

SPECIAL SCHOOL TEACHERS REQUIRE MORE GOAL-ORIENTED COLLABORATION WITH PSYCHIATRIC PROFESSIONALS IN NORTHERN FINLAND

ABSTRACT

Background. The problems of children and adolescents have increased in number and severity during the last years.

Objective. The purpose of this study was to elicit the views of special school teachers in the Oulu Province in Finland concerning their pupils' problems and the need, use and adequacy of relevant psychiatric services.

Methods. The information was collected from the Northern Ostrobothnia Hospital District in 1998 in Finland and responses were obtained from the 37 (97.4 %) special schools. The data were analysed using the content analysis method.

Results. Special-needs pupils had various behavioural and emotional problems that made it difficult for them to learn and for the teachers to teach. According to the teachers, the major obstacles in the process of helping special-needs pupils were the delayed admission for treatment and the lack of information necessary for the pupils' school work and goal-oriented aftercare, although there were also favourable experiences of functional co-operation and availability of useful information. Some schools lacked a reliable network for helping pupils and supporting teachers. The Finnish legislation on basic education obliges the providers of education to provide rehabilitation in connection with special education and to arrange relevant development, counselling and support services.

Conclusion. The rehabilitation of special-need pupils and the collaboration between school and mental health authorities is not optimally realised in spite of the legislation.

Keywords: psychiatric disorder, children, adolescents, special school, psychiatric services

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INTRODUCTION

School-aged children's problems and needs for care are often manifested as behavioural and emotional disorders and may be related to problematic life situations (1-4). In western countries, 15-22 % of school-aged children suffer from psychiatric disorders (2, 3, 5-7). A longitudinal epidemiological survey carried out in Germany focused on pupils aged 8 and 13. Two sets of measurements were made, and approximately 16 % of the pupils had psychiatric disorders on both occasions (5). Finnish epidemiological surveys have revealed psychiatric disorders in 14-22 % of primary school pupils aged 8-9 years (2, 3, 7, 8).

According to teachers' reports, 14-16 % of their pupils (7-12 yr.) have behavioural and emotional disorders (2, 4, 9). The need for psychiatric help is most pressing (38-44 %) among special-needs pupils (1, 10). Special schools also cater for intellectually disabled pupils, of whom 34-65 % have been shown by different studies to have psychiatric disorders (11-14). Most of the intellectually disabled persons in need of mental health services remain without adequate examinations and treatments (11, 15, 16). Pupils who are transferred from normal to special schools generally have multiple underlying problems (1) and are hence particularly liable to behavioural and emotional disorders (17).

Based on surveys carried out in the Oulu Province in 1998 and 2000, the behavioural and emotional disorders of children and adolescents have increased both in incidence and in severity (10). At school, pupils' problems are manifested as increasing behavioural and/or learning disorders. The problems may have been diagnosed at an early stage, but either no help has been available, or the parents and teachers have not known where to seek help. In a Finnish study on the marginalisation of children (18) public health nurses already identified many of the five-year-old children who, subsequently in primary school turned out to have inadequate basic care, exhibited an impaired mental well-being, and were hence at risk for marginalisation. The study failed to answer the question of why nothing had been done if the problems of these children had already been identified at the age of five. Moreover, the internal depressive symptoms of pupils often go unnoticed and without any form of intervention. (1, 5, 19)

Municipalities have set up special schools and/or special classes operating within normal primary and junior secondary schools to

cater for pupils with developmental, behavioural, or mental health problems that prevent their attendance in normal classes. According to the current Finnish practice, special education is tailored differently to intellectually disabled children (EHA), subnormal, or disabled children (EMU), pupils with mainly behavioural and adaptation problems (ESY) and children with physical disabilities (EVY), visual disabilities auditory disabilities (EKU), and reading and writing problems (LU-KI). As far as is feasible, each municipality with a hospital is also obliged to provide adequate education to hospitalised children. (20)

According to the statute on basic education (852/1998), the decision to enrol, or transfer, a pupil into special education should be preceded by a discussion with the pupil's legal guardian and, as far as possible, a psychological, or medical statement, or a social report concerning the pupil and his/her learning potential. Furthermore, in accordance with the law on administrative procedure (21), the involved parties must be heard and their access to information, as well as the right of the child to speak, must be guaranteed. Each special-needs pupil must be provided a personal programme of instruction (HOJKS), and the persons providing education to such pupils should also arrange supplementary rehabilitation and the other necessary development counselling and support. (20)

