



## Factors Affecting The Success Of Implementing Family Integrated Care For Adolescents Who Experience Bullying: A Literature Review

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### ABSTRACT

Background: Bullying is a negative action performed repeatedly by another person or a group against a certain individual. Various forms of bullying can be experienced by adolescents, such as verbal, physical, and relational bullying. Bullying has a significant negative impact on its victims. There is a consensus regarding the importance of family involvement in high-quality care. Family-centered care is expected to improve the quality of care for adolescent victims of bullying by involving families in nursing and medical intervention plans. Method: This is a literature review that uses PRISMA. The article search was conducted through electronic databases, including Pubmed, ScienceDirect, SAGE, and Google Scholar. The selected articles are published in the last ten years. The keywords used in this systematic review are "Bullying+Family Integrated Care+Adolescent". Results: The article search did not yield results on the implementation of Family Integrated Care for adolescents who experience bullying. Family Integrated Care is more often used in NICU patients or pediatric patients who experience anxiety disorders during hospitalization. However, the authors found the application of Integrated Care and Family Centered Care in interventions for adolescent victims of bullying. There are seven selected articles, and they indicate a need for increased intervention involving family roles. Nurses can work with families to improve the quality and efficiency of care, as well as increase their knowledge and competence in caring for adolescent victims of bullying.

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### Kata kunci:

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### ABSTRAK

Background: Bullying merupakan tindakan negatif yang dilakukan secara berulang oleh orang lain atau suatu kelompok terhadap individu tertentu. Berbagai bentuk bullying dapat dialami oleh remaja, seperti bullying verbal, fisik, dan relasional. Bullying menimbulkan dampak negatif yang signifikan terhadap korbannya. Pada saat ini, konsensus umum mengenai pentingnya keterlibatan keluarga dalam perawatan yang berkualitas tinggi telah banyak dilakukan. Perawatan yang berpusat pada keluarga diharapkan dapat meningkatkan kualitas perawatan yang berfokus pada remaja korban bullying dengan melibatkan keluarga dalam rencana intervensi keperawatan dan medis. Metode: Penelitian ini merupakan studi kepustakaan dengan menggunakan PRISMA. Pencarian artikel menggunakan database elektronik, diantaranya Pubmed, Sciencedirect, SAGE, dan Google Scholar. Artikel yang digunakan adalah jurnal yang terbit dalam 10 tahun terakhir. Kata kunci yang digunakan dalam tinjauan sistematis ini yaitu "Bullying+Family Integrated Care+Adolescent". Hasil: Dari hasil pencarian artikel, penulis belum menemukan penerapan Family

Integrated Care pada remaja yang mengalami bullying. Penerapan Family Integrated Care lebih sering digunakan pada pasien NICU atau pasien anak yang mengalami gangguan kecemasan saat hospitalisasi. Tetapi, penulis menemukan penerapan Integrated Care dan Family Centered Care pada intervensi untuk remaja korban bullying. Terdapat 7 artikel yang terpilih dan perlu adanya peningkatan intervensi yang melibatkan peran keluarga. Perawat dapat bekerja sama dengan keluarga untuk meningkatkan kualitas dan efisiensi perawatan, serta meningkatkan pengetahuan dan kompetensi perawat dan keluarga dalam merawat remaja korban bullying.

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## INTRODUCTION

Bullying is a negative action performed repeatedly by another person or a group against an individual. This power imbalance between the perpetrator and the victim is detrimental to the victim. Common forms of bullying are verbal, physical, and relational (Bowes L, Joinson C, Wolke D, 2015).

Verbal bullying includes name-calling, ridiculing, insulting, and humiliating the victim (Srabstein JC, 2010). Several global studies reported that bullying in adolescents poses health problems to the victims and society. Moreover, previous studies revealed that the prevalence of bullying ranged from a low of 4.8% to a high of 96.7% (Copeland WE, Bulik CM, Zucker N, 2015). Data from the Indonesian Child Protection Commission (KPAI) reported that 1,138 child protection cases were reported as victims of physical and psychological violence (KPAI, 2021). Based on the Central Statistics Agency's (BPS) data for 2018, there were 324 cases of physical violence against children aged 0-18 years and 306 cases of psychological violence. This number is predicted to increase yearly. Bullying is seen as an iceberg phenomenon, as only a few victims are brave enough to report it (Malik, 2014).

