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Final Report

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coordinamento nazionale comunità di accoglienza

INDEX

In Finland, the child welfare system provides services for both families with small children, and adolescents with disruptive behaviour, substance abuse, and criminal acts. The age for criminal responsibility is fifteen years (Chapter 3, section 1 of the Penal Code), and children of younger age are turned to the municipal social welfare for the assessment of further measures described in Child Welfare Act. Offenders between the ages of fifteen and twenty are subject to the Young Offenders Act. They have a mitigated scale of punishment, and can be sentenced to unconditional imprisonment only in very special circumstances. (Marttunen 2004). Annually less than ten children between fifteen to seventeen years of age serve their sentence in prison. (Rikosseuraamuslaitos 2017). More commonly these minors are, or become, clients in child welfare system.

The division of labour between the criminal justice system and supportive child welfare measures is clear: the criminal justice system cannot give child welfare orders, and the child welfare measures cannot be used as penal sanctions. The children and adolescents subject to Child Welfare Act have the right to an overall assessment of their situation and needs. The child welfare provides both in-home and out-of-home care, and the child welfare measures are always based on the best interest of the child. Out-of-home care can, however, be ordered against the will of the child and his/her guardians.

There is also a clear division of labour between the Finnish social and health sector. The child welfare system is distinctively based on social support, whereas the health services, including psychiatric and psychological support, are provided by the health sector. There are significant regional differences in the provision of care for children in need of both services.

In recent years, the number of clients both in child welfare and youth psychiatry have increased significantly. At the same time the number of shared clients has increased. However, it is important to note that the crime rate of minors has declined significantly in Finland during the last decade.

The institutional care of young people with penal measures and psychiatric problems is commonly organised by the child welfare services. The hospital units provide care for only short periods. Institutions providing care under the Child Welfare Act constitute the most common type of institutions aimed at young people with disruptive behaviour. The Finnish Child Welfare Act enables placing of children into foster families, professional family homes, or institutions. These services are funded by municipalities, which are also responsible for selecting the right service for each child. The services, however, can be provided by the public sector, private

sector, or non-governmental organisations (NGO's). Of all the children in out-of-home care, approximately 50% are placed in foster families, 10% in professional family homes, and 40% in institutional residential care (Child Welfare 2016). Residential care institutions are administered under the Child Welfare Act, and include children's homes, reform schools and other comparable child welfare institutions. An institution may have several units, but each unit may hold a maximum of seven children or young people, and a maximum of 24 children or young people may be placed in one building. Each unit must have a minimum of seven employees in care work. Institutions may be owned by the State, the municipalities, NGO's or private companies. Currently, approximately only 16 % of these institutions are owned by public sector.

Reform Schools

According to the Act on Child Protection Units Ran by *the National Institute for Health and Welfare* (1379/2010), Reform Schools that are owned by the State of Finland may provide services stated in the Mental Health Act (1116/1990). There are currently seven Reform Schools that house annually approximately 330 minors: five state reform schools, and two owned by NGO's. These Reform Schools are institutions with a long history of institutional care among minors with disruptive behaviour, social problems, and offending behaviour. Many of them are located in rural areas in different parts of the country. The State owned Reform Schools are managed by the National Institute for Health and Welfare, and supervised by a national board. In the field of child welfare services, they represent a form of care aimed at the most challenging group of young people. As State owned institutions with resources for developmental work, they also serve as paragons of high quality care.

It is characteristic for reform schools that the institutions have their own comprehensive schools, and they provide round-the-clock care in units under constant surveillance and support by a staff specialised in social education and care. There are 270 staff members working in the care units, and 24 teachers with 21 assistants working in the schools. The Reform Schools also offer special programs in Aggression Replacement Training, rehabilitation, family work, and after care. The duration of the placement is dependent on the progression of the child and his/her overall situation, ranging from a few months to several years in care.

The Reform School Students

In 2017, 260 adolescents were placed in Reform Schools owned by the State. 56 % of them were boys, and the average age in the beginning of the placement was 14, 8 years. In average, they had experienced two earlier placements before entering the Reform School. Majority of them (71 %) came from another institution. 17 % came from another Reform School, and 8 % came directly from home. Only two percent came from foster families, and two percent from hospitals. The average length of the placements of those that left care in 2017, was 18,5 months. Grounds

for placements varied, but in all cases the reasons were linked to anti-social behavior and similar matters. Interestingly, the most commonly used reason for a reform school placement was running away. Drug addiction or suspected addictive behavior was another strong indicator. Interestingly, criminal way of life was stated as a reason in the cases of only 33 adolescents. This may be due to the average age of placement being below 15, i.e. lower than the age of criminal responsibility. (Annualy Report… 2017.) Reasons for the placements are illustrated in Figure 1.