Pupils' behavioural and emotional disorders are generally not due merely to their intellectual disability, subnormality, maladjustment, or physical handicap, but also to some other problems inherent to the pupil's life situation, or consequent difficulties (1, 11, 17, 18). The child welfare clinics and school health care units, in particular, should recognise the impacts of psychiatric disorders on the child's learning ability and learning situations, and also inform the parents about them. According to the Oulu Province Board's report on the assessment of basic services (22), however, most schools have a school nurse present only for a limited time on a few days a week. School nurses do not have enough time to promote the welfare of children and adolescents with multiple problems and meet their parents. Special school pupils and their guardians have an even greater need for such support (1, 10). It is therefore important to find out what kind of problems pupils have and where help is available.

The purpose of this study was to elicit teachers' views of the problems experienced by special school pupils, their need for psychiatric health care, and the use and adequacy of psychiatric services. A fur-

ther goal was to describe the education and mentoring available to special school teachers for supporting their pupils' coping with, as well as the teachers' hopes concerning the development of psychiatric services.

MATERIAL AND METHODS

The data were collected from the Northern Ostrobothnia Hospital District in the course of a general survey on psychiatric health care in 1998 (10). The questionnaire was developed for the purposes of the project and addressed as a postal inquiry to the heads of the comprehensive and senior secondary schools, as well as special schools, within this district. The teachers were instructed to answer the questions together.

The questionnaire consisted of open-ended, questions. The teachers were asked about the problems they had encountered among their pupils, as well as the need for and the utilisation and functionality of psychiatric expertise and treatment. The teachers were further asked about the education and mentoring they had been given to support their work, and how they would like to improve the functionality of

Table 1. Special schools stratified by personal programme of instruction (HOJKS) and the number of pupils in 1998.

Schools	n	(Pupils) (n)	HOJKS (the number of pupils)			EHA/ EMU	EMU/ ESY	EHA/ EMU/ESY
			EHA	EMU	ESY			
Special schools	20	(724)		7 (317)	2 (93)	6 (148)	3 (62)	2 (104)
Special schools incorporated in normal comprehensive schools	10	(244)		5 (131)		2 (71)	2 (23)	1 (19)
Schools for children with intellectual disability	4	(156)	3 (49)			1 (107)		
School for children with impaired hearing	1	(57)				1 (57)		
School for children with physical disability	1	(50)				1 (50)		
Hospital school	1	(45)					1 (45)	
Total	37	(1276)	3 (49)	12 (448)	2 (93)	11 (433)	6 (130)	3 (123)

HOJKS = Personal programme of instruction

EHA = Special training-oriented programme of instruction for intellectually disabled pupils

EMU = Special accommodated programme of instruction for subnormal and disabled pupils

ESY = Special programme of instruction for disordered pupils

psychiatric services. The questionnaire was sent to 54 primary schools, 24 junior secondary schools, 20 senior secondary schools, and all 38 special schools operating in the area. This paper focuses on the responses obtained from 37 (97 %) of the special schools. Table I shows the schools that participated and their respective numbers of pupils (n=1276), classed by the personal programme of instruction.

The principal author transcribed the responses, verbatim, obtained from each school into separate text files. The data were then entered into the NUD*IST 4 software (23), which was developed for processing qualitative research. The software also produced quantitative findings, including frequency and percentage distributions. There were many kinds of responses to the questions. Some respondents had considered the questions quite profoundly, while others replied in one or a few words.

The data were analysed employing methods of content analysis (24, 25). The unit of analysis was utterance, which could be a word, a sentence, or part of a sentence. The research data were reduced by making questions. The reduced forms of the respondents' descriptions were categorised into mind maps and combined into categories. The problems described by the teachers were reduced by, for example, including aggressiveness as a problem only once in the analysis of the responses from a given school. The comparison of reduced replies was continued, and utterances expressive of similarities were classified into categories. Next, each category was given a general heading, such as behavioural problems, which made up a subcategory. Aggressiveness was placed into the same subcategory as behavioural problems. The subcategories were tested by presenting questions, e.g. "How do the pupils' problems interfere with the teacher's and pupils' activities in the classroom?", and more generic categories were then formulated. After that, the connecting categories were outlined. The generic and connecting categories were products of reflection and abstraction by the researchers. (24, 26)

The permanence of the classification and categories was re-assessed by the co-authors (27-29). The data pertaining to the availability and functionality of services were reduced, classified and abstracted by asking: What is available and what things work? What is not available and what things do not work? The availability of information necessary for the pupil's school work was classified and abstracted as a separate entity.

