REPORT

How the costs of protecting children accumulate II

LASTENSUOJELUN KESKUSLIITTO
CENTRAL UNION FOR CHILD WELFARE

SOILA
SOSIAALISET INNOVAATIOT LASTENSUOJELUSSA

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Co-funded by
the European Union

How the costs of protecting children accumulate II

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Central Union for Child Welfare online publication
2/2025

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Central Union for Child Welfare online publication 2/2025
ISBN: 978-952-7002-64-3 (PDF)
ISSN: 2489-4885

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Preface

Child welfare costs and their accumulation are highly relevant themes even today. There is increasing pressure to cut child and family services as the Government seeks to meet the adjustment targets it has set for Finnish general government finances, and the new wellbeing services counties struggle to make do with their funding. The Central Union for Child Welfare wanted to address this topic, which has been the subject of much interest and debate, again now that 12 years have passed from the previous report.

This report seeks to establish the price of these human stories. Every case is based on the real experiences of individuals and families, which effectively shed light on the reality behind the figures. The report poignantly illustrates and explores the connections between finances and the human experience. If what is humane is also more cost-effective, why should we not embark on changing the system in a more humane direction? Some of the cases present alternative realities in which more help would have been provided sooner.

To change course, we need the courage to invest more in children and families in the long term. It means that we may have to provide support to more children than now. The economic and human price of our current situation is so high that this is a change we cannot afford not to make. Ambition and good intentions alone will not suffice, however. Effective action is needed.

This report was created from the diverse contributions of the authors and the Central Union for Child Welfare's communications department and information services. The report charts people's paths through the services and calculates the price. It was a challenging task in many ways. My special thanks go to all of the people who shared their experiences for the report. Enjoy the report, I hope it will provide new insights!

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Summary

In 2012, the Central Union for Child Welfare published a report titled "How child welfare costs accumulate?". This publication is the second study of these costs, updating the previous report.

Much has happened in child welfare since the publication of the previous report more than a decade ago. Practically all of the trends that caught our attention back then have continued nearly unchanged: costs have increased, the number of emergency placements has kept growing, and the number of child welfare notifications has gone up especially sharply. The number of children in care has remained roughly at the same level since 2012. The child welfare system has been shaken by tragedies resulting in the deaths of children who were child welfare clients. The transfer of the responsibility for organising child welfare services to the wellbeing services counties from the beginning of 2023 was a major change.

The term "protecting children" has been used in the title of this publication instead of "child welfare" because the report goes beyond the scope of the Child Welfare Act. We have limited the costs examined in the report to those incurred from targeted services provided in childhood. Child welfare is not the only thing that has changed in Finland since the previous report, however. The age cohorts born in Finland are smaller, families are more culturally diverse, and the mental health issues faced by young people have been brought under the spotlight. For decades, we have known – or at least believed – that providing families with timely support based on actual needs is an ethically and financially sound model. But such a union of the humane and the economic still looks like a distant goal.

The six priced case studies are the backbone of this report. All of the cases are based on interviews, with the specifics changed to prevent identification. The institution-heavy services described in the case studies accumulate a price tag in the hundreds of thousands of euros in just a few years. The same amount of money could be used to provide quite intensive support to children and families through open care and other early-stage services. This is illustrated by priced case studies based on open services. In our opinion, correctly timed long-term support based on a personal relationship with the client would also save on costs.

Effectiveness is a byword of our times. This publication does not study effectiveness, but the current focus on that metric can contribute to the structural reform of child welfare. There are good models available, but their scope is still too narrow. As the age cohorts get smaller, we need to focus on every child more than ever before. If we are not able to find more ethical and financially sustainable operating models in these circumstances, it is highly doubtful that we would be able to do so in the future either.

GLOSSARY

Substitute care means arranging the care and upbringing of a child outside the home after the child has been taken into care.

Open care provides the child's parents and custodians with support for the child's upbringing. "Child welfare support in open care" is the first recourse before taking into care and placement in substitute care. The wellbeing services counties are responsible for the provision of open care.

Child welfare refers to the activities regulated by the Child Welfare Act: open care, after-care and substitute care.

