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Using self-report surveys in schools to study violence in alternative care: A methodological approach

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Abstract

In this article we explore a Finnish nationally representative self-report survey (N = 155, 299) conducted in a school as a tool to advance the study of violence in alternative care. By analysing the survey, we were able to provide plausible prevalence and estimates of risk factors of violence in alternative care, suggesting that self-report surveys conducted in schools are a useful and valid methodology for this type of research. Conducting the survey in a school setting enabled us to reach a nationally representative population of adolescents living in alternative care, which would be difficult to achieve in any other way. However, studying violence in alternative care with a school survey requires a large sample size. Even with quite a substantial dataset, detailed explanatory analyses were not possible due to the low number of observations. This emphasises the importance of other types of data in addition to survey data in explanatory analysis. Based on this study, we concluded that nationally representative self-report surveys conducted in schools could provide a useful tool and possibilities for replicable research design, which could thereby develop the research field further.

KEYWORDS
adolescents, alternative care, children, self-report survey, violence

INTRODUCTION

The present sentiment embedded in the Convention on the Rights of the Child (CRC) is, in short, that all children are entitled to care and protection and that it is the duty of the state to ensure these rights. If a child needs to be separated from their parents for protection and care by child protection measures and placed in out-of-home care, the child's right for care and protection remains and the duties of the public authorities become more prominent. Legal norms and a variety of quality standards for alternative care exist both internationally and nationally to guide public authorities and practitioners. Nevertheless, children may experience violence while in alternative care (e.g., Biehal et al., 2014; Carr et al., 2020; Sherr et al., 2017). Violence in alternative care takes on different forms and is explained through a variety of mechanisms. Furthermore, alternative care varies within and across different countries and child welfare systems (e.g., Burns et al., 2017). Consequently, research, needed to provide information about the nature and prevalence of violence in alternative care, is not without methodological challenges. New tools for measuring the nature and prevalence of violence in alternative care are needed to build empirically based research knowledge on violence and advance the study of violence in alternative care.

In this study we explore a nationally representative self-report survey conducted in a school as a tool to respond to previous methodological challenges. By analysing prevalence and risk factors of violence in alternative care based on

Key Practitioner Messages

- Nationally representative self-report surveys at school could provide a useful tool to study violence in alternative care.
- Children living in alternative care have the right to provide the information of their violence experiences in a survey in a same way than children living at home.
- Comparison between rates of violence in alternative care and at home provides a relevant platform to capture the nature and extent of violence experienced by children living in alternative care.

an extensive survey conducted among adolescents, we discuss benefits and challenges of the self-report survey data in studying violence in alternative care. We use the concept of 'violence in alternative care' to describe different types of physical violence, sexual violence and harassment, and emotional maltreatment, which in family violence literature would fit under the concept of maltreatment (WHO, 2016) or in the alternative care setting, under the concept of institutional abuse. However, 'institutional abuse' includes a variety of definitional problems (Corby, 2006; Stein, 2006) and more recent terminology suggests the use of 'violence in alternative care', although it also includes some definitional challenges (Brodie & Pearce, 2017).

RESEARCH ON VIOLENCE IN ALTERNATIVE CARE

Due to several well-documented methodological challenges, research on violence in alternative care is fragmented, scarce and has yet to attain an empirically driven comprehensive picture (Brodie & Pearce, 2017). First fundamental challenge is the definitional problem. Studies differ in defining alternative care and how it is seen in relation to extended family or kinship care (Brodie & Pearce, 2017). Further, research differs in defining violence in care. Those challenges are familiar with research on violence against children in general. For example, what is seen as unacceptable behaviour towards children and how concepts of violence, abuse, neglect and maltreatment are defined. These variations in defining both alternative care and violence arise largely from legislative and cultural differences. It is thus argued that a key element in understanding the scale and nature of violence in alternative care is to focus on regional and local analysis with an appreciation of cultural and historical context rather that aiming for creating an international picture (Brodie & Pearce, 2017).