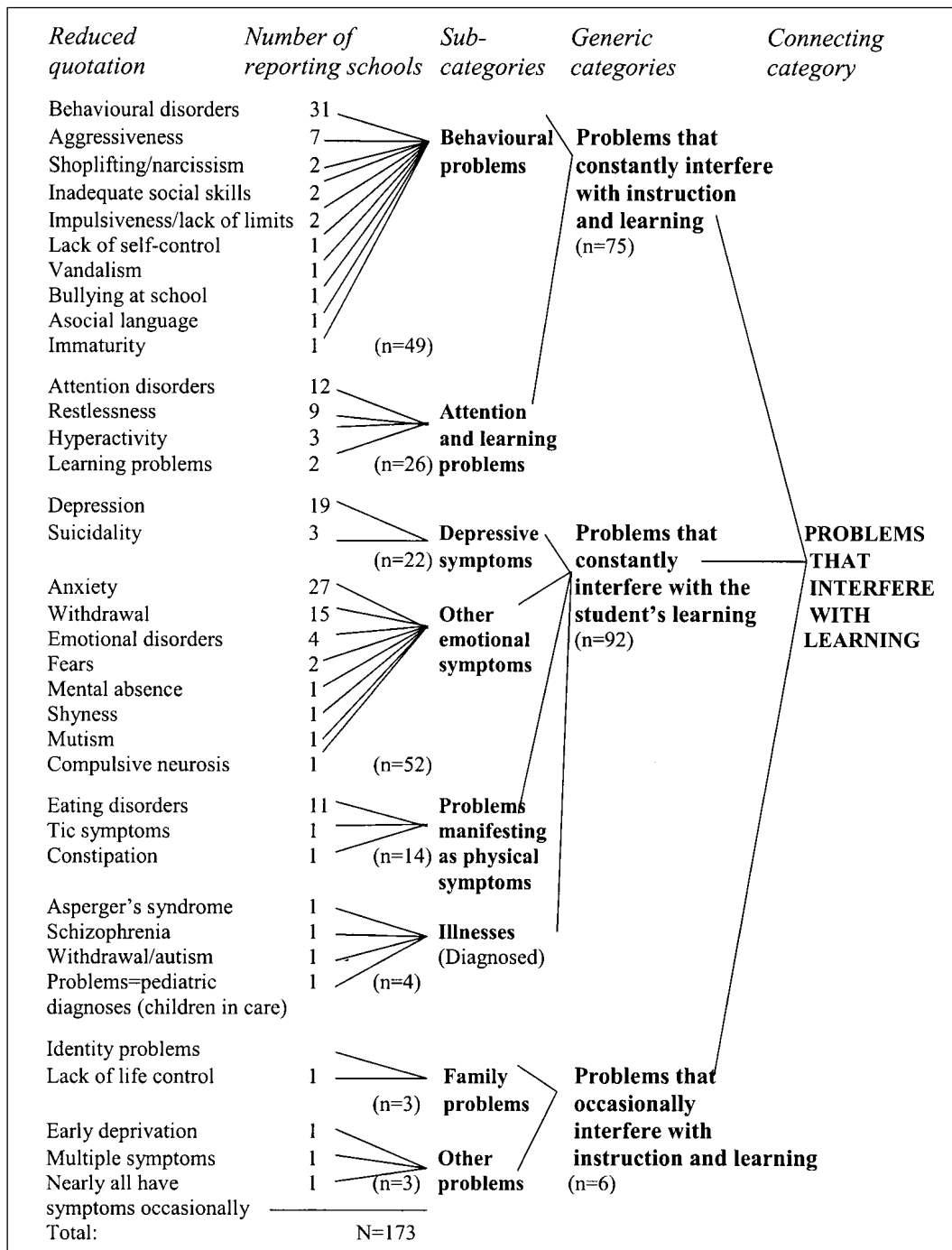


Figure 1. Category of problems that interfere with the learning of special school pupils based on reduced responses by special school teachers.