Protection of children is a blanket term for support offered to children, young people and families for the upbringing of children.

BACKGROUND TO THE REPORT

This report builds on and updates the earlier report published by the Central Union for Child Welfare on the same topic. We embarked on the update because the previous report has been frequently cited and widely circulated. The key figures of child welfare have continued on the same, somewhat concerning, trajectory since the previous report.

KEYWORDS

Child welfare, costs, child welfare substitute care, child welfare open care, family social work, preventive services

1.

Foreword: standing on the shoulders of giants

MITEN LASTENSUOJELUN KUSTANNUKSET KERTYVÄT (How Child Welfare Costs Accumulate?, Heinonen, Väisänen & Hipp, 2012) is one of our most read and quoted publications of all time. As an indication of the widespread interest generated by the report, it was also published in English in 2014. We embarked on this called-for update of the report because the topic is still every bit as relevant now than it was in 2012. The original report managed to capture something essential about the times and convey its message lucidly. We strive to live up to its example.

There is currently an effectiveness boom in our society, and the word has become a commonplace in the titles of webinars and seminars. "Effectiveness" naturally brings to mind costs and cost-effectiveness. This publication does not deal with cost-effectiveness as such, but the general buzz around the theme did contribute to the decision to update the report. When the decision was made in 2023, there were a number of ongoing Central Union for Child Welfare projects that were exceptionally useful for drawing up the report. These included the Lapset ja nuoret SIB (Children and Youth Social Impact Bond) programme, Kokemus tiedoksi (From Experience to Knowledge) project and SOILA (Social Innovations in Child Welfare) coordination project, all of which contributed to the success of the report.

This report builds on the 2012 report, but is more than just an update of the figures. The descriptions of events and the priced service paths linked to them were the strong point of the previous report. We have kept this approach for the update. This report has been drawn up by different people than its predecessor, and their different takes and approaches are reflected in the result. We opted on "protection of children" instead of "child welfare" for the report's title. We feel that this title better describes the broad-based calculation method that also includes costs outside of child welfare services. The first chapter of the report aims to build context for the later chapters and recap the most significant changes from the publication of the previous version. In terms of page count, the majority of the report is taken up by the case studies.

Services can have larger and smaller roles at different stages of people's lives. This report looks at those lives through services because the price of a service can be determined. In other words, the case studies are very much structured around the services but, we hope, without losing sight of the broader tapestry of life. Most services are more or less standardised. Therefore, they are seldom absolutely perfect for the individual's needs or provided at the absolutely perfect time. But perfect failure is as rare as perfect success.

The case studies can give the impression that there are shortcomings in our child welfare services, and this is probably also true to a degree. Some cases are likely to leave the reader with the impression that better outcomes could and should have been achieved for everyone involved. Some of the cases stress this point by presenting two alternative paths the events could have taken. The purpose of child welfare services is to make people's lives better, but a cheaper price tag is a nice bonus. The last three cases are intended to demonstrate that the accumulation of problems can be prevented and mitigated. The cost report inevitably focuses on figures and sums, but we do not want to put too much emphasis on money. Money is a unit of measurement and used as such in this report. Money can be used to convert that which actually happened to that which could have. It can make the unique events of a life at least somewhat commensurable with others. If a lot of money is expended somewhere, it usually means that a lot of effort and work has also been invested there. These resources should be allocated wisely, and money is an indicator by which such allocation can be illustrated. So we follow the euros, while seeking to maintain a neutral attitude to money, like cups and grammes in a recipe.

The union of the humane and the financial – chasing a mirage?

Not many people object to something that generates better results for less money. Few are opposed to timeliness and cost-effectiveness. In the language of cost-effectiveness, "better for less" is the option that should be chosen in all circumstances. Preventive services and the promised union of the financial and the humane – enabled by the provision of timely assistance – have long dominated the discourse on costs.