Several studies have aimed to provide an understanding of violence in alternative care by estimating its prevalence. For example, in a systematic review involving 18 epidemiological studies from the United Kingdom, the United States and Australia, Biehal et al. (2014) found that the incidence and prevalence of violence in alternative care ranged from 0.27–2 per cent and 3–19 per cent, respectively. Alternatively, Sherr et al. (2017) found in their systematic review that rates of maltreatment including physical and sexual abuse ranged from 13 to 93 per cent in large institutional settings. The most recent systematic review by Carr et al. (2020) found rates of unspecified child abuse in long-term residential care ranged from 39 per cent to 100 per cent, rates of sexual abuse ranged from 15 per cent to 100 per cent, rates of physical abuse ranged from 14 per cent to 100 per cent, and rates of emotional abuse ranged from 16 per cent to 99 per cent.

There are also studies estimating risk factors for violence in alternative care. Existing studies have mainly studied only associations between child and adolescent demographic characteristics, such as gender, age, ethnicity and violence in alternative care. Studies suggest that girls are more likely to experience sexual abuse and harassment or mental violence in alternative care (Ellonen & Pösö, 2010; Euser et al., 2013) whereas boys are more likely to experience physical violence (Euser et al., 2014). Findings of ethnic background as a risk factor are mixed (Ellonen & Pösö, 2010; Euser et al., 2014). Further, early institutionalised children tend to report more adverse experiences during their time in institutional care (Hermenau et al., 2014) as well as those who have experienced violence or neglect prior to out-of-of home care (Katz et al., 2017), and some studies have compared different types of out-of-home care, such as family-based settings and institutions, but findings of those studies are also mixed (Leloux-Opmeer et al., 2016). Other characteristics or factors, such as health-related issues, have been studied much less than sociodemographic characteristics, although studies have shown those to be significant predictor of violence among children living at home (Peltonen et al., 2014). There are some studies suggesting that disabled children are at greater risk of all forms of abuse and neglect in alternative care (Biehal & Parry, 2010; Billings & Moore, 2004) and that children in alternative care are a high-risk group for psychological, psychiatric, educational, social, health and behavioural problems (Vinnerljung et al., 2005).

Lack of versatile risk factor research, inconsistency of findings, and huge variation in prevalence studies brings us to the second well-known methodological challenge in studying violence in alternative care: limitations in data available. Violence in alternative care is typically analysed using administrative data and maltreatment reports

(Biehal et al., 2014; Font, 2015). Case reports or official data in general may result in bias findings in evaluating prevalence, while all incidents are not reported. This has become evident in the inquiries into historical abuse of children in different types of institutional settings. These inquiries demonstrate how the testimonies given by ex-residents reveal such past experiences of violence which were not recorded in any official reports previously (e.g., Kendrick & Hawthorn, 2015; Sköld & Markkola, 2020).

Because of the limitations of official data, self-report surveys are often viewed as better in measuring prevalence of violence in general (Ellis et al., 2010). Research on violence in alternative care has reported this as well. For example, recent meta-analytic evidence indicated that prevalence rates of violence in alternative care on self-report surveys are considerably higher than prevalence rates based on informant studies (Hambrick et al., 2013; Havlicek & Courtney, 2016; Lueger-Schuster et al., 2017). The advantage of self-report survey data is also the possibility of getting more versatile knowledge on violence as well as other areas of life, which is important particularly in risk factor studies and analysing cumulation of adversities. Despite these advantages, self-report surveys are rarely used in research on violence in alternative care.