RESULTS

Problems of special school pupils

The teachers used a variety of labels to describe their pupils' problems. Figure 1 shows the individual problems identified by the teachers among special school pupils, as well as the classified and abstracted subcategories. The responses from nearly all schools (31/N=37) pointed out behavioural disorders of variable severity. The responses from a given school occasionally identified certain aspects of behavioural disorder in more detail, such as aggressiveness and vandalism, but they were here classified into the same subcategory.

The classification of reduced expressions assorted the following 8 subcategories: behavioural disorders, attention deficit and learning problems, depressive symptoms, other emotional symptoms, problems manifested as physical symptoms, psychiatric and physical illnesses (diagnosed), family problems and other problems. The responses to this item contained most descriptions (n=92) of problems that constantly interfered with the pupil's personal capacity to learn, while the second largest category (n=75) consisted of problems that constantly interfered with instruction and learning, and there were 6 descriptions of problems that occasionally interfered with instruction and learning. These were used as generic categories. Next, the combining category was abstracted as "problems that interfere with learning". The teachers from the separate schools reported a total of 173 different problems.

Need of children and adolescents for specialised psychiatric health care

Help for pupils' problems had been sought at the local university hospital. Some respondents reported symptoms of their pupils, while some mentioned certain diagnosed illnesses that caused problems at school and a need to seek medical help. Help had been sought for both behavioural problems (n=15) and emotional symptoms (n=11), illness and family problems (n=3). The consultations for help (N=36) were clearly less numerous than the number of problems reported by teachers (cf. Fig. 1). At the next stage, the data were reviewed for teachers' descriptions of the use and functionality of child and adolescent psychiatric services.