We can observe a similar pattern in sports and exercise. The UKK Institute has put forward that the annual cost of passive lifestyles in Finland amounts to EUR 3.2 billion. Increasing the amount of exercise taken by citizens and directing people towards appropriate types of exercise would improve their quality of life and reduce costs. The people discussing these matters inside the child welfare sector should also look further afield at structurally similar fields, like sports and exercise. The child welfare service is not alone in chasing its mirage.

Calculations for adulthood are not presented in this report due to the methodology of the cost calculations, but it is clear that the real gains and losses are realised there. None of the services examined in this report are so expensive that they would not pay off in the long term if effective. Annual budgeting can funnel people into trying to spend the least amount right now or next year, but that is not the most important metric.

The cases presenting better and worse outcomes intentionally include a healthy dose of hindsight. One could criticise the fact that the same solutions are repeated in the better alternatives as well. In a way, this repetition underlines our own limitations. Our chosen approach favours relationship-based, proactive, and often long-term measures planned together with the client. Such support is termed "relationship-based support", and the people providing such support are also called "companions".

In some cases, it may seem like the services are based on too much foresight. How would those cases have developed without support? Such reflection is welcome. These cases suggest that a better quality of life and cost savings would have been in reach. The cases do not promise certainty or address the question of how the people in need of support could have been identified in real life. This report maintains its predecessor's cautious approach to effectiveness.

The practical work of reporting on costs largely comes down to finding the appropriate figures, moving them around and making calculations. This readily leads the mind to issues beyond the figures. This report raises at least two questions of broad significance.

The first is: will pouring more money into the current "machine" year after year improve the lives of children and young people. There is good reason to suspect that it will not.

The second question is related to the deeply-enshrined model of preventive, proactive, early intervention services. Even though we have known for decades, or have thought we do, that the right kind of help and support given at the right time will achieve better outcomes in terms of quality of life and the economy, we have yet to achieve this ideal. Why is this? These questions are partly answered in the conclusions. But to understand the reasoning for them, you need to read the preceding chapters.

2.

What has changed in child welfare since 2012 – and what has stayed the same?

More than 12 years have passed since the publication of the first part of this report, and the cost data used in that report predates even that. This chapter examines the similarities and differences in the environments in which the two cost reports were drawn up. First, we provide a brief recap of changes in Finnish child welfare.

The single most significant institutional change was the transfer of child welfare to the wellbeing services counties at the beginning of 2023.

KEY INSTITUTIONAL AND THEMATIC CHANGES IN CHILD WELFARE SINCE THE 2012 REPORT

- The child welfare tragedies in which a child welfare client was killed (in 2012, 2020 and 2023) were widely covered in the media. In response to the first tragedy, the child welfare notification duty was changed with an Act adopted in 2014.
- Social Welfare Act reform (2015)
- Restriction of the number of clients per social worker (from the beginnings of 2023 and 2024)
- Increase of the after-care age limit, followed by decrease (2020 and 2024)
- Health and social services reform and the transfer of child welfare to the wellbeing services counties (2023)
- Greater focus on children's neuropsychiatric disorders (developmental disorders related to the brain) and adolescent mental health issues
- Introduction of new child welfare funding models, e.g. SIB (social impact bond)

Key figures of child welfare from 2012 to the present

The number of children placed in substitute care has remained fairly stable from the previous report: there are still roughly 17,000 children in care (the term used in official statistics is "children placed outside the home", but we use the term preferred by those with experience in the field). In the age cohort, the percentage of children in care has increased by 0.1 percentage points, i.e. by less than a thousand individuals. The number of children in care has been declining very gradually for the past few years (Child Welfare 2022, Child Welfare 2023). The statistics indicate the total number of children who were in care at some point in the year.

The number of adolescents (13–17-year-olds) in care has grown by just under a thousand people from 2012, which amounts to 0.1 percentage points in the age cohort. The 2012 report pointed out that the child welfare situation was getting worse for adolescents, and there has been no improvement in this regard. The number of 3–12-year-olds taken into care for the first time has decreased from 2012 (Child Welfare 2023), but so has the number of children aged 3–12. The number of emergency placements has grown clearly, by about a thousand placements in absolute terms and a quarter in relative terms compared to 2012 (Sotkanet, ind1078).

