Protecting the Troubled Youth - the Finnish Case

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Situation of Children and Young People in Finland

• In the end of 2016, there were 5.5 million people living in Finland, of which 1.2 million were 0 to 19 years of age

• Among European countries, Finland is traditionally regarded as a Nordic welfare state

• According to a recent Report by Unicef (Innocenti Report Card 13) Finland is among the most equal of 41 EU & OECD countries for children
  • Income, schooling, health and satisfaction in life
  • 1st place for Denmark, Finland in the second place with Norway and Switzerland

• Among different child welfare models, Finland represents a family service oriented system (Gilbert et al. 2011)
  • Prevention
  • Universal support for all families & focused support for families in need
Child Welfare Model in Finland

• Child welfare model’s principles (Child Welfare Act, section 4)
  • Most importantly, the best interest of the child
  • Support for the whole family
  • Action must be taken with as much sensitivity as possible, and support by in-home care must be given precedence
  • If out-of-home care is needed, this must be arranged without delay
  • Out-of-home care is **never permanent**: reuniting the family must always be taken into account
  • A child can be taken into care against his own or his guardians will, but 80% of the care orders are done on voluntary basis

• Child welfare offers
  • In-home care services (counseling, financial support, family work, interdisciplinary networks, support persons and support families etc.)
  • Out-of-home care services (foster families, residential / institutional care)
Children and young people aged 0–17 receiving support in in-home care as a percentage of the total population of the same age in 1996–2015

The definition of receiving support in community care was changed by the Social Welfare Act that entered into force on 1 April 2015.

Source: Child welfare.OSF.THL
Children and young people placed in out-of-home care, of which children taken into care and children in emergency placement, 1991-2015*

*The same child may be included both under children in emergency placement and children taken into care.

Source: Child welfare.OSF.THL
Children placed in out-of-home care as a percentage of the population of the same age in 1991–2015, % *

*According to the latest reason for the placement.

Source: Child welfare.OSF.THL
Psychiatric Treatment of Finnish Children

- The first psychiatric hospital units for adolescents were founded in the 1970’s (Lehto-Salo ym. 2002; Pösö 2004).
- Children with psychiatric issues are provided care in outpatient care clinics, medical treatment, therapy, and short-term care in hospitals (eg. Lämsä et al. 2015)
- Treatment towards outpatient care measures
- Growth in the numbers of adolescents
Outpatient psychiatric care of children and young people in Finland

Psychiatric inpatient care of children and young people in Finland
Children with offending behaviour

- In Finland, children under 15 years of age are regarded as incapable of crime (*doli incapax*)
- Acts committed by children under the age of 15 result in notification to the municipal child welfare
- 15 to 17 years old are subject to the Young Offenders Act, but to child welfare as well
- Child welfare operates independently from the criminal sanction system, and vice versa
- Child welfare reaches offending children quite well (Savolainen & al. 2006)
  - 40% of the first-timers are contacted, 90% of the children that are caught more than 4 times are targeted with intensive child welfare measures
  - Number of contacts increases as a consequence of criminal behavior
- The likelihood of out-of-home care increases with the number of crimes
- Less than 10 children aged 15 to 17 years of age are in prison
Shared clients in child welfare, psychiatry, and criminal sanction system

- Child welfare, psychiatry, and criminal sanction system have a long shared history, with many tensions and contradictions between the professions.
- Traditionally young people with disruptive behavior have been moved to child welfare units – and especially to reform schools (Lehto-Salo et al. 2002; Pösö 2004).
- Currently the number of shared clients in psychiatry and child welfare is significant (Kiuru & Metteri 2014a), and the estimated prevalence of psychiatric disorders among the child welfare clients varies between 30 to 90%.
  - According to Pasanen (2011) 50% of the children placed in children’s home could be diagnosed with psychiatric disorder, whereas the percentage was 89 among those adolescents placed in reform schools (Lehto-Salo 2011).
  - Among the children placed in out-of-home care, offending behavior was a significant factor for 20% of the children (Heino et al. 2016, figure 19).
  - Among reform school students, the prevalence of offending behavior was 50% prior to the placement (Kitinoja 2005, table 57).
Shared clients in child welfare, psychiatry and criminal sanction system

• The adolescents with conduct disorder that oppose psychiatric care and treatment, create a serious challenge for the system (Lehto-Salo ym. 2002; Pösö 2004; Lehto-Salo 2011; Timonen-Kallio 2012; Könönen 2016; Sinko 2016).