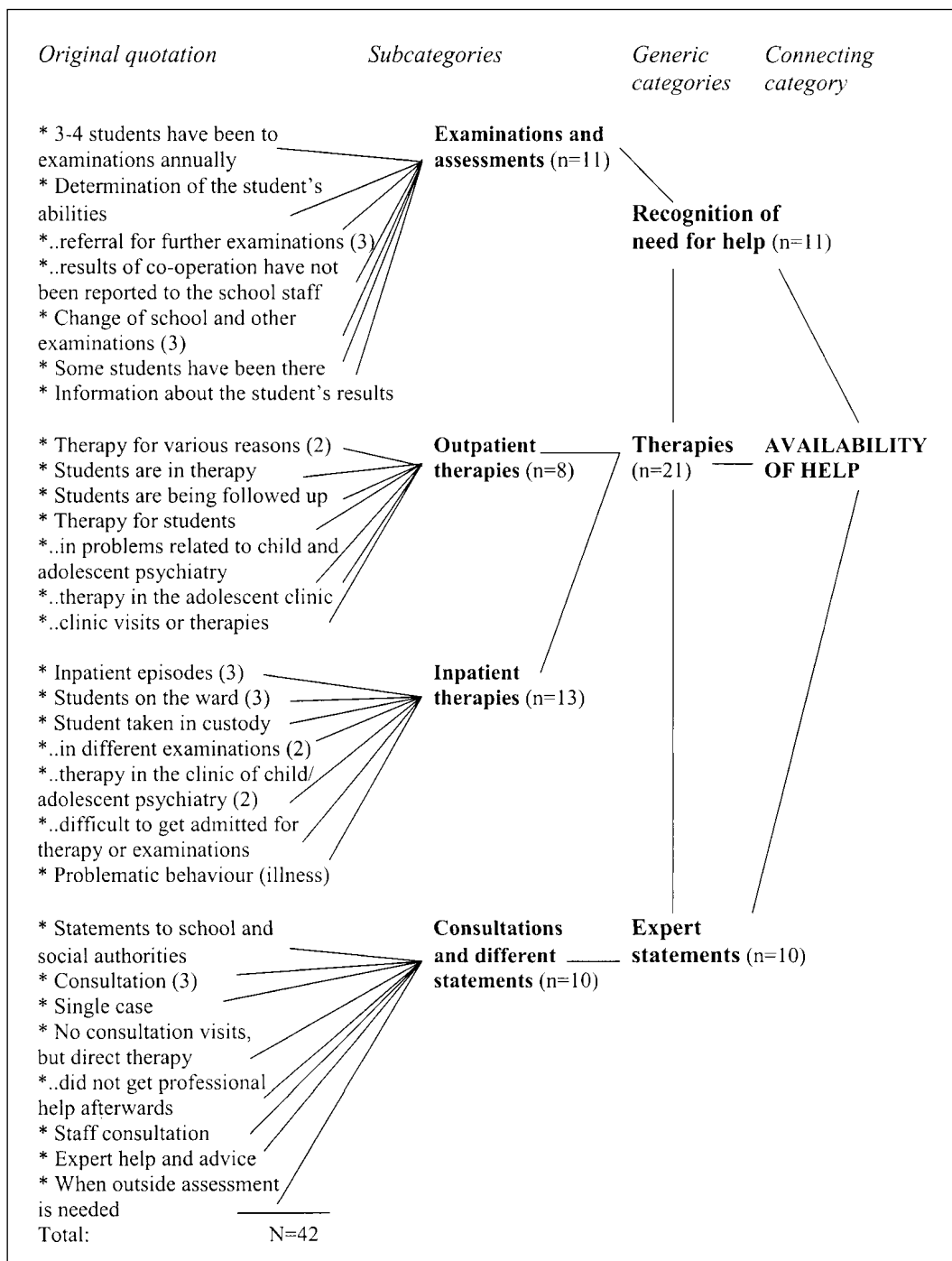


Figure 2. Category reflecting the use, quality and availability of services provided by a university hospital for special school pupils.

Use and functionality of specialised health care services

According to the responses (N=37), child and adolescent psychiatric services available at Oulu University Hospital (OYS) had been used by 27 (73 %) schools. These services had not been used by nine schools, of which six, however, had used services provided by other central hospitals.

The services provided by Oulu University Hospital to special schools included examinations and assessments, outpatient treatment, inpatient treatment, consultations and various statements (Fig. 2). The services included the verification of the need for help and various treatments and/or therapies and expert statements. The experiences of the schools (27) that had used specialised health care services were good in seven (25.9 %) cases, variable in 12 (44.5 %) cases and negative in five (18.5 %) cases. Three (11.1 %) schools that had used these services did not answer this question. Favourable experiences of functional services were reported from the schools where the teachers had participated in the process of helping their pupils.

What is available and what things work?

The data included descriptions of satisfaction with the availability and quality of services, as well as the functionality of co-operation. By classifying the reduced descriptions, the connecting category was formulated and entitled "Co-operative help and support in everyday life". The name of the connecting category illustrates the content of the service in the cases where the respondents felt they had received help. By comparing, classifying and abstracting the descriptions of the functionality of services, a connecting category was formulated and labelled "Availability of services and goal-oriented co-operation".

"Quick admission in acute situations"

"- the detailed baseline assessment helps to start the work and to delineate/describe the problem." "Telephone service has been good."

"The feedback discussions following inpatient episodes have been good."

"... good suggestions for further work ... Things are not left hanging in the air." "Prophylactic effect"

The reports of good experiences from some school also included proposals for improvement concerning the follow-up of aftercare, or the availability of test results useful for school work.

"In principle, they are good. The follow-up at school after a pupil's discharge from hospital should be improved. The school staff should be informed of the pupils' test results without a separate request."

What is not available and what things do not work?

The responses that commented on the lack of services mostly highlighted the lack of examinations, treatments and/or therapies, opportunities for aftercare and co-operation, as well as special expertise and the teachers' continuing education. By comparing, grouping and abstracting the responses, a connecting category was formulated and entitled "Not enough help or support in everyday life".

"It is difficult to get someone admitted for examinations and treatment – the process is too slow."

"More inpatient episodes". "There's a need for neurologist services (e.g. more detailed examinations)."

"Some link ... for pupils with both intellectual disability and mental health problems ..."

"There should be more follow-up after the inpatient episodes."

"There could be regular co-operative meetings at least twice per school year."

"Telephone consultations should be arranged regularly ..."

"Regular continuing education."