In addition to the source of the data, a lack of representativeness creates further data limitations. For example, case report data are usually based on one institution or are provided by NGOs, which may be of variable quality or methodological transparency (Brodie & Pearce, 2017). Also, existing survey studies are rarely nationally representative. Most of the existing survey studies are based on random sampling of children and adolescents living in alternative care (Carr et al., 2019; Euser et al., 2014; Havlicek & Courtney, 2016) by first including a random selection of childcare facilities in the selected study area and participants then randomly selected from each facility (Allroggen et al., 2017; Euser et al., 2014). This strategy is compared more to a community sample than a nationally representative sample. Further work is thus needed to develop tools for measuring the nature and prevalence of violence in alternative care and to provide replicable research designs. In this study, we explore a self-report survey methodology at school as a tool for providing nationally representative versatile knowledge of violence in alternative care to mitigate these data-related problems.

SELF-REPORT VICTIMISATION SURVEY AT SCHOOL

Self-report survey methodology is seen as the best way to measure violence, or experiences of crime in general, independently of criminal justice or clinical statistics in criminology (Kivivuori, 2011). Since the 1950s, the self-report method has had a close relationship with schools as an institutional locus of data collection when studying adolescents. It is shown that data collection in schools has higher external validity compared to home contacts. (Naplava & Oberwittler, 2002). There is also literature showing the importance of including minority groups into these surveys. On one hand, this provides information on minority groups which are difficult to obtain elsewhere when adolescents are able to respond to school surveys despite their background. On the other hand, it increases external validity of the data (Köllisch & Oberwittler, 2004). This is particularly true in countries such as in Finland, which have a unified education system for all children regardless of their socio-economic background or personal characteristics. Because school surveys reach all children and adolescents, self-report surveys at school have had a major impact in studying prevalence and nature of children's and adolescents' violence experiences at home, which was also very fragmented and scarce in nature. We argue that the same development can be seen in studying violence in alternative care by enabling adolescents living in care to report their experiences of violence through school surveys without their caregiver present and without pointing out their minority position. They have the right to provide that information in the same way as children living at home.

AIM AND CONTEXT OF THE STUDY

Aim of the study

In this paper, we explore how nationally representative self-report surveys conducted at school advance the study of violence in alternative care. By utilising the Finnish School Health Promotion Study (SHPS) from 2019 to analyse prevalence and risk factors of violence in alternative care, we discuss the benefits and challenges of self-report survey data in studying violence in alternative care.

Study context: a short overview of alternative care in Finland

Alternative care for children who need to be placed out of their home for child welfare reasons has two main types in Finland: foster care (foster families) and residential care in institutions. In addition, professional family homes exist in

the provision of out-of-home care as well and they are a mixture of the characteristics of foster and residential care. There are, for example, professional qualifications needed for the people working in the professional family home, similarly to residential care but differently from foster care. The number of children in a professional family home is the same (seven) as in a unit of a residential institution. According to the Child Welfare Act, foster care should always be given the first priority, and placements in residential care should be considered only if they are in the best interest of the child (Pösö & Huhtanen, 2017). In practice, residential care is used for teenagers in particular, and it may be a result of new decisions of a care order, emergency placement or voluntary supportive care, or that of a change of an earlier placement in another type of out-of-home care.

Alternative care is regulated by the Child Welfare Act and related quality standards of care. While children are in care, their rights for contact and movement, for example, may be restricted under certain conditions following a decision of restrictive measures. Such restrictions may be carried out only for the best interest of the child and never for the sake of punishment (Kalliomaa-Puha et al., 2021).

DATA AND MEASURES

Data

The study is based on the Finnish School Health Promotion Study (SHPS) 2019. SHPS is a school-based cross-sectional anonymous survey designed to examine the health, health behaviours and school experiences of adolescents. The SHPS is sent to all Finnish municipalities every second year and is aimed at all eighth and ninth grade students (14–16 years old) and first and second grade students in high schools and vocational schools (16–20 years old). The vast majority of schools participate to the survey resulting in 95 per cent of all age groups being represented in the data. The survey was conducted primarily electronically during the school day under the supervision of teachers. The survey was voluntary and anonymous. The SHPS has received ethical approval from the ethics committee of the National Institute for Health and Welfare.