Adolescence is a transitional period between childhood and adulthood in the human life span, which lasts between the ages of 12-21 years (Hurlock, 2012). In this transitional stage, individuals focus on gaining knowledge and intellectual abilities. This stage is also called the developmental stage of ego identity vs identity confusion, where a person is faced with the need to find their identity and life purpose (Santrock, 2012). Adolescents that grow up in a good environment will thrive and develop positive attitudes. Likewise, negative associations during adolescence can lead to identity deviation, committing crime or violence, such as bullying or rebellion (Ministry of Health, 2010). The various forms of bullying experienced by adolescents can negatively impact them in many aspects, such as their cognitive and academic aspects, emotional aspects, and social relations. Smokowski et al. (2014) found that adolescent survivors of bullying have low school satisfaction, strong perceptions of being discriminated against, and have their learning process negatively impacted in later years.

The long-term impacts of bullying can affect an individual's performance in adulthood and society at large. Teenage victims of bullying tend to show psychological problems, such as depression, decreased self-esteem, and anxiety (Tobias J & Wales J, 2014). However, research conducted by Caroline (2017) found that adolescent victims of bullying used a series of coping strategies that focused on emotional problems and active behavior aimed at reducing or eliminating stress. Family-centered care is oriented

towards supporting and involving the family to improve the patient's treatment quality, psychological well-being, and overall clinical outcome. There is a consensus regarding the importance of family involvement in high-quality care for hospital care (Committee on Hospital Care, 2012). However, data suggest that the extent to which family-centered care is implemented (or lack thereof) in hospitals and health systems varies across institutions, countries, and regions (Gooding et al., 2011).

In 2014, cases of youth violence in Indonesia reached 2,642 cases; in 2015, it decreased to 2,466 cases; in 2016, it rose again to 2,531 cases; and from 2017 to July 2020, there were 643 cases in Indonesia. In Central Java, several cities reported more than 100 cases of violence, such as Brebes, Cilacap, Banyumas, Kebumen, Kendal, Batang, and Semarang. In the psychiatric treatment room at the PKU Muhammadiyah Gombong Hospital, from December 2021 to September 2022, 15 teenage patients experienced bullying. However, the author has not found any literature regarding the application of Family Centered Care and Family Integrated Care to adolescent survivors of bullying in Indonesia. So far, the authors have only found literature on the application of Family Centered and Family Integrated Care to NICU patients or pediatric patients who experience anxiety due to the hospitalization process and other physical complaints.

Due to the aforementioned phenomena, it is necessary to research a family-oriented approach that focuses on treating adolescents who experience bullying. It is also hoped that nurses can perform their roles optimally and work together with these families. This system was created to identify the supporting factors and barriers to practicing family-centered practices for adolescents who experience bullying.

## METHODS

The design of this article refers to the Preferred Reporting Items for Literature Review and Meta-Analysis (PRISMA) approach. A systematic review was conducted according to the PICO model, which is a clinical information search method consisting of four components: P (patient, population, problem), which in this study were adolescent survivors of bullying; I (intervention, prognostic, factor, exposure), which is the application of the Family Integrated Care model; C (comparison, control), the articles examined in this paper did not use comparison interventions; and O (outcome), which is Family Integrated Care. The search was performed on electronic databases, including Google Scholar, Science Direct, Pubmed, and SAGE, based on the selected keywords and predetermined inclusion and exclusion

criteria. The selected articles were published less than ten years ago and were open access articles. The exclusion criteria included articles published before 2012, articles in languages other than Indonesian and English, and articles about nursing services that do not apply family-centered care and integrated care models to adolescent survivors of bullying.

The article searches with the PRISMA flow method began with searching several databases for relevant articles using the selected keywords: "Family Integrated Care+Bullying+Adolescent". A total of 25,357 articles were obtained from the search. Next, duplicate articles with the

same title were eliminated. The search is then continued by eliminating articles with irrelevant titles on the topic being studied. Then, the authors screened the article's abstracts per the predetermined inclusion criteria. Articles that did not fit the inclusion criteria were eliminated. The articles that passed were then screened again through full text screening. Finally, articles that meet the inclusion criteria and have no issues regarding their research methodology were selected for further evaluation in this article. The whole process resulted in 7 articles for the systematic review. The detailed article search flow based on PRISMA can be seen in Figure 1.