The 2012 report also highlighted the impact of the Child Welfare Act, which was still fairly new at the time, on the obligation to file a child welfare notification. The number of child welfare notifications has kept growing steadily since 2012 and more than doubled in this period (104,000 > 215,000), which admittedly was one of the stated aims of the second reform of the Act. In 2023, a child welfare notification had been filed for over a tenth of minors and every sixth teenager (Child Welfare 2023). The number of notifications has been growing steadily, apart from a temporary dip at the initial stages of the COVID-19 pandemic (Sotkanet, ind1085, Child Welfare 2023). There was a rapid decrease in the number of open care child welfare clients a few years after the previous report. This change was mostly driven by legislative amendments as opposed to changes in the circumstances of children and families.

In some years, the Youth Barometer has asked whether the respondent's family had been involved with child welfare social work during the respondent's time at school. The share of those answering "yes" grew by six percentage points and that of those answering "no" decreased by four percentage points between 2015 and 2018, when 14% of respondents answered that their family had been involved with child welfare social work. Only a marginal percentage of children is affected by child welfare measures at any given moment, but their cumulative percentage of child welfare social work clients is considerable.

Total child welfare costs have grown

The continued growth of child welfare costs is a key ongoing trend behind this report. The total costs of institutional and family care in child welfare services have increased clearly from 2012, hitting the billion-euro mark in 2022. When inflation is factored in, the costs have grown by roughly a quarter. Statistics on the costs of open care services have been compiled since 2015. Since then, the real costs have increased by approximately 15%. The costs of open care services amount to roughly a third of total child welfare costs (Sotkanet, ind4684). The costs of open care services have increased especially sharply in relation to client numbers, with an exceptionally steep rise of roughly a third in the costs of open care services from 2022 to 2023 (Sotkanet, ind4684).

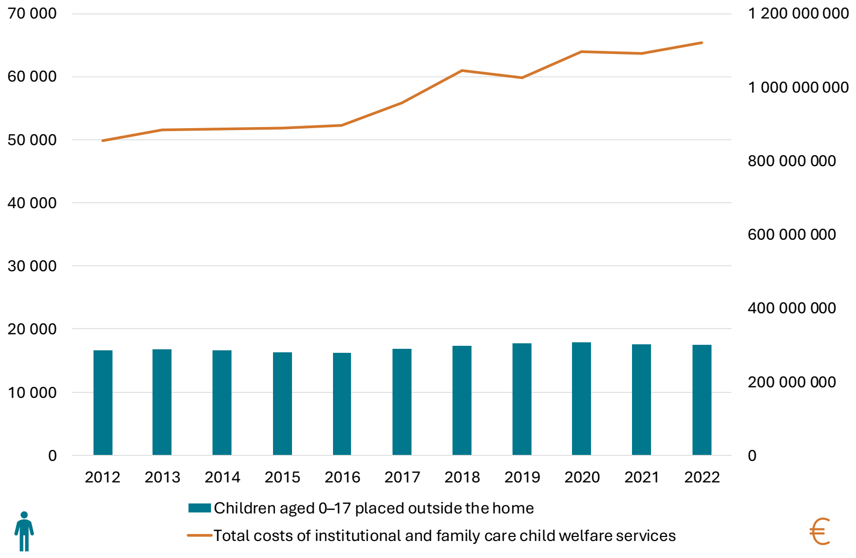


Figure 1.
Number of placed children and costs of substitute care (in 2023 currency) in 2012–2022.

The accumulation of costs is every bit as relevant now as it was in 2012. The total costs of child welfare have been estimated at 1.3 billion euros (Child Welfare Statistics, 2022, Child Welfare, 2023), which is the same amount we spend on cancer treatment (Kääriälä & Hiilamo, 2023). For the sake of comparison: approximately 5.5 billion euros were spent on the basic education of the entire age cohort in 2022. The total costs of child welfare and open care social services for children, young people and families amounted to just under 2.2 billion euros in 2023 (Sotkanet, ind.5830).