The original data from 2019 included 155,299 respondents. Our analysis focuses on those who had been in alternative care for at least the past 12 months: 1240 (1.5%) of the eighth and ninth grade students and 516 (0.8%) of the secondary grade students. This represents the population of adolescents living in alternative care among this age group well (Finnish Institute for Health and Welfare, 2022).

Respondents whose alternative care had lasted less than 12 months were excluded from the data. This was done, because the survey asked about experiences of violence in the previous 12 months, and for the shorter stays in alternative care, it was not possible to be sure that the abuse had been perpetrated by the adults in the facility. In addition, secondary school students over 18 years old as well as those adolescents living somewhere other than a professional family home or residential care were excluded from the data. Finally, answers classified as implausible responses were also removed from the data. Respondents who had indicated that they could not see, hear, walk, take care of themselves or speak in a way that was understandable to anyone other than their family were classified as implausible. This kind of response combination was judged impossible for adolescents attending regular school. The final data includes 465 respondents living either in residential care or professional family homes, excluding children in foster care. For external validity, descriptive findings of violence in alternative care were compared to rates of violence among adolescents living at home (n = 126,501).

The analysis examines the experienced violence in alternative care by adolescents who have been placed in residential institutions and professional family homes for the past 12 months. Violence in alternative care constitutes experiences of sexual harassment and violence, emotional maltreatment and physical violence by a caregiver in alternative care. In addition, we analyse prevalence of restrictive measures perceived as punishment among adolescents in alternative care.

Measures

Sexual harassment or sexual violence was asked about in two separate questions, both including several items. First, the respondent was asked whether they had experienced harassing sexual suggestion or harassment on the phone or online in some of the following contexts: at one's educational institution; in hobbies; in the street, at a shopping centre or in other public place; in their own home on in some else's home; or in other private space. Second, the respondent was asked whether the respondent had experienced: compulsion to undress; unwanted touching of intimate parts of the body; pressure or coercion into sexual intercourse or other sexual acts; offering money, goods or intoxicants in exchange for sex.

In both of these questions, a follow-up question about the perpetrator was included. The list of potential perpetrators included: a friend or some other known child or adolescent; an adult in one's family (mother, stepmother, father, stepfather, parent's partner); foster mother or father; sibling (sister, brother, half-sister, half-brother); other relative (grandparent, aunt, uncle, cousin); instructor or caregiver at a professional family home or a child welfare institution; teacher or other adult at the school; coach, hobby instructor or similar; stranger; other person. The respondent was able to choose multiple options.

A dichotomous (yes/no) variable was constructed by indicating 'yes' if the respondent had experienced at least one of these acts of harassment or violence where the perpetrator referred to adults in alternative care (instructor or caregiver).

Emotional maltreatment was asked about by listing acts and asking whether a respondent had experienced some of those acts. The acts were: refused to speak to him for a long time; verbally abused, for example, called names; threatened to abandon or leave one alone; throw, hit or kicked objects (e.g., slamming doors); locked one up; threatened one with violence. The acts of **physical violence** asked were: grabbed one so hard that it hurt; pushed or shaken one angrily; pulled one's hair; slapped one; hit one with their fist or an object; kicked one; otherwise hurt one physically. A follow-up question about the perpetrator was made for those indicating some experiences of mental or physical violence. Options were: mother or stepmother, father or stepfather, foster mother, foster father, instructor or caregiver at a professional family home or a child welfare institution, other parent or guardian. The respondent was able to choose several persons.

One dichotomous (yes/no) variable was formed from the questions about emotional maltreatment and one from the questions about physical violence. If the respondent had experienced at least one of the acts and where the perpetrator referred to adults in alternative care, a respondent was categorised as 'yes' for emotional maltreatment and/or physical violence. Instead of individual items, aggregate-level dichotomous variables were used to have a higher number of observations in maltreatment and violence variables, following the common way in analysing violence experiences of children and adolescents (see e.g. Finkelhor et al., 2015).