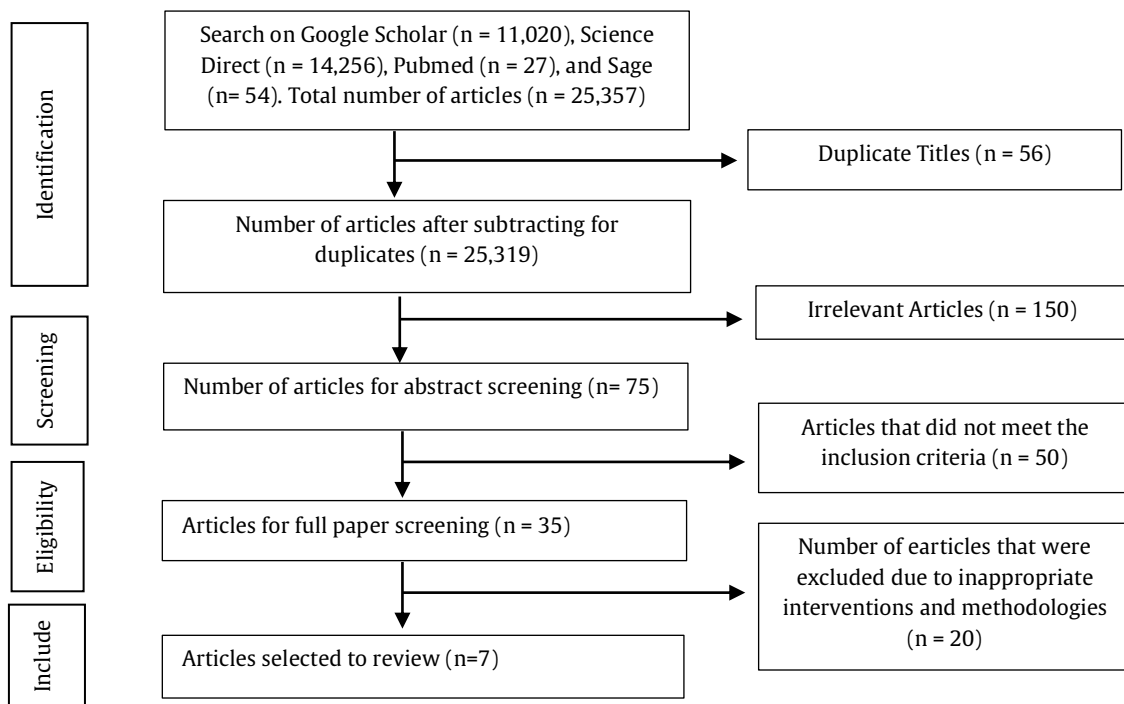


Figure 1

## RESULTS AND DISCUSSION

Seven articles met the criteria and were evaluated in the systematic review. The article's quality was assessed using The Joanna Briggs Institute (JBI) checklist for experimental studies, checklist for cohort studies, checklist for randomized control trials (RCT), and checklist for study articles. A summary of the article is shown in Table 1.

Bullying is defined as an act that hurts other people and can be divided into several categories: physical bullying, such as hitting, pushing, stealing, or damaging property; verbal bullying, which includes giving bad nicknames, mocking, teasing, or making nasty comments; social bullying, which consists of spreading gossip and damaging friendships; and cyberbullying, which is done through electronic media (Farrington DP, 1993). Bullying is a serious global problem. It often occurs in adolescence, usually peaking at age 12. Bullying can cause disturbances in emotional development and cause physical and mental problems for its victims (Austin S, & Reynolds G, 2012).

The family-centered practice relies on the understanding that the victim's family would understand them best and involves the family as a collaborative partner in all aspects and decisions about care. Johnson et al. (2018) stated that family-centered care is "a framework for delivering health

care that creates changes in care policies, programs, facility design, and daily practice." A family-centered care approach's benefits and positive outcomes are borne from its ability to create "a framework for health care delivery that creates changes in care policies, programs, facility design, and day-to-day practice (Espe Sherwin, 2008 & Mackean et al., 2012).

Although family-centered care has grown, its development has faced obstacles and difficulties. Evidence shows that service providers have had difficulties in its implementation (Care et al., 2015). A study by Wong (2014) raised four themes that become obstacles to implementing family-centered care: knowledge and practice gaps, the role of psychiatric nurses, the professional identity of psychiatric nurses, and management support. Furthermore, Martha Craft-Rosenberg and Patricia Kelle's (2004) research stated that the most challenging obstacles were families that trusted their cultural practices more than healthcare professionals and structural barriers such as lack of time, service coordination, and rural location. Moreover, commitment and good teamwork are essential for nurses to apply family-centered care.

