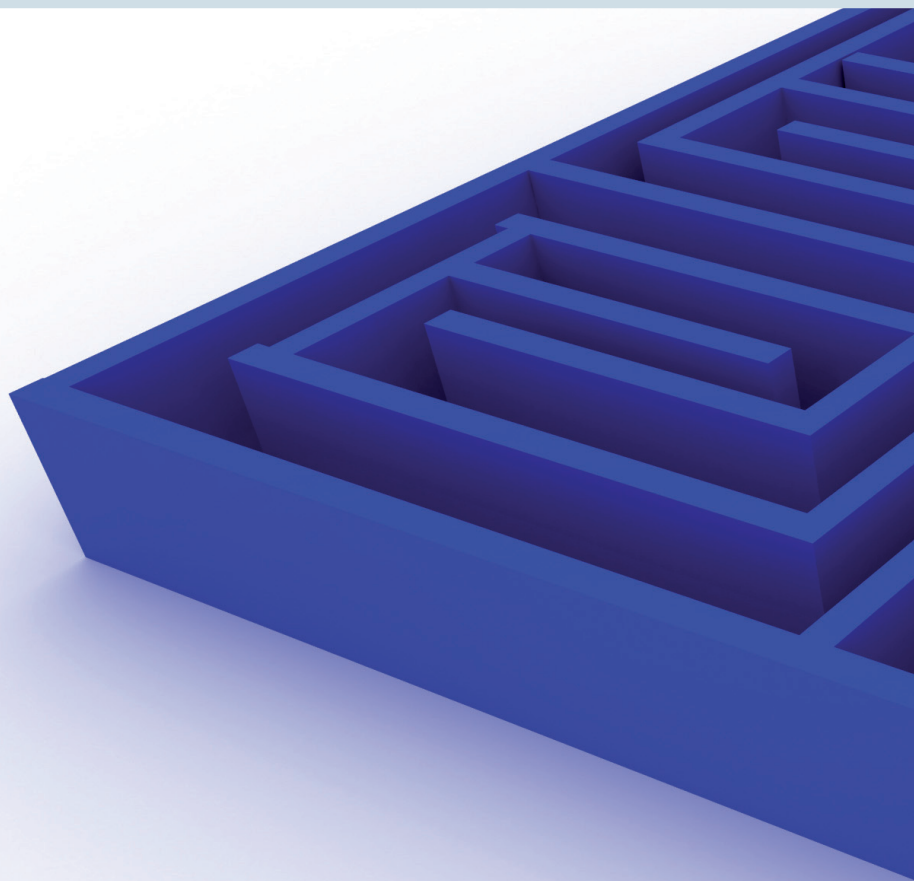
53) Avslutning

54) 36) Hva kan bidra til bedre tilgang til BUP sine tjenester for barn og unge som er i kontakt med barneverntjenesten?

55) 37) Hva er viktige hindringer for tilgang til BUP sine tjenester for barn og unge i kontakt med barnevernet?

56) 38) Har du andre kommentarer vedrørende denne undersøkelsen?

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