For the analysis, a dichotomous sum variable of above-described sexual abuse or harassment, emotional maltreatment and physical violence was also constructed to describe whether the respondent had experienced at least some of those forms of violence at least once during the past 12 months.

Health-related characteristics were used in estimating potential risk factors of violence in alternative care. Health-related characteristics included variables of perceived health, long-term illnesses or health problems, moderate or severe anxiety, depression and physical or cognitive limitations. The question about perceived state of health included the following options: 1) very good, 2) fairly good, 3) average, 4) fairly bad or very bad. The variable was dichotomised (0 = very good or fairly good, 1 = average, fairly bad or very bad) for the analysis. Respondent's long-term illness or health problems were measured by if a respondent had any illnesses diagnosed by a doctor with a yes/no question. The variable describing moderate or difficult anxiety is based on the GAD7-scale (generalised anxiety disorder). The answer options in the question battery of seven sub-questions were 1) not at all, 2) for several days, 3) on most of the days and 4) almost every day, and they were re-classified as follows: 1 = 0, 2 = 1, 3 = 2, 4 = 3. The variable was dichotomised (0–9 points = no anxiety and at least 10 points = moderate or difficult anxiety. Depression was scanned with PHQ-2 scale [Patient Health Questionnaire 2]. Answer options were 1) not at all, 2) several days, 3 more than half the days or 4) nearly every day, and they were re-classified as follows: 1 = 0, 2 = 1, 3 = 2, 4 = 3. The variable was classified as dual (less than 1 point = no depression and at least 1 point = depression).

Physical limitations were measured by asking which of the following are easy or hard for the respondent; seeing, hearing, walking, taking care of oneself, talking. A similar question was presented about cognitive limitations and included learning, remembering, concentrating, acceptance of the change, behaviour controlling and making friends. The answer options in both questions were: no difficulties, some difficulty, a lot of difficulty, cannot do at all. A dichotomous variable was formed from both of the questions, where respondents were given a value of 'yes' if they answered 'a lot of difficulty' in at least one of the activities listed in the question.

Placement-related factors included variables describing the type of child welfare facility where a respondent lives, including: professional family home or a residential institution; duration of the current replacement: 1–3 years, 4–6 years or at least 7 years; number of different placements over lifetime: 1–3 or at least four.

Background characteristics included variables describing respondent's gender (male/female), school (primary school or secondary school) and foreign background (whether the respondent was born in Finland or abroad).

Restrictive measures were used as an example of group-specific questions. Respondents background factors or living situations were not used to determine the presentation of specific questions, but previous responses were utilised to target specific questions. Utilising online surveys allows for target-specific questions to generate in response to specific respondents according to previous responses. This allows for posing alternative care-related questions to display just those respondents indicating that they are living in alternative care. The SHPS questions related to experiences of

restrictive measures was targeted to just those living in alternative care. In SHPS, it was asked whether the respondent had experienced some of the following: restricting one's contacts, restraining, restricting one's freedom of mobility, having been denied food as a punishment, a group punishment and being punished without knowing why. As described above, children's rights for contact and movement may be restricted under certain conditions for the best interest of the child. However, these should not be used as punishment. Despite this, adolescents may perceive some incidents as punishment, and those experiences are important to study to improve practices. In this analysis we used a dichotomous (yes/no) variable to describe if respondent had perceived some restricting measures as punishment by combining three latest items.

Analysis strategy

Rates and differences in rates according to background characteristics were analysed by using distributions and cross-tabulations. The chi-squared test was used to test statistical significance. A logistic regression analysis was performed to analyse associations between dependents and independent variables for estimating potential risk factors. As a dependent variable a combined variable of emotional maltreatment, physical violence, sexual harassment and sexual violence was used. A combined variable indicated 'yes' if the respondent had experienced at least one type of emotional maltreatment, physical violence, sexual harassment and sexual violence. Health-related characteristics, placement-related factors and background characteristics including respondent's gender, school and foreign background were used ad independent variables. The statistical analyses were performed using SPSS Statistics 26.