Integrated family-based care has also been applied to adolescents who use illegal drugs and experience symptoms of emotional and behavioral disorders. Research has shown

that for mental health concerns, the direct involvement of parents in care has a significant effect on adolescent outcomes and retention (Hawley KM, 2005). Furthermore, Sheidow et al. (2021) found higher levels of satisfaction and parental involvement in the OPT-A (Outpatient Treatment for Adolescents) group of adolescents who used illicit substances or experienced anxiety and were given treatment using the integrated family model compared to TAU. As much as 96% of adolescents in the OPT-A group continued their treatment for at least three months - compared to only 65% in the TAU (Treatment as Usual) group, which received specialized therapy for adolescents with anxiety, mental disorders, and substance use. These figures have become a benchmark for retention success in outpatient treatment (Hser et al., 2001). The OPT-A diagnosis successfully targeted several parenting variables. Adolescents' perceptions of direct and indirect parental supervision improved earlier in OPT-A compared to TAU. Indirect parental supervision (e.g., monitoring their children when they are not at home) and using rules and expectations is more effective with youth who use illicit substances.

The long-term impact of bullying manifests in psychological problems, such as depression, decreased self-esteem, and anxiety. Lexine et al. (2014) found that adolescents who were victims of bullying showed immediate and delayed depression, psychosis, and anxiety. These long-term impacts should be prevented with early detection and followed up with appropriate interventions. Lambert et al. (2016) conducted an integrated care early detection study for adolescents and young adults with psychotic disorders. The study revealed that early detection and integrated care have significantly improved clinical and functional outcomes more than standard care in adolescents and young adult patients with psychosis.

Furthermore, integrated care has been studied in adolescents with depression. Courtney et al. (2019) compared integrated care and usual care pathways. They found that applying integrated care to adolescents who experience depression can reduce depressive symptoms and have positively improved the development of children and adolescents.

Family-centered care is a philosophical approach and a set of principles that can guide the delivery of health care services. It emphasizes that health care must be provided within the context of the strengths and needs of the patients, families, and communities (Johnson et al., 2008). This approach promotes the involvement of patients, their family members, and healthcare providers to make informed decisions about the medical care and support services the patients and their families receive. Family-centered care is oriented toward supporting and involving the family and improving the patient's quality of life, psychological well-being, and clinical and overall outcomes.

Many interventions have been taken to reduce bullying behavior in adolescents. For example, curriculum-based reduction of bullying material has been socialized through lectures, video recordings (professionally made with local content), innovative cartoon stories (used to promote discussion), and creative drawings. There have also been multidisciplinary interventions that include training that focuses on developing social and behavioral skills through peer mentoring and social workers (Naidoo et al., 2016). The results of this study indicate a decrease in bullying rates among students. This intervention also improves skills and assists students in avoiding bullying.

Many parties agree with the importance of family involvement in caring for hospitalized children (Johnson et

al., 2008). However, the extent to which family-centered care is implemented in hospitals has yet to reach a consensus, given the varying health systems across institutions, countries, and regions (Gooding et al., 2011). The application of the patient and family-centered care (PCC) models has been applied in several places, such as the NICU and PICU rooms, and on various pediatric patients with ADHD, asthma, obesity, sleep problems, and mental health disorders (Care et al., 2015).

In this systematic review, the authors have not found any studies on the application of Family Integrated Care or Family Centered Care on young survivors of bullying. Therefore, it is necessary to conduct research on this topic to ensure that Family Integrated Care can be implemented properly in health services. To achieve this, cultural change is needed from both health care providers' and families' mindsets. According to Simpson et al. (2021), there are at least five main principles of Family Integrated Care that need to be implemented, namely, (a) partnership with families: a positive and respectful partnership between staff and families - families are encouraged to be involved in patient care as primary caregivers; (b) empowerment: families should have access to information that outlines their role as caregivers and are oriented on the philosophy of an integrated approach - they would provide ongoing individualized care and receive teaching and supporting skills from healthcare professionals; (c) wellbeing: families and staff have access to psychological health support and mental health specialists; (d) culture: providing educational and training activities for healthcare providers and families; and (e) environment: the care unit should be comfortable with personal storage facilities and special accommodation access for families returning home after treatment.