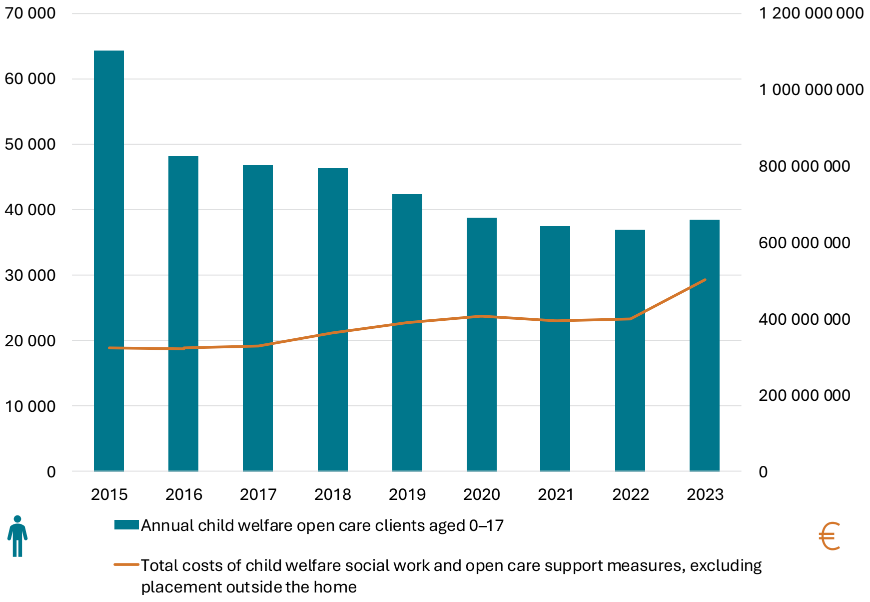


Figure 2.
Child welfare open care client numbers and costs (in 2023 currency) in 2015–2023.

The costs of family care and institutional care have increased steadily also in periods when the number of children in care has not. The costs of child welfare open care services have increased despite the decrease in client numbers.

Changes and constants in circumstances

Each new age cohort has been smaller than the last every year since 2012. The birth rate has been low, but immigration has been fairly brisk. There were roughly 56,000 fewer children in Finland in 2023 than in 2012. In other words, it is possible that the calculated costs per child have grown even when the total costs have not. Compared to the situation in 2012, the number of families in which at least one of the spouses was born abroad has doubled in Finland.

Schools are being closed at an increasing rate, which has been an ongoing trend for three decades. Urbanisation has proven to be a pandemic-proof megatrend: an ever greater percentage of children is being born in ever larger cities, while other children have to travel farther to school and hobbies and to meet their friends. Compulsory education / the right to education has been extended until adulthood since the previous report.

Slightly under a thousand minors are committed to involuntary psychiatric care each year. This number has remained fairly stable in the 2000s, while the percentage of involuntary psychiatric patients has increased by two decimals in the age cohort (Sotkanet, ind.3058). Since the turn of the millennium, the number and percentage of minors treated for mental health disorders have decreased quite clearly, i.e. by nearly a thousand individuals and over half a percentage point of the age cohort. The number of institutional care periods has grown considerably in adolescent psychiatry, while the number of days in care has decreased (Sotkanet, ind.2565, 2566).

The number of minors receiving reimbursements for antidepressants has multiplied in the 2000s. In 2001, there were 3,000 such children, up to more than 17,000 children in 2023 (Sotkanet, ind2357). Their percentage of the age cohort is very close to that of children in care. Pharmaceutical treatment of children's hyperactivity and attention deficit disorders has increased rapidly in the last few years. In 2022, 5.2% of Finnish children (aged 6–12) took ADHD medications. Regional differences are considerable, with the number of diagnoses exceeding the medical estimates of the disorder's incidence by a significant margin in some places (Aalto-Setälä & Vuori, 2023). Based on the school health survey, feelings of anxiety have nearly doubled among lower secondary school pupils in the past decade (Sotkanet, ind328).

Pupil-specific expenditures in basic education have grown by over 10% since the previous report. The percentage of pupils receiving intensified support in basic education has more than doubled since 2012 (Statistics Finland 2024, support for learning).