RESULTS

Estimating prevalence

Of the adolescents in alternative care (n = 465), 8 per cent had experienced physical violence, 14 per cent emotional maltreatment and 7 per cent sexual violence or harassment during the past 12 months perpetrated by an instructor or a caregiver in alternative care. When analysing specific acts seperately, for example in physical violence, differences in rates between acts (pushing, shaking, hair pulling, hitting, kicking) were very small.

Asking several violence experiences in the same survey also enables the analysis of poly-victimisation, which is suggested to be a major issue among all youths. Of all adolescents in alternative care, 18 per cent had experienced some type of violence measured here. Experiences of maltreatment perpetrated by adults in the child protection system seem to pile up to some adolescents. Approximately one-fifth of the adolescents who had experienced violence in alternative care reported they had experienced all the forms of violence and 45 per cent at least two forms of violence asked in the survey.

To evaluate the external validity of the measure among adolescents in alternative care, findings can be compared to findings among adolescents living at home. According to the SHPS, 10 per cent of adolescents living at home with parents (biological or step) reported experiences of physical violence, 15 per cent for emotional maltreatment and less than 1 per cent for sexual violence or harassment. Rates of physical violence and emotional maltreatment are very similar to rates among adolescents in alternative care, which can be seen as a support for external validity. Rate of sexual abuse was significantly lower among adolescents living at home, which also supports external validity, while sexual abuse in the family (incest) showed to be much less common than other forms (Fagerlund et al., 2014; Sariola & Uutela, 1999).

However, among adolescents living at home, experiences of milder forms of physical violence were clearly more common than experiences of severe violence; whereas among adolescents in alternative care, variation between specific acts was very small. This could indicate that adolescents in different contexts identify violence differently and in the home setting, milder forms of violence are identified easier.

Variation in prevalence can be analysed in association to respondents' background characteristics (Table 1). Statistically significant differences can be found in regard to several health-related background characteristics and factors related to place and duration of care. Between boys and girls in alternative care, statistically significant differences were found only in experiences of physical violence when 12 per cent of boys and 6 per cent of girls reported these incidents. Adolescents with foreign background experienced more of all types of maltreatment in alternative care than those with Finnish background (Table 1.) These differences according to background factors may imply that girls or adolescents with foreign background are more at risk for institutional abuse. However, differences may also reflect differences in tendency to identify abuse and therefore cannot automatically be seen as risk factors. When compared to adolescents living at home, girls reported more emotional (girls 23%; boys 8%) and physical violence (girls 13%; boys 6%) and

TABLE 1 Proportion of those who experienced violence in alternative care according to background factors, % (n = 281–393)[a]

	Emotional maltreatment	p-value	Physical violence	p-value	Sexual harassment and violence	p-value	At least some type of violence	p-value
Gender		0.055		0.114		0.097		0.263
Female	23		6		8		33	
Male	18		12		13		28	
School level		0.223		0.112		0.529		0.143
Primary school	22		10		11		31	
secondary school	17		6		12		26	
Foreign background		<0.001				<0.001		<0.001
Finnish	16		5	<0.001	3		22	
Foreign	42		32		40		58	
Child welfare facility		0.023		0.041		0.067		0.246
Professional family home	30		14		16		37	
Child protection institute	16		7		9		26	
Time in placement		0.337		<0.001		<0.001		0.015
1–3 years	17		3		4		24	
4–6 years	29		20		22		42	
At least 7 years	19		13		16		29	
Number of different placements		0.001		<0.001		<0.001		<0.001
1–3	17		5		7		24	
At least 4	31		20		24		46	
Perceived state of health		0.016		0.055		0.226		0.003
Very good or fairly good	17		8		9		23	
Average or bad	24		7		15		41	
Long term illness or health problem		0.031		0.389		0.356		0.044
No	16		8		10		25	
Yes	27		10		12		37	
Moderate or difficult anxiety		<0.001		0.028		0.011		<0.001
No	16		7		9		25	
Yes	39		16		22		54	
Depressive symptoms		<0.001		<0.001		0.010		<0.001
No	14		5		7		20	
Yes	33		15		19		49	
Physical limitation		0.008		<0.001		<0.001		<0.001
No	18		7		7		25	
Yes	39		22		36		56	
Cognitive limitation		0.227		0.538		0.055		0.044
No	17		8		8		25	
Yes	25		10		14		36	