**Table 1. Summary of reviewed articles**

Title and Author	Research design, sample, and sampling technique	Results	Limitations
<p>The Next Step in Integrated Care: Universal Primary Mental Health Providers (2019)  Adrienne A. Williams</p>	<p>The author did not involve people or animals as participants in the writing of this article. Only studies with an experimental design were included. They conducted a PubMed search, which focused on research published between 1998 and 2013. Of the 139 papers reviewed, 81 met the final inclusion criteria.</p>	<p>There are three barriers to the current mental care model: the binary view of mental illness (healthy vs. mentally ill), stigma, and prevention. The proposed model states that patients must meet their primary mental health provider (PMHP) for mental health care annually when in good mental health for examination and prevention. PMHPs can provide care anywhere, similar to primary care doctors, while referring specialists for other ailments. In this PMHP model, each patient will have two doctors who will be assisted by other teams (such as pharmacists, case managers, and social workers). The PMHP model will enable a more equal and balanced approach to physical and mental health.</p>	<p>Several barriers prevent this type of model from being implemented, including finance, professional education and training, and objectives for further development.</p>
<p>A Narrative Synthesis of the Components of and Evidence for Patient-and Family Centered Care (2015)  Kaitlin.P. Gallo, PhD, Laura Campbell Hill, BA, Kimberly Eaton Hoagwood, PhD, and Suchin Serene Olin, PhD</p>	<p>This article used the narrative synthetic method. Only research articles were selected.</p>	<p>This research reviewed 68 articles that applied the patient and family-centered care (PFCC) model. There are 5 core components in PFCC implementation: education from patient and family and healthcare providers, sharing information from the family to health care providers, social-emotional support, adapting care to suit the family's background, and decision making. There are 4 outcome categories: health status, experience, knowledge and attitudes of the patient/family, and the behavior of the patient/family and the behavior of the provider. Several articles discussed the implementation of Family Integrated Care in pediatric patients and children who were treated in the NICU and PICU rooms. There was only 1 article that discussed the application of FIC in mental health care.</p>	<p>The review focused on the 5 general components of the PFCC and 4 outcomes that are commonly reviewed in the PFCC articles. However, these components are not exhaustive. Additionally, the included studies varied significantly in quality, and there was a possibility of missing studies that met the inclusion criteria. There were also field limitations.</p>
<p>Early detection and integrated care for adolescents and young adults with severe psychotic disorders: rationales and design of the Integrated Care in Early Psychosis Study (2016) (Integrated Care in Early Psychosis Study III) Ashli J. Sheidow, Ph.D.*, Kristyn Zajac, Ph.D.*, Jason E. Chapman, Ph.D.*, Michael R. McCart, Ph.D.*, Tess K. Drozdowski, Ph.D.</p>	<p>Method: This is a cohort study conducted over 1 year. It compared early detection intervention and integrated care settings with historical controls or standard care settings.  Sample: Adolescents and young adults aged 12-19 years with severe early-phase psychosis (i.e., within 2 years of treatment).  Sampling technique: Samples were taken per the study's inclusion criteria: young adolescents aged 12-19 years, sufficient knowledge of German, patients in the early stages of psychosis identified 2 years after initial treatment, a diagnosis of schizophrenia, delusional disorder, mental disorder unspecified psychotic, and have given their written informed consent.</p>	<p>Patients in the combined early detection and integrated care (EDIC) group demonstrated a higher rate of achieving remission of combined functional psychosis at 6 months compared to the standard care group.</p>	<p>ACCESS III conducted many different and intensive interventions to improve mental health literature, disease stigma, service utilization, and pathways to nursing. Due to the large overlap of these four measures, it is still unclear which intervention will contribute the most to reducing DUP (Duration of Untreated Psychosis).</p>