Changes in the number of children also affect costs

The sharp decline in the birth rate and number of children since 2010 means that the number of children in care will decrease if their percentage in the age cohort remains the same. This in turn would mean a reduction in costs by roughly 160 million euros by 2030 (according to a rough estimate for the purposes of this report). Even more financial room could be gained if we could manage to lower child welfare key figures to the levels seen at the beginning of the millennium, or if all wellbeing services counties would follow the example of those that place the least number of children in care.

Share of family care first grew, then fell

The share of institutional care of all placements is one percentage point higher than in 2012. The share of institutional care first dropped to around 44% but then increased to nearly half of all children in care in a few years. Even the 50% threshold has been crossed in some wellbeing services counties. The changes have happened quickly since the previous report (Sotkanet, ind419). The growing share of institutional placements is connected to the general growth of the number of adolescents in care. Institutional placements constitute more than a third of the costs of child welfare and family social services, totalling approximately 600 million euros per year (Child Welfare 2023).

Fairly major regional differences

There are large regional differences in the numbers and percentages of children in care. In 2023, a total of 1.6% of children in Finland were in care. Regional variation in this percentage is not remarkable in itself. What is remarkable is that the largest and smallest percentages can sometimes be found in neighbouring municipalities with relatively similar economic structures and other characteristics. There are also major differences in the shares of family placements and institutional placements between regions.

Trends identified in the previous report have mostly continued

Clear continuing trends can be identified in child welfare from the previous report, including the growth of costs and percentage of adolescents in care. The numbers of child welfare notifications and emergency placements have also continued to increase since the previous report. In addition, a significantly larger percentage of decisions on taking children into care are being disputed today (Child Welfare 2023).

The numbers of open care clients and the share of family care in all placements have fluctuated. The most significant institutional break is related to the transfer of child welfare to the responsibility of the wellbeing services counties. Another major factor, the impact of which is still under assessment, has been the change in child welfare social work staffing requirements, implemented in two phases.

3.

Six cases, seven children, hundreds of professionals

THIS SECTION PRESENTS SIX CASE STUDIES: Helena, Sami, Elias, Niko, Aamu and the siblings Ella and Aava. Some of them are based on actual events to a greater degree than others, and all of the cases have been embellished and adjusted in different ways. Experts by experience in child welfare have produced a fairly large number of descriptions available from public sources (for a listing, see Hokkila, 2023, p. 14). The authors used their discretion and borrowed events freely from different descriptions when constructing the cases. The authors also asked for input from artificial intelligence when it was thought to be useful. The three last cases are the truest to life, while the events of the first three have been aggregated, modified and distanced from actual events to a greater degree. Interviews have also been used when creating all of the cases, and they are based on real people in that sense. The pandemic of 2020 is discussed in the cases because it had such a major impact on the lives of children and young people.

The first three cases follow their protagonists until adulthood. In the others, the case study ends at a younger age – in one of them while the subject is still a baby. This naturally also affects the costs. In chapters 3.1. (Helena, Sami and Elias) and 3.2 (Niko, Aamu, Ella and Aava), the figures are scaled differently because of the high variation in costs.

Helena's case is based on discussions with Helena's mother. The discussions were structured around a timeline on which the events were recorded. Her mother (called "Jaana" in the case study) asked and received Helena's permission for relating the events in the chapter. The details and times of the events have been modified to prevent identification. Parts were added to and removed from the case. In Helena's story, things began to escalate when she started lower secondary school.

Sami's case study relies the most heavily on documentary sources, which were a few years old at the time of writing. Sami was not interviewed directly for the report, but he gave his permission for the publication of the case study through his representative. The events and records were also reviewed with Sami's representative. The details of the case have been altered significantly, but the calculations are based on fairly detailed records.

Elias's case study is based directly on his interview. Elias also went through the events and calculations himself and made both corrections and additions to the records.

Niko's case study is based on an interview of his mother, with some clarifications provided by the family's social worker. The calculations are based partly on the actual costs and, for certain services, partly on service price information available from public sources. The same figures were used for all the case studies in this report for costs taken from the service price list.