[a]All respondents did not answer to all background questions and therefore the number of observations varies between variables and does not reach the full 465 respondents in any of the questions, which is the size of the data.

TABLE 2 Regression analysis explaining experiences of violence in alternative care[a]

	OR (95% CI)
Female gender (ref. male)	1.74 (0.81–2.74)
Second degree (ref. primary school	0.98 (0.45–2.11)
Foreign background (ref. no)	5.82 (2.37–14.30)
Professional family home (ref. child welfare institution)	1.95 (0.89–4.29)
Duration of the placement (ref. 1–3 years)	
4–6 years	2.32 (0.99–5.45)
At least 7 years	1.06 (0.42–2.72)
At least 4 different placements over a lifetime (ref. 1–3)	2.78 (1.26–6.09)
Perceived state of health bad (ref. good)	2.43 (1.09–5.41)
Long term illness diagnosed by a physician (ref. no)	1.65 (0.78–3.50)
Moderate or difficult anxiety (ref. no)	1.32 (0.49–3.60)
Depressive symptoms lasting at least 2 weeks (ref. no)	2.37 (1.00–5.89)
Physical limitation (ref. no)	1.40 (0.52–3.75)
Cognitive limitation (ref. no)	0.68 (0.30–1.54)

[a]Emotional maltreatment, physical violence, sexual harassment, sexual violence combined.

adolescents with foreign background reported more emotional (foreign 18%; Finnish 15%) and physical violence (foreign 12%; Finnish 9%).

Estimating risk factors

Estimates of risk factors are usually based on regression models although in cross-section settings typical with survey data, these associations are only correlates and cannot be seen as evidence of causal relations. Regression models require an adequate number of cases in the data and the requirement rises when the number of explanatory variables increases. Although SHPS is very large data set, reliable regression models could not be made separately on physical violence, emotional maltreatment and sexual abuse because of low number of cases. However, a regression model was constructed by combining dependent variables to include all respondents who had experienced at least some kind of violence in alternative care.

Whereas the descriptive analysis above suggests rather strong associations between several characteristics related to the type of the placement and respondent's health, in the explanatory analysis, where all characteristics are taken into account at once, only the respondent's foreign background, experiences of several placements and respondents perceiving his/her health as poor appear as significant predictors of violence in alternative care (Table 2).

Targeting questions: perceptions of punishment

Of all the adolescents living in alternative care, 53 per cent reported experiences of being left without food, a group punishment or a punishment where respondent did not know the reason for the punishment – all incidents which should not take place in alternative care. Those experiences were most common among adolescents with foreign background and adolescents with anxiety or depression. Adolescents living in institutions reported more experiences of punishment than adolescents living in professional homes (Table 3.)

DISCUSSION

It is well-documented that studying violence in alternative care includes methodological challenges. Because of these difficulties, there is a lack of replicable study designs and representative findings to promote an empirically based understanding of the phenomenon. In this article, we explored employing a self-report survey at school methodology to the study of violence in alternative care.