Title and Author	Research design, sample, and sampling technique	Results	Limitations
<p>Verbal Bullying Changes Among Students Following an Educational Intervention Using the Integrated Model for Behavior Change (2016)                      Saloshin Naidoo, Ph.D. Benn K. Satorius, Ph.D. Heion de Vries, Ph.D, Myra Taylor, Ph.D.</p>	<p>Method: This study applied a randomized control trial, using a school-based educational intervention to reduce verbal bullying. It was conducted among 10<sup>th</sup> graders in 16 urban and rural schools in KwaZulu-Natal, South Africa, in 2013.                      Sample: 240 students in the intervention group and 240 students in the control group.                      Sampling technique: There were 8 groups with 30 participants each in the intervention and the same for the control groups (16 groups in total).</p>	<p>After the intervention, there was a decrease in verbal bullying and an increase in social norms. Awareness of verbal bullying was also associated with decreased verbal bullying behavior.</p>	<p>This study was designed to be completed within one year and has demonstrated its potential. However, it did not demonstrate long-term improvements or whether reductions in bullying and attitudes toward bullying will be sustained. Nevertheless, the school-based training programs proved to be successful in this study. However, the involvement of teachers and school health teams is necessary to ensure the program's sustainability.</p>
<p>Randomized Controlled Trial of an Integrated Family-Based Treatment for Adolescents in Community Mental Health Centers (2021)                      Ashli J. Sheidow, Ph.D.*, Kristyn Zajac, Ph.D.*, Jason E. Chapman, Ph.D.*, Michael R. McCart, Ph.D.*, Tess K. Drazdowski, Ph.D.</p>	<p>This study applied the Randomized Control Trial method.                      Sample: The inclusion criteria in this study were adolescents aged 10-17 years, on an outpatient basis, living with parents/adult caregivers, and were determined by clinical staff to require treatment for comorbid substance use and internal disturbances (mood and anxiety).                      Sampling technique: A total of 134 youth/families were randomly assigned to receive OPT-A or regular services.</p>	<p>Substance use: In the 3<sup>rd</sup> month of treatment, the substance use of the OPT-A group decreased to 29%. Meanwhile, group increased to 56% in the TAU group. In the 18th month of treatment, both groups experienced an increase in substance use, but the OPT-A group experienced a lower increase.                      Internalizing symptoms: From the start of treatment to the 6-month follow-up, the internalizing symptoms decreased more significantly in the OPT-A group (to 44.7) than the TAU (to 42.6) group.                      Externalization problem: There was no significant difference between the two groups.                      Parental satisfaction with treatment: OPT-A had significantly higher satisfaction than TAU.                      Parental involvement in treatment: OPT-A had a higher involvement in treatment compared to TAU.                      Work alliances: There was no difference as the work alliance scores were relatively stable over time.                      Treatment motivation: The two groups did not differ from baseline to subsequent assessments regarding the motivation to reduce substance use.                      While this study could not make definitive conclusions about the effectiveness of OPT-A for adolescents with substance use and comorbid diagnoses, it is possible that OPT-A would work differently and produce better outcomes for adolescents with problems who meet the diagnostic criteria for comorbid problems.</p>	<p>The limitations of this study were that the OPT-A and TAU treatments were dissimilar and uncontrolled. The changes over time were assessed by comparing it to the baseline. A simpler alternative would be to examine patterns of change over time. However, it would not be supported by modeling measures and would also eliminate direct comparisons with mainstream adolescent treatment.</p>
<p>Effectiveness of an Integrated Care Pathway for Adolescents with Depression: A Pilot Clinical Trial Protocol (2019)                      Darren B. Courtney MD; Amy Cheung MD; Joanna Henderson Ph.D.; Kathryn Bennett Ph.D.; Marco Battaglia MD; John</p>	<p>This study aims to improve the treatment response in depressed adolescents by implementing the Integrated Care Pathway (ICP), which was developed using recommendations from high-quality clinical practice guidelines and measurement-based care</p>	<p>The feasibility outcome measure for each hypothesis has appropriate operational definitions for its outcomes:                      1. For hypothesis 1, the participants recruited were candidates who completed all basic steps, starting from the initial registration.                      2. The basic measurement was timed by the research assistant while sitting in the assessment room until the completion of the final questionnaire.                      3. The RA completed a "Clinical Compliance Form" for each participant</p>	<p>If the four feasibility hypotheses are met, the researcher will conduct the research using the RCT method. There is no randomization process, there are no double-blind procedures, and like most psychosocial interventions, participants are aware of the</p>