Inadequate functionality of services was described by the respondents in situations where services were not flexibly available, the users were dissatisfied with the quality of services, or the continuity of treatment and target-oriented co-operation were not functional. The negative experiences were mostly related to the long waiting times for examinations and treatment, the lack of co-operation, and the difficulty of acquiring information about matters related to the pupil's school work. Dissatisfaction with the specialised health care services was described as follows:

"We are often told that there is no room in the hospital and the waiting times are long. The threshold to refer to, or seek, professional help therefore remains high and may become even higher."

"Improvement of the quality of therapy: no consultation visits, but ... therapy."

"More detailed treatment plans."

”The basic feeling is that the hospital is somewhere very far away, and that the person gets admitted and, sometimes, later returns to school. ... The hospital does not contribute much to the everyday life at school. The heavy medication started at hospital has sometimes caused problems after discharge.”

By grouping and abstracting the comments on the lack of functional services, a connecting category was formulated and entitled ”Availability of services and goal-oriented co-operation are not functional”

Use and functionality of services at family counselling clinics

The services of family counselling clinics had been used by 30 schools out of 37. The experiences of family counselling services were reported as very good by two schools and mostly good by 17 schools. One response described the experiences as notably family- and human-oriented. The family counselling staff had also drawn on the teachers’ expertise, and the teachers felt they had been really participating in the process of helping the pupils.

”Positive. Teachers feel more free to consult the family counselling clinic. The homes are familiar with the family counselling clinic, and the threshold to contacting is hence low and only few parents are opposed to such consultation. The particularly positive point is that the teachers are invited to the initial and final meetings at the family counselling clinic. There is good telephone consultation, and even anonymous questions are answered”

Eight schools reported variable experiences, and two schools did not evaluate their experiences, as it was considered difficult. One comment on variable experiences pointed out that the process of working out problems was slow and the principle of confidentiality occasionally caused problems. It was also difficult to arrange an appointment for a child, or an adolescent, because the family counselling clinic expected the parents to make the appointment. Only one response reported downright negative experiences, but that comment was not specified further.

The constant staff turnover was said to make systematic co-operation difficult. Some of the respondents suspected that the family counselling clinic staff are not familiar with the everyday work at school and do not always trust the teachers’ expertise. Aftercare may

also remain “hanging in the air” and fall completely under the teacher’s responsibility. One respondent pointed out that not even teachers always understand the significance of the tests and examinations.

Availability and functionality of other services

Experiences of other services, such as those of private medical practitioners, were reported by 16 schools, while 15 schools had no such experiences, and the answer was missing in six cases. The experiences of other services were variable. One respondent pointed out that their experiences were good, but the pupil dropped out of treatment/therapy: *”good, but the parents did not continue to support the treatment/therapy. Not enough aftercare.”* Another response focused on therapeutic relationships and complained about the lack of information. *”The information is really inadequate. You do not even know if the pupil has attended the therapy sessions, or not. We cannot monitor the pupil’s non-attendance during this therapy.”* The teachers of one school had no experience of such services, but they had heard about them: *”We have heard that he is in treatment/therapy; that’s all.”*

Availability of information necessary for the pupil’s school work

Nine schools did not answer this question. The availability of information necessary for the pupil’s school work was adequate (n=9), variable (n=3), or inadequate or non-existent (n=16). These experiences were combined into a category titled “Sometimes you get information, sometimes you don’t”. The category reflects the lack of goal-oriented co-operation: information necessary for the pupil’s school work was only provided occasionally to the schools. Satisfaction with the availability of information and co-operation was described by one respondent as follows: *”... they have always contacted the teacher, and they have even been present in the co-operative negotiations.”* Another response described dissatisfaction with the availability of information and pointed out some possible reasons for the lack of information: Satisfied? *”No, we’re not. ’Confidentiality’; possibly parental reluctance to co-operate (fear, shame??)”*.

The teachers found it sometimes difficult to understand the language used to report the findings. The following responses show how some teachers were disappointed at the lack of information:

”The primary nurse directly reported to the teacher about the matters of one pupil (during the past ten years). –The teachers ask the consulting psychiatrist if they need information. – The hospital usually provides no information to the school, and the teacher has not been invited to attend meetings at the hospital. – Some findings (e.g. the psychologist’s statement) are so difficult to understand that it seems the hospital and the school are speaking different languages. The views about the adolescent and his/her life situation may be quite contradictory.”