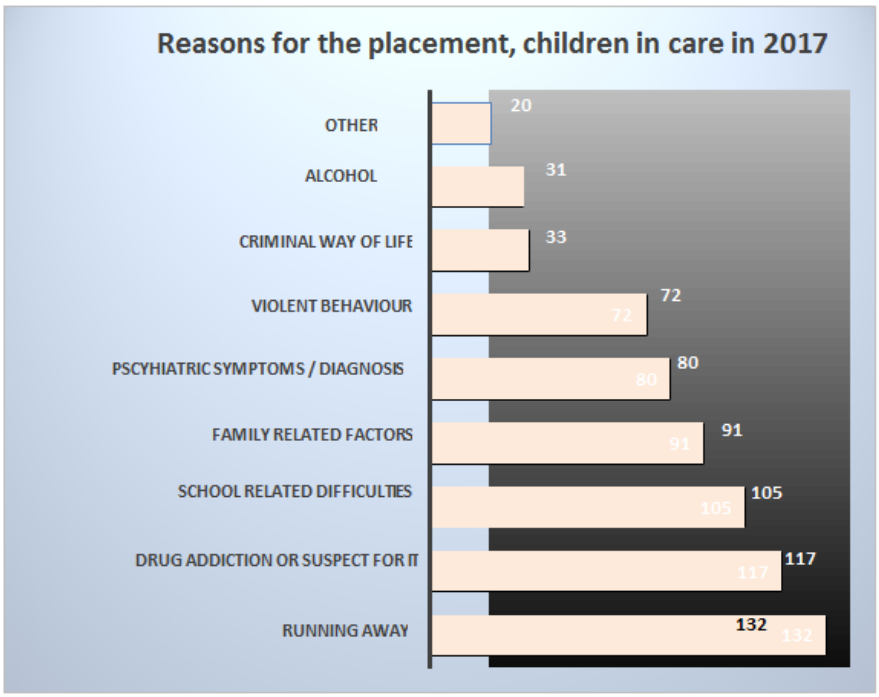

Figure 1: Reasons of the placement in State Reform Schools in 2017. The same child may have several indicators (Annual Report of the State Reform Schools 2017).

Reform School students' psychiatric, neuropsychological and psychosocial profile differentiates significantly from the general population. A Recent study indicates that they suffer from a wide range of psychiatric symptoms of both internalizing and externalizing spectrum. 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. The most common causes for mortality were substance-related deaths and suicides. (Manninen 2015.) 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.)

As the majority of the Reform School students have negative experiences from school, special attention to positive learning experiences is being promoted. Majority of the adolescents have insufficient emotional and cognitive skills. Unrecognized learning disabilities are also common. However, it is important to bear in mind that the young people placed in out-of-home care are not a homogenous group.

Reform Schools at the Era of Service Reforms

In spite of reforms schools' legal right to provide mental health services, and the psychiatric profile of the students, reform schools are not defined as mental institutions in the field of child and youth welfare services. Thus the staff is seldom specialised in psychiatric care. In reform schools the treatment of young people has been based on the personal and stable guidance provided by the caretakers, regular and secure everyday life, supportive psychological and physical health, provision social support, and family work. The psychologists working within reform schools have dealt mainly in the school context e.g. providing tests for assessing the cognitive skills of the students. (Vuorelan koulukodin 2013.) The emphasis has been on co-operation with the treatment network of each individual child. The institutions have relied heavily on the local health services for providing psychiatric services and psychological support for the students, but there are significant differences in the organisation of this cooperation both regionally and individually.

The challenges in providing adequate psychiatric support for reform school students has for long been acknowledged, and reform schools have recently taken steps for developing their services. For ensuring adequate psychiatric support, some reform schools have established special units that provide care for those adolescents that are diagnosed with psychiatric or personality disorders. Two of these reform school units were selected for our case studies during this project.

This project has been carried out during an era of major transformation of health and social services in Finland. In 2017–2018 the Ministry of Social Affairs and Health has lead preparations for five key projects in health and wellbeing, of which several focus on children, young people, and families. Key project 3, *Programme to address reform in child and family services* aims at promoting children's rights in decision-making and services. The focus is on preventive services, early support and care, and timely services. The aim is also to curb the rise in costs for remedial services and to reduce costs. (Programme to…) Thus there is a common will for developing services that better meet the needs of the young people.

1.2 The actors involved

Researcher group
The Finnish sub-study was conducted by the Finnish Youth Research Network (FYRN). The project was lead by Research Manager, Adjunct Professor Kaisa

Vehkalahti, and carried out by Dr. Soc.Sc. Elina Pekkarinen and M.Soc.Sc Noora Hästbacka.

National Advisory Board

Chair of the National 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 of Social Work Tarja Pösö, University of Tampere
- Manager Matti Salminen, Child Welfare Units of the State, National Institute for Health and Welfare
- Councillor in Medicine Helena Vorma, Ministry for Social Affairs and Health
- Senior researcher Miika Vuori, The Social Insurance Institution of Finland

2. Project objectives

As described above, in Finland a clear division of labour has been established among the social, health, and criminal sanction services. This division causes constant friction in the interface of these sectors. The children in need of both social and psychiatric support are usually clients in both systems, but the cooperation in between these sectors has its shortcomings.