Title and Author	Research design, sample, and sampling technique	Results	Limitations
Strauss; Rachel Mitchell; Karen Wang; Peter Szatmari	frameworks. This study is a pilot, parallel, non-randomized, controlled clinical trial. The participants were aged 14-18 years at ICP and TAU. They were recruited from outpatient adolescent psychiatry clinics within two Toronto academic hospital sites in Canada: The Center for Addictions and Mental Health (CAMH) and the Sunnybrook Center for Health Sciences (SHSC). Recruitment lasted for 21 months. A total of 30 youths were recruited for ICP and TAU groups in each location, with 60 participants in total.	taking the ICP. 4. The proportion of scheduled time points completed for the main outcome was calculated as the “number of CDRS R ratings completed.”	treatment they are receiving.
Contextual Barriers to the Successful Implementation of Family-Centered Practice in Mental Health Care: A Hong Kong Study (2014) Oi Ling Wong	This study aimed to identify nurses' perspectives on factors that hinder the adoption of family-centered practices in mental health services in Hong Kong and to compare pre- and post-test scores on the Family Nursing Practice Scale. This study employed a mixed methods approach using both quantitative and qualitative methods to further explore family-centered knowledge in clinical practice. The quantitative section was filled by 34 nursing practitioners who completed the questionnaire questions before and after training in the application of family-centered nursing practice. Meanwhile, the qualitative section was obtained from 10 participants through focus groups and special interviews.	Quantitative findings: The comparison of pre- and post-test scores of the Family Nursing Practice Scale revealed significant changes in participants' confidence, satisfaction, knowledge, skills, and comfort in working with families. Qualitative findings of the analysis: The factors influencing the adoption of family-centered practices in mental health services were identified. Four main themes emerged: 1. The gap between knowledge and practice 2. The role of the psychiatric nurse 3. The professional identity of the psychiatric nurse 4. Management support	The qualitative section was performed with a small, specific, non-randomized population, which makes the findings difficult to generalize to the larger population.

## CONCLUSION

The application of integrated care in health care settings has been widely used in adolescents who experience behavioral disorders and the use of illegal drugs. Although many integrated nursing interventions have been performed in schools and healthcare settings, it is undeniable that the implementation of integrated nursing services has also experienced several obstacles. These obstacles include nurses' lack of knowledge of integrated services, nurses' workload, community stigma, and management support. Currently, no study has investigated the application of the Family Integrated Care model to adolescents who experience bullying. However, based on the reviewed journals, applying the integrated nursing model is quite effective in dealing with the problems faced by adolescents.

## RECOMMENDATION

Future research should focus on the application of the Family Integrated Care nursing model to adolescent survivors of bullying to add to the literature on the topic. It is necessary to conduct a systematic review of the interventions applied to adolescent survivors of bullying by examining journals that specifically discuss this matter from broader databases, not only open-access journals.