Further education and mentoring of special school teachers

At 26 special schools, the teachers had had some further education concerning children’s and adolescents’ problems. No further education had been provided at ten schools. Five of the responses from these schools pointed out that such education had been part of the special teacher’s professional education. The answer to this question was lacking in one case. The experiences of further education were good at 17 schools, variable at three, scant at three, and too short-term and quite general at one. The good experiences were described as follows: *”... helps to understand the child’s problems and to find ways to help the child ...”*. According to two responses, more education would be needed.

Mentoring had been available at 17 special schools, no mentoring had been available at 16 schools, and four schools did not answer. Good experiences were reported by 14 schools, of which one needed further personal mentoring. One school had scant experiences. The need for mentoring was mentioned:

”... We have no experiences of mentoring. But we would definitely need it, as we often hear exhausted comments about the lack of opportunities to analyse one’s experiences. ”Collegial mentoring”, or discussion between teachers, or other adults, help some ...It is not possible for teachers to have mentoring during their working hours. And there are probably too many budget cuts to make such mentoring possible.”

Mentoring had been quite useless at one school, and had been irrelevant at another.

Special school teachers' wishes concerning the development of psychiatric services

Special school teachers hoped for more multi-professional co-operation in the everyday life of schools and weekly, or even daily, help with problematic cases. There should also be more opportunities for contacts and support for everyday education and instruction. Feedback on the pupils' treatment and expert help for a personal programme of instruction (HOJKS) were considered important.

"Prompt feedback about the hospital visits to the school nurse and, if necessary, the teacher."

"Co-operation; More would be needed ... should participate in the personal programme of instruction in case the pupil needs treatment and/or therapy."

The teachers hoped for information about their pupils' treatment, which could be provided by the specialised health care staff. They also hoped for more education about child psychiatry because of the large variety of problems shown by special school pupils. Open-house at the hospital had been a good way to find out more, and there should be more such occasions. It would be especially useful to find out about the operation of the child psychiatry wards.

The expectations of special school teachers with respect to experts of child and adolescent psychiatry include multi-professional co-operation in everyday work, feedback to the school and expert help in the personal programmes of instruction, more information about the available services and education, as well as goal-oriented and reciprocal co-operation. By further grouping the expectations, the following two generic categories were formulated: multi-professional support and expertise in everyday life, and goal-oriented and reciprocal competencies. The connecting category was abstracted as "Multi-professional and goal-oriented co-operation in everyday life". This category highlights the teachers' expectations for the development of services.

DISCUSSION

For the present study, information about psychiatric disorders was collected in 1998 from all special schools in the Oulu Province. Ac-

According to the findings, pupils' problems and distress are manifested in many different ways and the problems interfere with both pupils' and teachers' work. Moreover, pupils' behavioural symptoms also disturb other pupils' work. According to Ikäheimo (3), teachers are well aware of their pupils' symptoms, but the criterion for referral to treatment is that the teacher is unable to make the child learn, or stop disturbing others. Even in the present survey, the responding teachers described special pupils' problems that had caused them to consult the psychiatric professionals of the university hospital notably less often than their more general behavioural and emotional problems. The results seem to indicate that teachers are slow in seeking help for their pupils and tend to assess the situation critically, as has already been shown in previous studies (e.g. 1, 3, 5).

Special schools were satisfied with the functionality of specialised health care services when services were available and there was goal-oriented co-operation. Dissatisfaction was described as situations where services were not flexibly available, or the teachers were not content with their quality, or the continuity of treatment was not guaranteed, or there was no goal-oriented co-operation. Some dissatisfaction was also caused by the fact that psychiatric services are not always available for the mental health problems of intellectually disabled pupils. Previous studies (12, 16) have also shown that most of the intellectually disabled people who need mental health services remain without appropriate assessment and treatment and/or therapy.

According to the teachers' responses, child and adolescent psychiatric services were felt to be more accessible in the family counselling clinic, and at the local university hospital the access to services was found to be difficult and slow. However, a well-timed support of special health care could give necessary assistance to the schools by precipitating the pupil's recovery.