Aamu's story is based on an interview given by her mother and clarifications made by a social worker with the mother's permission. Aamu's mother also reviewed the text before publication. The calculations are based on both actual costs and publicly available service price information.

The case of Ella and Aava is based on separate interviews with their mother and with Ella. The family's affairs were also discussed with their social worker with the family's permission. In addition to Ella and her mother, Aava has also reviewed the text even though she did not participate in the interview. The calculations are based on both actual costs and publicly available service price information.

FOR THE PURPOSES OF THIS REPORT, THE COSTS HAVE BEEN DIVIDED INTO THE FOLLOWING CATEGORIES:

● Targeted services provided at school. Includes: special-needs education, student welfare services, school youth work, school health care, school physician, referrals from school, school psychologist, hospital school.

● Family social work and child welfare open care. Includes: family work, mobile child welfare, intensive family work, social instructor, investigation, preparation of taking into care, network meeting.

● Child welfare substitute care. Includes: institutional care, family care, special care, emergency placement, institutional substance abuse treatment during placement, judicial system's expenses during placement.

● Services provided at home. Includes: home service, child care, support family.

● Peer groups and group activities.

● Relationship-based support, professional support person. Includes: professional support person, companion, support person.

● Therapy for parents and family counselling clinics. Includes: therapy for parents, family counselling clinic, family therapy.

● Psychiatrists, psychologists and therapy for children. Includes: occupational therapy, speech therapy, children's psychiatric inpatient and outpatient care, ward psychiatrist's appointments, psychologist's appointments in the ward, other child psychiatry.

● Mentoring, tests, examinations, neurology. Includes: neuropsychiatric disorder test, neuropsychiatric disorder mentor, adjustment training, neurology, neuropsychiatric disorder mentoring.

● Other. Includes: rehabilitation allowance, informal care support, other costs.

3.1

Helena, Sami and Elias – what if they had gotten help sooner?

Helena

○ = Costs in euros

▬ = Years

The calculations are based on rough figures

REAL

37 594 €

Targeted services provided at school

Therapy for parents and family counselling clinics

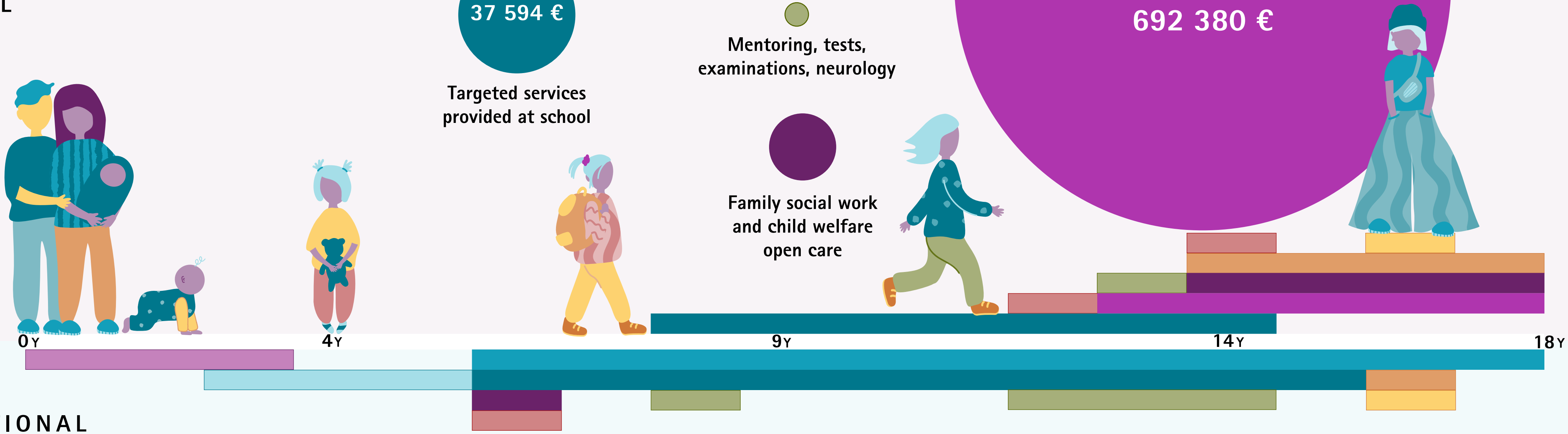
Psychiatrists, psychologists and therapy for children