Earlier studies indicate that psychiatric system identifies the need for child welfare services (Kiuru & Metteri 2014a), and the child welfare system identifies the need for psychiatric assessment, quite well (Timonen-Kallio 2012). There are shared fields for practices. These include the aim of safeguarding the child; crisis intervention; supporting the every-day life, and supporting the family (Kiuru & Metteri 2014b). These shared fields of practices demand shared concepts and understanding of each others' work. Effectiveness requires that all the parties complete their tasks. However, the fact that the systems are dependent and separate at the same time, causes tensions and conflicts. Problems may also derive from unrealistic expectations, experiences of being "commanded", and lack of communication (Timonen-Kallio 2012; Sinko 2016). In addition, the legislation and its interpretations create barriers for multi-professional practices (Ristseppä & Vuoristo 2012). Those 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).

These earlier findings created a context for the project goals that are described in Figure 2. In order to map the situation, make the practices visible, and name the meanings of the work, a thorough analysis of the specialized units in two reform school institutions were carried out.

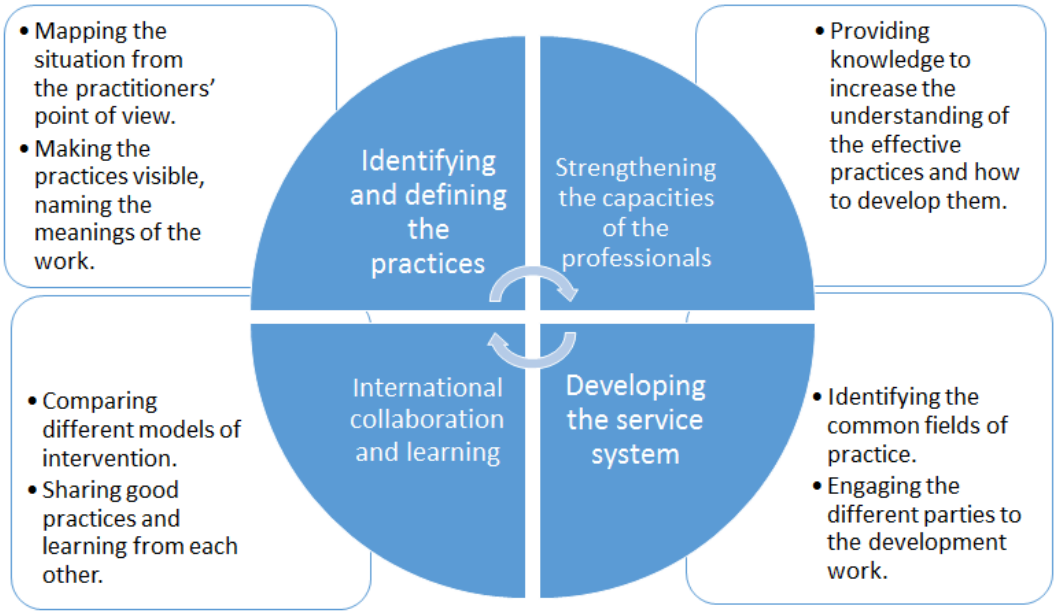

Figure 2: Different fields of goals of the project in Finland.

3. Capacity building and the two levels of intervention

3.1 National level: experimentation

a) Test sites and the primary actors involved

The two reform school units that were chosen as test sites, have an emphasis on psychiatric support. The first one is a unit in State owned *Reform School Sairila*, which is located in the city of Mikkeli in Eastern Finland. The second one is a unit in a NGO owned *Family Rehabilitation Center Lauste*, which is located in Turku in Western Finland.

Researcher Noora Hästbacka visited the units and conducted in-depth interviews with the practitioners. This intervention comprised of ten (10) in-depth interviews in Lauste, including eight (8) care workers, unit manager (1), and psychiatric nurse of the local clinic for adolescent psychiatry (1). In Sairila Reform School (5) in-depth interviews were completed with the unit manager (1), the Reform School manager (1), school director (1), social worker (1), and care worker (1). In addition to this, three (3) in-depth interviews were carried out with experts, of which two (2) with consulting psychiatrists for adolescents, and one with a special expert in child welfare (especially child removals and out-of-home care). In addition to the individual interviews, a discussion (1) with National Multidisciplinary Expert Group

for Research in Child Welfare, and a focus group discussion (1) with Lauste personnel were held. Altogether nineteen (19) interviews and discussions with different parties were held. These highlighted the weaknesses and strengths as well as the development needs of the practices carried out not only in the two case study units, but in Finland in general.