The availability of information necessary for pupils' school work was considered highly problematic. Based on the teachers' descriptions, information may, or may not, be available. The descriptions by the respondents satisfied with the availability of information, however, showed that the necessary information can be obtained. Professionals may interpret the law on privacy protection (30, 31) so strictly as to even make it difficult to see what is best for the child. The legislation passed by the society to protect a certain group of people may even be quoted in ways that cause harm to the very persons it is meant to protect. Similarly to the public health care services, the private

services also included problems of emphasising privacy protection too much, and the main challenge was the need to co-ordinate the content and functionality of the whole network (parents, teachers and social and health professionals).

According to Øvretveit (32), confidentiality in many modern social and health care service systems consists of within-team confidentiality, which means that the patient's data are not disclosed to persons who are not members of the team without the child's and/or parents' permission. Problems arise when different members of the team operate in accordance with different confidentiality principles, or the sanctions for violating confidentiality are weak, or non-existent (32). Issues of confidentiality should be discussed in more detail, as it is possible that a health care professional in a difficult situation will choose to maintain confidentiality "just in case". Nevertheless, according to the Finnish law on specialised health care, the intermunicipal board for the hospital district is obliged to provide state and municipal authorities with information considered necessary for them to do their duties. Delays and problems in the flow of information will result in numerous extra procedures, which impair the pupils' recovery and increase costs (1, 33).

Education and mentoring were considered important ways to support teachers. Nevertheless, about one third of the responding schools provided no opportunities for their teachers to attain further education. Mentoring was only available in about half of the schools. According to Arajärvi (34), teacher education contains little or no information on how to approach a physically, or psychologically, deviant pupil. In our study, the acquisition of further education and mentoring was generally up to each teacher's own activity and/or the employer's support. Mentoring has been considered to help the teacher to perceive his or her work more analytically to provide new approaches to confirm professional identity, and to support the teacher's personal growth and work motivation (35-37).

The credibility of the findings in this study may be questioned on the basis that the teachers of each special school were asked to answer the questionnaire jointly. We cannot know if all teachers actually contributed to the content of the answers. The findings concerning the problems encountered among pupils and the seeking and availability of help were parallel to those obtained previously (e.g. 1). When assessing the applicability of the findings, we can postulate

that the special school teachers have jointly reflected on the content of the questions more thoroughly than they would have if they had filled in the questionnaire on their own. This would make the findings more widely applicable.

The dimensions of children's behavioural disorders have been studied and tested by, for example, Hartman et al (38) in a multi-national study, where they discovered validity problems in the classification. In this study, the teachers' descriptions of the problems most commonly encountered among special school pupils were classified into subcategories and generic categories (Fig. 1). We also classified the problems for which help had been sought at a university hospital. The contents of the categories turned out to be quite similar, although the teachers listed notably fewer problems of the latter type than common pupils' problems (Fig. 1). The process of analysis has also been illustrated by direct quotes of the respondents' comments, in order to allow the reader to evaluate the researcher's neutrality.

The other researchers of the team commented on the classified sets of data and suggested ways to specify the classifications. In these situations, the researcher re-read the data and re-classified them several times. Whenever there was some ambiguity concerning the interpretation, the researcher re-classified the data. For example, the problems encountered among special school pupils (Fig. 1) were classified twice by the researcher (24.9.2001 and 10.2.2002, and the percentage of agreement shown by the reliability of the classification was $168/173 \pm 5 = 97$). The services available to special school pupils at the university hospital (Fig. 2) were respectively classified twice, the reliability of the classification being $46/42 \pm 4 = 91$ (24, 25, 39).

In the future, the services of child and adolescent psychiatry are expected to develop towards goal-oriented and multi-professional co-operation. The research indicated that the data also included descriptions of the functionality of goal-oriented and multi-professional co-operation and the availability of information necessary for the pupils' school work. Still, the lack of functional integration between hospitals and schools may be problematic at many special schools. In the case of special schools, where pupils are placed following assessment by social and/or health care professionals, it is difficult to understand the lack of integrated aftercare. Is it so that the sparsely populated northern regions are becoming marginalised in terms of expert services, too? Even these services may be concentrated, along with

the general population, in the most densely populated parts of the country, and long distances always make it difficult to maintain contacts.

Proposals for further research

In Northern Finland, further research should focus on studying the treatment chain and/or the service network of special school pupils and the responsibilities for co-ordinating the different stages. Who is responsible for the overall functionality/working of the multi-professional network? Is the responsibility for the co-ordination of aftercare left to the pupil's parents? If so, who helps and guides the parents?

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