• Institutions that truly integrate child welfare and psychiatric care are still quite rare, even though the number of private units is increasing

• Reform schools have traditionally been institutions that take care of adolescents with conduct disorders, offending behavior, and child welfare needs (Pösö 1993; 2004)
Reform Schools for adolescents with multiple challenges

- Five state owned, two privately owned (n=7), for app. 270 children
- Characterized by unique structure and legislation, long institutional histories, own comprehensive schools, and round-the-clock care in units by a staff specialized in psychosocial treatment
- Offending is significantly high among reform school students both prior, during and after the placement
- The reform school students suffer from a wide range of psychiatric symptoms of both internalizing and externalizing spectrum (Manninen 2013).
  - In another study, 89 % of the reform school students had at least one psychiatric diagnose, 76 % had a conduct disorder, 50 % had an affective disorder, and 40 % had a substance related disorder. 40 % of the students were suicidal, and 50 % had learning difficulties. (Lehto-Salo 2011.)
- The reform school staff identifies psychiatric symptoms quite well, but symptoms that reveal a risk for psychosis, challenges in social relations, and depressive symptoms particularly among boys, are often unrecognized (Manninen 2013)
- Some reform schools have established special units for adolescents with psychiatric needs (Pekkarinen 2017)
Fact for Minors – project

• Five European countries – Italy, Spain, Portugal, Germany, and Finland
• The aim of the project is to strengthen the capacity of professionals working for or with children in alternative care
• To strengthen the interagency and multidisciplinary cooperation of the professionals
• To raise awareness in regards to children in alternative care, at national and EU level
Fact for Minors – project activities

- Identification, adaptation and testing of successful intervention methods to address the needs of children with mental health disorders in alternative care
- Strengthening of multi-agency and multi-disciplinary cooperation in the area of child protection in the 5 partner countries by developing a capacity building methodology
Why do we participate in the study?

• Children that have been in out-of-home care have more challenges than others in many areas of welfare and health
  • Lower schooling, more unemployment and welfare dependency, more psychiatric problems, more criminal behavior, higher mortality (Ristikari et al. 2016)

• During a five-year follow-up the prevalence of psychosis was higher among the reform school adolescents than in the general population, and 75 % of the boys had been sentenced for a criminal act. (Manninen 2013.)

• In another register based study, former Reform School students were found to have a seven-fold risk for premature adult-age death compared to a matched control group (Manninen & al. 2015)
  • The most common causes for mortality were substance-related deaths and suicides. (Manninen 2015)

• Aim of our participation in this project is to provide better psychiatric support for young people placed in Reform Schools and thus in other child welfare institutions
Setting the Scene for data collection

• Researcher M.Soc.Sc Noora Häsbacka & Dr. Soc.Sc. Elina Pekkarinen
• Manager of the research docent Kaisa Vehkalahti
• National Advisory Board
  Head of the Board: Special expert Päivi Känkänen, National Institute for Health and Welfare
  Members:
  • Development manager Jussi Ketonen, Lauste Family Rehabilitation Center
  • Senior researcher Marko Manninen, National Institute for Health and Welfare
  • Professor Tarja Pösö, University of Tampere
  • Manager Matti Salminen, Child Welfare Units of the State, National Institute for Health and Welfare
  • Councilor in Medicine Helena Vorma, Ministry for Social Affairs and Health
  • Senior researcher Miika Vuori, The Social Insurance Institution of Finland
Alternative care units of the project

• Research focuses on two reform school units with emphasis in psychiatric support
  • A unit in State owned reform school Sairila in Mikkeli (Eastern Finland)
  • A unit in NGO owned reform school Lauste in Turku (Western Finland)
• Both units are relatively new as they were founded during this decade
• The number of clients is very low and the number of staff is high
  • The client / staff ratio is higher than in the average units, and the units hold only 4 – 5 adolescents at a time
  • The number of nurses is higher than in the average units
• The placements are long-term – from months to years depending on the situation of the child
• Providing care and education is a central mission of the units
Data

• In Lauste, ten (9) in-depth interviews were completed
  • Eight care workers (8), unit manager (1)

• In Sairila, five (5) in-depth interviews were completed
  • Unit manager (1), reform school manager (1), school director (1), social worker (1), care workers (1)

• In-depth interviews with experts (4)
  • Psychiatric nurse from a hospital’s polyclinic for adolescent psychiatry (1)
  • Consulting psychiatrists for adolescents (2)
  • Special expert in child welfare (especially child removals and out-of-home care) (1)