Both units, Lauste and Sairila, are relatively new as they were founded during the decade of 2010. In Sairila, the unit was founded on the grounds of an already existing unit, where old practices were reformed, and staff remained the same. In Lauste, a totally new unit was founded and new workers were recruited upon the establishment of the unit. The physical organisation of the units is different: one is located in the same court with the other reform school units, whereas the other one is located within a long distance from the other reform school units, in another town. However, the ways of organizing the practices within the units is quite similar. The number of clients is very low – only four to five (4–5) adolescents at a time – and the number of staff is high, the client / staff ratio being higher than in the reform school units in general. The number of personnel with education in medical nursing is also higher than usual. The placements are long-term – from months to a year depending on the situation of the child. The units share the general principle of providing comprehensive care and support for these young people.

Table 1: Characteristics of the units

	Lauste	**Sairila**
Guidance, monitoring	Private NGO	The National Institute for Health and Welfare (i.e. owned by the State)
Structure	Independent unit that is geographically detached from the rest of the institution by locating in another city. The unit has two compartments.	Located on the same site with the rest of the institution (35 places total). Organised as a part of the demanding care programme, which also includes a short-term special care unit and two compartments.

Children / Young people	5+5 Children "age out" i.e. stay until the age of 18.	4 Children perform their elementary school and move out.
Staff	Unit manager, social worker and careworkers.	Unit manager, team manager, careworkers, specialists (social worker, psychologist).
Education of the staff	No earlier experience in reform school units; training in social care; Dialectic Behavioral Therapy -training for all staff.	Earlier experience in reform school units; training in social care; psychiatric nurses.
History	Founded for practical needs in 2013. Personnel has been recruited from outside, with emphasis on psychiatric skills (= work experience from hospital departments). There were difficulties in launching the department and staff resigned (especially those that had previously worked in the hospital sector).	A department created for practical needs that rose in the substance abuse department. The "old" policies were revised.
Development of practices	Penalties have been abolished and the rules have been reduced.	The activity was developed based on the experience of the staff, with emphasis on care.

Psychiatric services	Collaboration with the local hospital district. In addition, the consultant psychiatrist regularly works as a supervisor for work counseling. The department has started monthly meetings with the psychiatric polyclinic, which aims to develop cooperation.	The department uses the services of consulting psychiatrists. Many young people have a treatment contact with the local psychiatric polyclinic.
Practices with aggressively behaved young people	Holding	Isolation
Other special issues	One place for emergency placements, which influences group dynamics and care workers use of time.	

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

Strategy

Strengths

The findings in Finland indicate that the underlying principle of taking care – not punishing – these young people is the primary strength of the Finnish system. Putting the emphasis on caregiving and meeting the individual needs of the adolescents appears to be an effective strategy. The two specialized within the reform school system can themselves be regarded as a significant reformation in the field of residential care for adolescents with conduct disorders and other similar issues.

Challenges

There are major challenges involved in the very beginning of the process. Often the intervention – i.e. placement to the unit – comes too late as a last resort option: the problems have escalated and developed over a long period of time, and majority of the young people have experienced several placements already before their placement to the special unit. Reduction of psychiatric care in hospital departments is also problematic. Strict borders between different disciplines and

professions fragment the support available for these young people, constituting yet another challenge.

Although the principle of providing individually tailored care is a strength, it may cause problems on the system level. As the multi-professional cooperation is based on individual processes and general protocols and structures are missing. Together the general fragmentation of the system and individuality of the processes cause ”bouncing” of the adolescents in the border surfaces of the service system.

Organisation

Strengths

The ratio of the staff, the small number of clients, the high education level of the staff and management, and integration of the school within the unit are effective practices.

Challenges

Distances – between the professions and concrete physical distance – cause problems. The separation from "society" and institutionalization may form a risk to the normal trajectories of the young people. The physical distance between the institution and the young’s own community is a problem, which also challenges the family work provided by the units. The stigma of the institution may cause problems in later life.

Even though it was seen as a significant strength that departments are not hospital-like, occasionally this produced difficulties for certain young people. For example medical restraint cannot be used in these units. For such treatment the young person has to be taken into hospital. There are also limits for keeping children that have committed severe crimes. Therefore, approximately ten minors are annually placed in adult prisons in Finland, which violates the UN’s Convention on the Rights of the Child.

The legislation-based age-barriers cause problems for the continuity of support of both child welfare and psychiatry. Also criminal sanction system is very distant from the social and health care, and collaboration between these three is shallow.

Theories and methodologies

Strengths

The units base their practices on eclectic and flexible theoretical framework, which is individually tailored. The education and practical knowhow of the different workers in the units is high. The adolescents are seen as actors with a potential for change, and strong support for their education, therapeutic needs, and structuring of everyday life is being offered. Small units and high ratio of staff allow individual

lines of care and child-based support. Understanding the significance of early childhood and the importance of attachment theory, developmental challenges and traumas, are rooted in the practices.

Challenges

These issues are strengths and challenges at the same time: strong professions and eclectic theoretical frameworks result in lack of common language and diffusion in the use of different concepts. Common values and visions are difficult to find. The relationship between adults and young people always includes elements of power, and control of care workers may feel arbitrary by a young person.