TABLE 3 Proportion of those who experienced punishment in alternative care according to background factors, % (n = 281–393)

	Experiences of punishment (%)	p-value
Gender		0.248
Female	51	
Male	54	
School level		0.065
Primary school	54	
Secondary school	49	
Foreign background		0.001
Finnish	51	
Foreign	66	
Child welfare facility		0.007
Professional family home	41	
Child protection institute	57	
Time in placement		0.312
1–3 years	55	
4–6 years	53	
At least 7 years	46	
Number of different placements		0.006
1–3	50	
At least 4	61	
Perceived state of health		0.006
Very good or fairly good	50	
Average or bad	58	
Long term illness or health problem		0.042
No	48	
Yes	57	
Moderate or difficult anxiety		0.002
No	48	
Yes	64	
Depressive symptoms		0.003
No	45	
Yes	66	
Physical limitation		0.058
No	51	
Yes	58	
Cognitive limitation		0.008
No	46	
Yes	60	

By analysing nationally representative self-report survey data collected in schools, we were able to report plausible prevalence and estimates of risk factors of violence in alternative care suggesting that self-report survey at school is a useful and valid methodology for this type of research. Conducting the survey in a school setting enabled us to reach a nationally representative population of adolescents living in alternative care which would be difficult to achieve in any other way. Based on comparisons to findings among adolescents living at home, there is no reason to doubt the external validity of these findings. The fact, that respondents were proximal to the alternative care – living there presently – also increases the validity and reduces recall bias (Carr et al., 2019; Euser et al., 2014). By using multiple questions of violence and other areas of life, which is a key element of self-report methodology, we were able to provide a versatile picture of violence in alternative care.

In addition, as adolescents were asked to join the survey as part of their ordinary school day, similarly to their school peers, adolescents living in care did not have to worry about their answers becoming known to their caregivers.

Therefore, it is unlikely that adolescents underreported their experiences for fear of their caregivers becoming aware. Responding at school equalises adolescents as informants; therefore, regardless of their backgrounds all adolescents are entitled to report their violence experiences.

However, some questions remain. First, studying violence in alternative care with a school survey requires a large sample size. Although the original data include 155,299 respondents, there were only 465 adolescents living for at least a year in alternative care and 84 of those had some experiences of violence. The numbers were sufficient for descriptive findings and explanatory analysis where all types of violence were combined but too small for more detailed explanatory analysis. The small sample size should be accounted for in interpreting the results of the explanatory analysis.

On the other hand, although generalised, the regression model conducted in this article provided interesting findings. Whereas descriptive analysis suggested rather strong associations between several characteristics and violence experiences, only respondents' foreign background, experiences of several placements and respondents perceiving his/her health as poor appeared as significant predictors of violence in alternative care when controlling for other factors. This suggests that characteristics associated with higher prevalence of violence are not always the cause of violence but may describe differences in reporting and identifying violence. The role of specific background characteristics comes across best when all possible characteristics are accounted for in the same model, which again requires rather large datasets. Differences in tendencies to report have been acknowledged in the Finnish national action plan for the prevention of violence against children, suggesting new violence-based practices and education to be developed to increase ability of adolescents' living in alternative care to identify violence (Ministry of Social Affairs and Health, 2020, p. 471–480).

Finally, analysing violence experiences in alternative care in the same survey as adolescents' violence experiences at home provides several important advantages. First, it provides an important possibility for evaluation of external validity. Second, it compared rates of violence in alternative care and at home and brings light to differences in identifying violence, which is important in supporting children's and adolescents' abilities to identify violence in all settings and living environments. That comparison, as such, provides a relevant platform to capture the nature and extent of violence experienced by young people at a certain time.

Based on this study, we conclude that nationally representative self-report surveys at school could provide a useful tool and possibilities for replicable research design that respect cultural and contextual differences and, thereby, develop the research field further. This is necessary to give children the opportunity to inform researchers about their abusive experiences in alternative care and to challenge child welfare practitioners and policymakers to abolish – or at least reduce – violence.

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CONFLICTS OF INTEREST

There is no conflict of interest.

ETHICS STATEMENT

There is no research funding to be reported and because of the secondary use of public research data, ethics approval statement was not needed.

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