• Focus group interviews / discussions
  • National Multidisciplinary Expert Group for Research in Child Welfare 30.3.2017 (1)
  • Previously interviewed participants from Lauste + director 29.5.2017

→ 18 individual interviews, one expert group discussion, one focus group discussion
Analysing the data

• Completing a matrix that looks for the strengths and weakness of the strategies, organizations, theoretical and methodological frameworks, practices, and collaboration between the institutions and services

• Practical solutions for each thematic part
Strategy

STRENGTHS

• These specialized units are in themselves a significant reformation in the field of residential care for adolescents with conduct disorders and other similar issues
• A focus on caregiving and meeting the individual needs of the adolescents is an effective strategy

WEAKNESSNESS

• The responsibility on providing psychiatric care has been pushed on child protection
• Problems are met in the strict borders of disciplines and professions, which fragments the support, and causes bouncing of certain children in between the systems
• Deficiencies in the placement process – breaks and inadequate actions
• Multidisciplinary co-operation is based on individual processes, and general protocols and structures, i.e. the big picture, is missing

SOLUTIONS

• Careful assessment of the children
• Precise profiling of the institutions
• Better co-ordination of both the individual client cases, and the field
Organization

STRENGTHS
• Aim at holistic and integrated care and schooling
• The ratio of the staff, the small number of clients, the education of the staff and management

WEAKNESSNESS
• Distances – in between the professions and concrete physical distance
• Psychiatric practices, such as medical restraint, cannot be used
• The stigma of the institution
• Peer group dynamics, learning “bad habits”
• Criminal sanction system is very distant

SOLUTIONS
• Strengthening the psychiatric skills of the workers
• Reducing the stigma of child protection
• Utilizing the peer group and everyday activities as tools for care
• Creating contact to the professionals in the criminal sanction system
Theoretical references and methodologies

STRENGTHS

• Eclectic and flexible theoretical framework, which is individually tailored
• Good relationship as a corner stone for good care
• Stabilizing the structures of everyday life

WEAKNESSNESS

• Strong professions and different theoretical frameworks cause lack of common language and diffusion in the use of concepts
• Shared values and visions are difficult to find
• Lack of time for building trust in all relations

SOLUTIONS

• Dialogue
• Adequate length of the placement
Practices

STRENGTHS

• Having a pair of personal key workers for every child is effective (also Lehto-Salo 2011; Marttila 2013)
• Getting enough background information, settling with enough time
• Living everyday life together with the child
• Hobbies and other leisure activities outside the unit too

WEAKNESSES

• Lack of time
• Ending of the placement comes too early
• The adolescents that oppose psychiatric care, or are in the system by force, are at the core of the practical problems: how to help them?

SOLUTIONS

• Accompanying the child, keeping in touch, spending time together
• Developing after care and support for second level schooling
• Careful assessment of the adequate placement, and careful planning of the removal
• Finding alternative ways of supporting the children that oppose psychiatric interventions
Collaboration between institutions and services

STRENGTHS

• Multi-professional collaboration at its best is open, fluent, respectful and dialectic, and based on sharing, dialogue and mutual reflections

• The adolescents that move to the unit from psychiatric hospital unit, who have a thorough assessment and care plan done, and information delivered openly, are the ones that receive good outcomes

WEAKNESSES

• There are still legal issues that force respecting the borders – particularly in reference to medication, restriction orders and secrecy (also Ristseppä & Vuoristo 2012).

• Large problems in collaboration rise from unclear division of duties, arrogant and commanding manners, lack of trust, and arbitrary decision making (also Timonen-Kallio 2012; Sinko 2016).

• Exchanging of information is still problematic, and due to not only legislation, but also inadequate working cultures.

SOLUTIONS

• Enabling psychiatric consultation and guidance

• Exchange of information and common discussion

• Respect, dialogue, building trust between professionals
Conclusion

• In international comparison, Finnish system has its strengths
  • The young people are not sentenced to care, and residential care is not a punishment
  • There is a strong will for collaboration and integration
  • The staff both in child welfare and in psychiatric care is highly trained, and the residential care units are relatively well resourced
  • The placements are long-term, and include after care until the age of 21
• There are still borders and fragments in the service system, which challenges multi-professional collaboration
• The most scarce resource is time
• There is an urgent need for tools that enable communication and dialogue within and in between the different systems
• There are still children in the adult’s prisons – how should we help them?
For more information

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Thank You!