Peer relations and group membership are not acknowledged as potential strengths, on the contrary, the peer relations are seen as a threat. In the future, the activities could take into account the therapeutic effects of group and peers, and the importance of belonging to the group. At the moment, more emphasis is placed on young people's attachment to trustworthy adults.

Practices

Strengths

Careful assessment of the adequate placement forms a base for an effective placement. The starting point for rehabilitation is getting to know the child, and directing the gaze from problems to abilities. The working practices are based on integrating special expertise and support into the child's growing environment, and thus offering intensive and comprehensive support for everyday life. Each child has a pair of personal key-workers, and the staff team does the caring by presence, interaction, and by stabilizing the environment. Restructuring the distorted attachment, and creation of trust by a safe adult figure constitutes a cornerstone for the units' work. Another cornerstone is stabilization of everyday life by structures, security, and emotional regulation.

Challenges

There are challenges connected to the "bouncing" of children and young people in the system – an issue that is related to the structures and the impractical practices of the service system. On one hand, avoidance of diagnosis can be seen as a positive from the perspective of avoiding labelling the child or making too early and incorrect judgements. On the other hand, however, delays in the psychiatric assessment and diagnosis may lead to postponing the needed treatment and care. The adolescents that oppose psychiatric care, or are in the system by force, are at the core of the practical problems.

Leaving care is a critical phase, and often happens too early. Breaking the relation with the key worker may multiply the trauma of losing close relationships.

Secondary education is particularly demanding, and many drop out. There is no adequate support in the vocational schools for these adolescents.

There are also problems in sharing information especially upon young people's arrival in the unit. The appropriateness of professional secrecy is being questioned. There is also distrust between authorities and institutions, and ambiguity in the sharing of information.

Collaboration between services and institutions

Strengths

The main agents of institutional collaboration include the school, the municipal social work and the youth psychiatry. The responsible social worker sets targets for foster care and monitors the development of the young person during the time in care. Parents and families are also included in the circle of the most important collaborators.

Collaboration between the reform school units and psychiatry is not as established as the collaboration with the municipal social work is. Details of the collaboration are presented in table 2.

Table 2. Psychiatric treatment in practice.

Traditional practices	**New approaches**
Individual meetings and discussions with the child (often with nurses, regular and "therapeutic")	*Joint care* (taking the careworker along to the meetings with the psychiatric nurse or psychiatrist)
Planning and monitoring medication (psychiatrist, meetings quite rarely)	Entering the child's everyday environments (e.g. the unit, school, home etc.)
Polyclinic visits (multi-professional team, individual visits)	Providing psychiatric support in the everyday settings (e.g. the unit, school, home etc.)
Psychotherapy (private therapist with public funding, regular, intensive and long-term appointments)	Alternative psychotherapy methods (e.g. Dialogue Behaviour Therapy, occupational therapy)

Regular meetings with the family, the unit, ant the social worker (rarely)	*Combined care* (sharing information and experiences with other professionals, participating in care)
Private consulting (psychiatrist, psycho therapist) - Professional guidance, educating the staff - Treatment for the child (evaluation and medication)	**Own psychiatrist at the unit** - Participating in the everyday life of the unit - Being part of the unit

At its best, multidisciplinary collaboration is seamless, transparent, respectful and open for other's experiences and opinions. Good cooperation emphasizes willingness to listen, and appreciation of different views in open dialogue. As the treatment is voluntary for the children, and not all of the young people are willing to participate or benefit from traditional counselling, it is necessary to provide other forms of treatment. In such cases, the units have an opportunity to have consultation from the local psychiatric polyclinic or private psychiatrists.

Challenges

Many of the careworkers interviewed for this study felt that their position was subordinate, and that their views were not respected by other professionals. Challenges in collaboration with hospital units, social workers, and psychiatrics are common. Those who have the power to make the most important decisions may have the least experience of the young person's everyday life. There is a lack of common concepts, values and visions between the professionals.

c) Different theories for practices capable of increasing the quality of the work carried out by network members and through multi-agency cooperation;

In the previous section, several ideas for developing the practices and multi-agency cooperation have already been given. Many practical solutions for developing the collaboration were given. For example entering psychiatric services to the units was seen as a solution. Also, having monthly meetings or other regular meetings with the different professions, is an acceptable practice. Getting to know each other's work, and sharing understanding, are good practices. Unnecessary legal barriers to cooperation should be assessed and dismantled.

Experimentation of strategies and practices within the identified settings

In Finland, actual experimentation of the strategies and practices within the identified setting was not established. Instead, the Finnish team invested in sharing information produced in the project with not only the two units, but with a wider audience. This investment aimed at influencing the current reform of social and health service system, and at promoting information based management. Thus the results found in the project were presented in fourteen (14) presentations in conferences, seminars, and meetings, which all aimed at improving multidisciplinary dialogue by offering knowledge on these issues. Two (2) of the presentations were targeted directly to the units that were involved in the project, together with collaborating regional networks. Altogether approximately 600 people participated in these seminars and lectures, of which the largest audiences have reached over 200 people.