## REFERENCES

- Austin S, Reynolds G, B. S. S. (2012). leadership and counselors working together to address bullying. *Education*, 133(2):283–90.
- Bowes L, Joinson C, Wolke D, et al. P. victimization during adolescence and its impact on depression in early adulthood: prospective cohort study in the U. K. B. 2015;350:h2469. P. P. 26037951; P. C. P. P. (2015). Peer victimization during adolescence and its impact on depression in early adulthood: prospective cohort study in the United Kingdom. *PubMed Central PMCID*.
- Care, F. Gallo, K. P. Hill, L. C. Hoagwood, K. E. & Olin, S. S. (2015). *A Narrative Synthesis of the Components of and Evidence for patient- and family-centered care*.
- Caroline. (2017). *Giving Victims of Bullying a Voice: A Qualitative Study of Post Bullying Reactions and Coping Strategies*.
- Chair-Dr. Judith Simpson. Debbie Bazalel. Dr Nikki Crowlwy. Dr Aniko Deireil. Nadia Keake. Rebecca Lemin. Chelsie Letts. Dr Maha Mansour. Dr Liz McKenchnie. Dr Neil Patel. G. S. (2021). *Family Integrated Care A Framework for Practice*. November.
- Copeland WE, Bulik CM, Zucker N, et al. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *Int J Eat Disord*. *PubMed PMID*, 48, 1141141–1149.
- Courtney, D. B. Cheung, A. Henderson, J. Bennett, K. Battaglia, M. Strauss, J. Mitchell, R. Wang, K. & Szatmari, P. (2019). *Effectiveness of an Integrated Care Pathway for Adolescents with Depression: A Pilot Clinical Trial Protocol*. November, 115–133.
- Depkes. (2010). *Kesehatan Remaja, Problem dan Solusinya*. Salemba ; medika.
- Farrington DP. (1993). *Understanding And Preventing Bullying*. Great Britain. *Routledge*.
- Gooding, J. S. Cooper, L. G. Blaine, A. I. Franck, L. S. Howse, J. L. & Berns, S. D. (2011). *Family support and familycentered care in the neonatal intensive care unit: Origins, advances, impact*. *Seminars in Perinatology*. <https://doi.org/10.1053/j.semperi.2010.10.004>
- Hawley KM, & W. J. (2005). (2005). Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcomes. *Journal of Clinical Child and Adolescent*. *PsychologyPubMed: 15677286*.
- Hser YI, Grella CE, Hubbard RL, Hsieh SC, Fletcher BW, Brown BS, & A. M. (2001). An evaluation of drug treatments for adolescents in 4 US cities. *Archives of General Psychiatry*, 58(7), 689–695.
- Hurlock, E. (2012). P. P. J. E. (2012). *Psikologi Perkembangan*.
- Johnson, B. Abraham, M. Simmons, L. Edgman-Levitan, S. Sodomka, P. Schlucter, J. & Ford, D. (2008). *Partnering with patients and families to design a patient- and family-centered health care system: Recommendations and promising practices*. Retrieved from *Institute for Patient- and Family-Centered Care*.
- KPAI. (2021). *No Title*. <https://databoks.katadata.co.id/datapublish/2022/01/27/kpai-aduan-anak-jadi-korban-kekerasan-fisik-mendominasi-pada-2021>
- Lambert, M. Schöttle, D. Sengutta, M. Ruppelt, F. Rohenkohl, A. Luedecke, D. Nawara, L. A. Galling, B. Falk, A. Wittmann, L. Niehaus, V. Sarikaya, G. Handwerk, U. Rothländer, W. Rietschel, L. Gagern, C. Lange, B. Meigel-schleiff, C. Naber, D. ... Karow, A. (2016). *Early Intervention in the Real World Early detection and integrated care for adolescents and young adults with severe psychotic disorders : rationales and design of the Integrated Care in Early Psychosis Study ( ACCESS III )*. <https://doi.org/10.1111/eip.12361>
- Lexine A. Stapinski, Ricardo Araya, Jon Heron, A. A. M. & Paul S. (2014). Peer victimization during adolescence: concurrent and prospective impact on symptoms of depression and anxiety. *Anxiety, Stress & Coping An International Journal*, Volume 28, (Issue 1). <https://doi.org/10.1080/10615806.2014.962023>
- Malik, A. (2014). *Ministry for Women's Empowerment and Child Rights. National Strategy on Elimination of Violence Against Children: Republic of Indonesia*.
- Martha Craft-Rosenberg, Patricia Kelle, L. S. (2004). Family-Centered Care : Practice and Preparation. *Families in Society*. *The Journal of Contemporary Social Service*.
- Naidoo, S. Satorius, B. K. de Vries, H. & Taylor, M. (2016). Verbal Bullying Changes Among Students Following an Educational Intervention Using the Integrated Model for Behavior Change. *The Journal of School Health*, 86(11), 813–822. <https://doi.org/10.1111/josh.12439>
- Santrock, J. . (2012). *Life-Span Development (Perkembangan Masa Hidup )* (Edisi 13 J).
- Sheidow, A. J. Zajac, K. Chapman, J. E. McCart, M. R. & Drazdowski, T. K. (2021). Randomized Controlled Trial of an Integrated Family-Based Treatment for Adolescents Presenting to Community Mental Health Centers. *Community Mental Health Journal*, 57(6), 1094–1110. <https://doi.org/10.1007/s10597-020-00735-z>
- Smokowski, Paul R. PhD, MSW, Evans, Caroline B. R. MSW, Cotter, Katie L. M. (2014). The Differential Impacts of

Episodic, Chronic, and Cumulative Physical Bullying and Cyberbullying: The Effects of Victimization on the School Experiences, Social Support, and Mental Health of Rural Adolescents. *Violence and Victims, Vol 29*(Issue 6). <https://doi.org/10.1891/0886-6708.VV-D-13-00076>

Tobias J, Wales J, S. E. S. (2014). Towards better education quality: Indonesia's promising path. *London: Overseas Development Institute.*

Wong, O. L. (2014). Archives of Psychiatric Nursing Contextual Barriers to the Successful Implementation of Family-Centered Practice in Mental Health Care: A Hong Kong Study. *Archives of Psychiatric Nursing, 1–8.* <https://doi.org/10.1016/j.apnu.2014.02.001>

<https://jateng.bps.go.id/dynamictable/2019/09/25/517/jumlah-kekerasan-berdasarkan-jenis-kekerasan-yang-dialami-oleh-anak-usia-0-18-tahun-korban-kekerasan-di-provinsi-jawa-tengah-2015---2018.html>

[https://bankdata.kpai.go.id/tabulasi-data/data-kasus-perlindungan-anak-2016-2020.](https://bankdata.kpai.go.id/tabulasi-data/data-kasus-perlindungan-anak-2016-2020)