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

The Finnish case study was supported by a national advisory board consisting of representatives of the key national public entities involved in child protection, leading Finnish experts in the field, and key stakeholders representing the two reform schools participating in the project. Originally the Finnish case study was supported by the Finnish Ombudsman for Children. However, as the project proceeded and the care units participating in the project were selected, it became evident that it would be important to include the highest national authority in the field, the National Institute for Health and Welfare, in the national board. Hence, the supportive national public body has been the National Institute for Health and Welfare since March 2017.

The National Advisory Board has held four (4) meetings, in which the board has offered the research group with invaluable insights for implementing the project in Finland, establishing connections with key actors in the field, discussing the results of the projects, and discussing the dissemination of the results. Two members of the National Advisory Board have participated in each international project meeting held in the project. Chair of the National Advisory Board, Special Expert Päivi Känkänen (National Institute for Health and Welfare), has represented Finland in the meetings of the Transnational Advisory Board.

3.2 Transnational level:

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

We have participated in the transnational work by providing results from our project both in the written and presentation form. The transnational collaboration has provided us understanding of the different models in participating countries, and that the challenges are often shared across the nations. The most interesting

finding has been the similarity of the young people's characteristics in different societies, and the similarity of the interventions in each partner country.

We have shared the results and models of the other partner countries in four (4) different conference- and seminar presentations in the Spring of 2018, and reached an audience of 180 people. There has been a very intensive interest for the international results of the project.

b) The transnational advisory board and actor network: To what end?

The representative of Finland changed after the kick of meeting in Rome, and since then the Finnish member of the transnational advisory board Päivi Känkänen participated in all the meetings organised by the transnational advisory board.

4. Results

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

The Finnish results support the earlier findings concerning the strengths and challenges met in the system. However, there were several new implications, which are also presented in the previous sections. Making the challenges visible and thinking of them together, provided a lot of practical solutions for the institutions that took part in the Finnish case study.

An important finding was the willingness of the professionals to participate in this project, which required critical and intensive reflection of their own professionality and work. The openness and honesty of the interviewees constitutes a good ground for future work.

The central findings of the Finnish project can be found in the following table 3.

Table 3: The findings of the project in Finland.

	What works?	What does not work?	Practical solutions

Strategies	The interventions are based on care - not punishment. Integration of psychiatric care in the everyday life of the communities	Responsibility is moved solely on child protection. There are groups of children that fall in between the sectors (especially young people with conduct disorder, very aggressive and suicidal behavior, and personality disorders) Deficiencies in the placement process. Lack of criteria for quality. Lack of "big picture".	Careful evaluation and assessment in the beginning of the placement. Profiling of the institutions. More efficient co-ordination of the child protection field.
Organizations	Holistic and integrated care. More staff compared to standard units. Small groups, ability for individual, youth centered and youth based approach. Intensive and long-term support.	Isolation from the society, distance from the families and communities. Stigma. Problems with the peer groups. Deficiencies in the set of available practices.	Strengthening the skills of the care workers. Reducing the stigma of child protection. Development of therapeutic methods: utilizing the peer group and everyday activities.

Theoretical references; methodologies; experiences	Understanding of young people's development and the background of disruptive behavior. Good relationships as a cornerstone for good care. Attachment theory. Strenght based and solution based approach. Stabilization of the everyday life by structures. Youth based approach.	Focusing on problems and disturbances, lack of preventive measures. The contradictions between autonomy and control. The paradox of acceptance and change. Boundaries and freedom - unsettled issue?	Finding a middle way in between autonomy and control. Trust in the child's capabilities and success. Opening the world, finding words for emotions. Acknowledging the peer relations as a potential strenght and resource.
Practices	Having a personal key worker. Getting to know the child personally. Getting the background information. Not abandoning the child. Good networks. Persistence, allowing both success and failure.	Lack of time. Problems in sharing information. Ambiquities in secrecy. Limits set by time: ending of the placement and aftercare. Secondary schooling.	Development of effective and safe ways of sharing information. Accompanying the child both to the unit and away from the unit - work in the transitions. After care and continuity, making the safety net firm. Developing support for the secondary education.

Collaboration between services and institutions	Psychiatry entering the unit. A model of joint care. Careful assessment and care plan made in collaboration. Provision of expertise and support for the units.	Lack of respect, failure to listen to each other. Division of responsibility concerning the care. Inadequate support from the hospital. Legislation and working structures. Commanding style of collaboration, arbitrary practices. Lack of trust in other professionals. Lack of common concepts, values and visions.	Creation of common concepts, common understanding and common vision. Enabling dialogue and mutual discussions. Respect, understanding and dialogue. Building trust, getting to know each other's' work. Entering psychiatric services to the units. Monthly meetings. Using private psychiatrists or hiring own psychiatrists to the units.

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

During this project, it has become even more evident that the young people that are the core of this project, need multi-professional support and care of high quality. We have begun to call these children as children in four margins - they are characterized by 1) special educational needs, 2) child welfare needs, 3) psychiatric needs, and 4) criminal behavior. However, traditional ways of working do not fit with these children. Many psychiatric practices (medical care, psychotherapy, hospital care) are seen as inadequate or unsuitable for these young people – and often the children themselves also view these services unappropriate.

Creation of common concepts, common understanding and common vision among the professionals is in the heart of the capacity building process. Exchange of information and common discussion is needed, and this collaboration has to be built on respect for each other's knowhow. Together with getting to know each other's work, this builds trust between the professionals.

Practical solutions for bettering the situation include establishing psychiatric

services in the units, and arranging regular meetings between the professionals. Solutions for the lack of psychiatrists could be provided by 1) the use of private psychiatrists as consultants in the reform schools; or 2) recruitment of psychiatrics in the units.

Time is a scarce resource, and many of the challenged identified in this project were connected to the lack of time. To begin with, young people's reform school placements are often delayed. Upon discharge the relationships and rehabilitation process are disrupted, and the after-care of these young people needs immediate attention by the whole society.

In the future, the possibilities for therapeutic effects provided by groups and peers should be taken into account in the reform school activities. The importance of belonging to a group should be taken into consideration as an integral part of young people's treatment. At the moment emphasis is placed on creating attachment to a trustworthy adult.

c) What is the appropriate intervention model? The role of institutional actors and other involved actors

The Finnish model of taking care of young people that have several concurrent challenges is comprehensive and aims at continuity. Currently the Finnish institutional care for these adolescents has challenges with regard to both of these aims. In figure 3 the tricky aim of accomplishing both of the ideals – comprehensiveness and continuity – in the same process is being illustrated.

Figure 4 aims to suggest, how different services should be provided for the young people that are placed in institutional care. Currently the institutions typically rely on one or the other: some institutions have psychiatric knowhow integrated in the unit staff, others utilize the networks outside the institution. We suggest that all the institutions should have resources to do both: to have adequate professional skills available in the unit for the ones that need it there, and strong professional networks outside the unit for the ones that are able and ready to build relations outside the unit too. The network should include the criminal sanctions agency more closely than it does today.

This era of major reforms in the Finnish health and social welfare sector provides a critical time for proposing these suggestions and changes in the Finnish system.

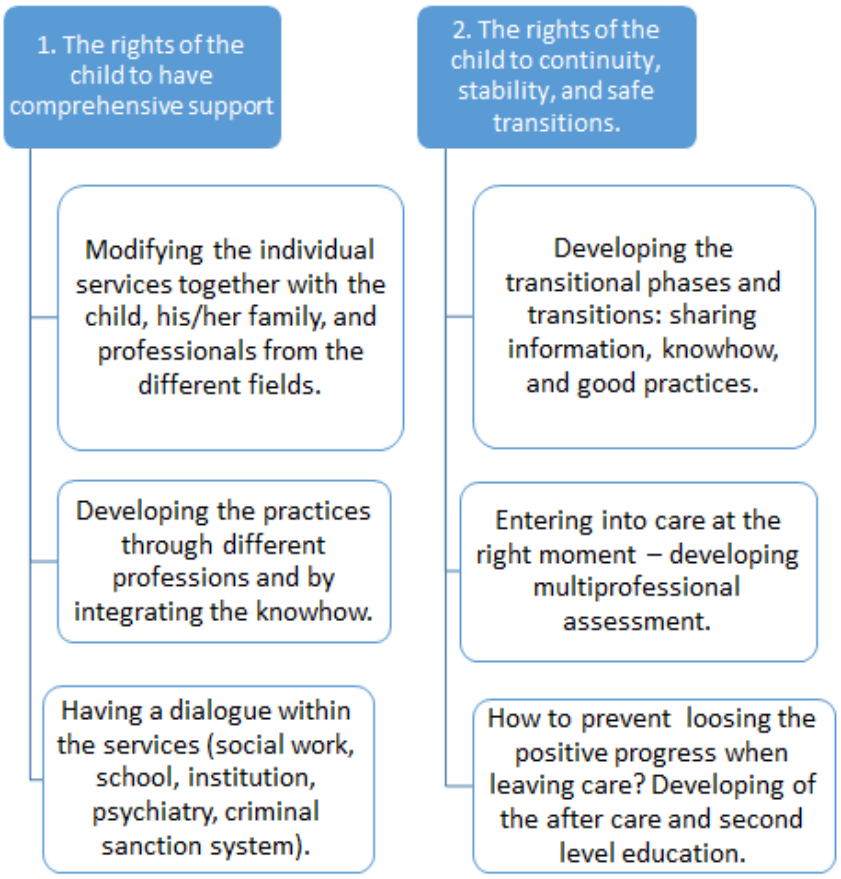

Figure 3: The comprehensive and continuing care of the child - how to accomplish both?

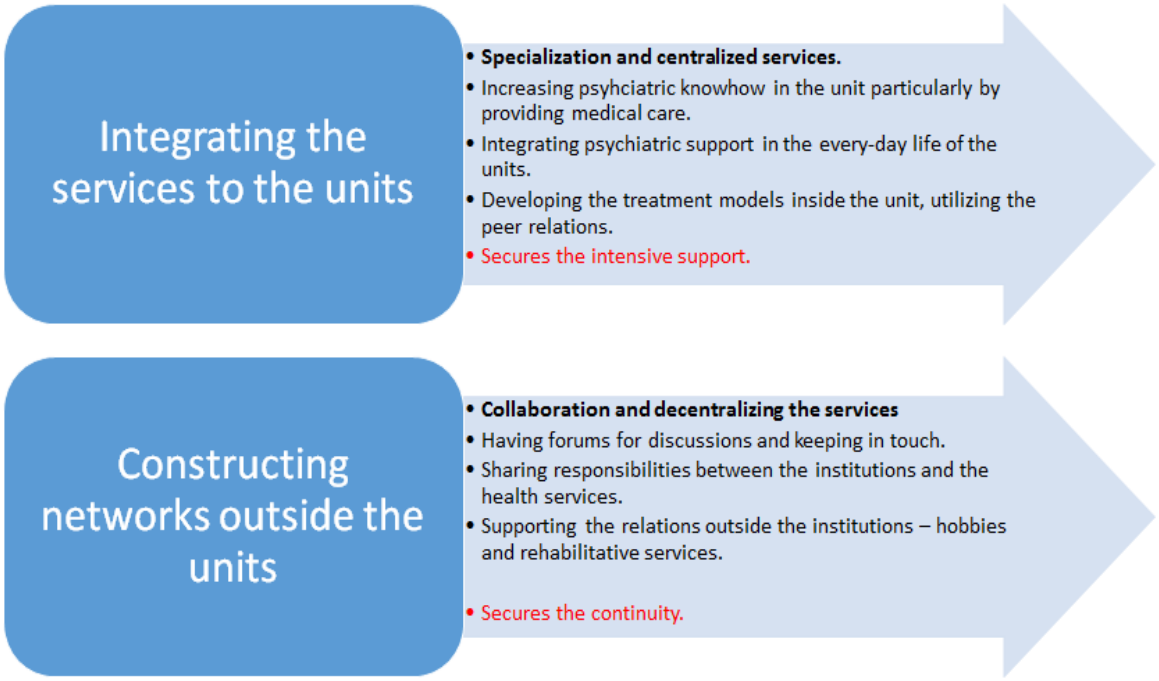

Figure 4: The optional or the parallel ways of arranging multi-professional support in the reform schools: could we have both?

5. Prospects for the future

This project has provided us with valuable insights from the professionals, who work with the "children in four margins" on the grass-roots level. The project was motivated by the will to learn from their unique experience, their opinions, worries and hopes – and to build upon this expertise. However, the most important actors in the process are the young people themselves. Without taking their experiences and viewpoints into account the proposed reforms in reform school practices cannot be accomplished. Within the agenda of the FACT for Minors project it was not possible to include young people's voices in the study. In the future, it would be valuable to conduct a similar, comparative study assessing the European practices from the perspective of children and young people placed in these institutions.

Appendix :

Limits and generative aspects of the project.

There were several limitations in the data:

Qualitative interviews are not representative of all different professionals, and one should not generalize the results. However, quite comprehensive and general practice recommendations were expected from the partner countries.

Subjectivity of "good practices", "challenges", and their definition. For example, good practices for care workers may be different from the practices that promote

young people's well-being and rehabilitation: we can only access the first but we aim at describing the latter.

During the project it came obvious that there are young people that are left out of these units. What happens to them? Where are the serious offenders? During this project we started to raise awareness of the position of the minors in adult prisons. We have had two meetings with the representatives from different ministries, National Institute for Health and Welfare, and the Criminal Sanctions Agency. We have visited the Helsinki prisons' unit for young men (less than 24 years of age). There are currently 10 minors in the Finnish prisons.

The Finnish team also raised a question of whether it is a sign of the dysfunction of the service system in general that we even need these places? At the same time it was really shocking to realize, how similar these young people's characteristics and challenges were in each partner countries. Is this a phenomenon that we cannot prevent?

Considering the actions carried out, what would you have improved in the structure and in the objectives of the project?

The project has been of great significance and cooperation with other teams has offered us an invaluable opportunity to learn from the systems in other European countries. However, the coordination of an EU-project involving several member states is always demanding. Regarding the relatively short time-line of the project, we would have hoped that the model for designing and implementing interventions would have been clarified more clearly right at the beginning of the project, in the first kick-off meeting in Rome. From the perspective of management, it would be easier if the administration (including reporting and financial management) took place in the EU participant portal.

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