Mentoring, tests, examinations, neurology

Family social work and child welfare open care

Child welfare substitute care 692 380 €

Other



FICTIONAL

Services provided at home

Peer groups and group activities

73 276 €

Targeted services provided at school

Relationship-based support 81 996 €

Mentoring, tests, examinations, neurology

Other

Family social work and child welfare open care

Therapy for parents and family counselling clinics

Psychiatrists, psychologists and therapy for children

Total costs €

☐ Real
765 916 €

☐ Fictional
264 751 €

[Examine the costs in more detail]

Helena: a NEPSY kid juggled between institutions

Helena is from a town in Central Finland. This case study is based on discussions with Jaana (Helena's mother), documentary materials and a timeline created by the mother, on which the events were recorded. The first course of events described in the case is focused on the last four eventful years of Helena's childhood. Nearly all of the costs were also accumulated in that period. The alternative scenario depicts events over a longer period, with the costs accumulated more evenly during childhood. We first provide a concise narrative of what happened. This is based on a combination of sources with altered times, dates and other identifying features. One simple observation, based on real events, stands out in this case: summer is the riskiest season in terms of child welfare. The other thing that draws attention in this case are the frequent changes in placement.

From birth to primary school

Helena was Jaana's first child and a preterm baby. When Helena was discharged, Jaana slept little and poorly. In retrospect, Jaana thinks that she considered some things to be normal when a child is young because she did not have any point of comparison. Helena's parents separated amicably when she was little. A person close to Jaana noticed special characteristics in Helena's behaviour in preschool age, but no more attention was paid to the matter. Helena was in family day care, which she enjoyed and where she was surrounded by caring and close adults. Helena's enthusiasm for music was apparent from her early childhood.

Primary school

Jaana met a new partner and they started a new family in another town in Central Finland. Helena little brother was born soon after. He was also a preterm baby, and lack of sleep again made the family's everyday life challenging. Jaana recalls that Helena had trouble with some subjects at school. Helena studied them with a special-needs teacher from the second grade until the end of primary school. She loved music lessons.

Jaana's feeling that Helena needed more intensive support kept growing during Helena's time in primary school. She educated herself, sought information and learned by experience to address Helena's special needs. There was only time for this at night, and Jaana also got information from websites and online chat forums. In primary school, Helena was examined by the school psychologist after a fairly long wait. The psychologist made some findings, but did not provide clear instructions on how to proceed. The family visited the family counselling clinic a few times but felt that it gave them almost no help.

Towards the end of primary school and in the summer after primary school, Helena and Jaana spent many happy moments doing things together. Their shared love of music gave them joy.

Lower secondary school

The transition to lower secondary school was difficult. The subject teacher system, changing classrooms for every lesson, and the size of the school caused many issues. Helena was referred to examinations due to neuropsychiatric symptoms and was diagnosed with a neuropsychiatric disorder.

Soon after starting lower secondary school, Helena was transferred to a small class, which made school considerably easier for her. The first summer in lower secondary school was extremely difficult. Helena's younger sibling slept better, but Helena was not happy at home. She listened to loud music, which caused arguments. Her overnight absences and other issues led to a placement in open care for two months.

Helena returned home in early autumn and continued going to school in her small class, where she could study and listen to music relatively freely at school. In the eighth grade, she had many happy moments, vacations and family celebrations with her family. The younger sibling became a child welfare client, which gave the family support at home and some much needed rest. Family services were also provided, but they focused more on the parents' relationship than on Helena's situation. The parents had therapy both together and separately. After the placement, the situation got better before it got worse.

The COVID-19 pandemic was difficult for the whole family. It affected Jaana's employment opportunities and Helena's remote school did not work out, even though her family tried to support her. Even her band's rehearsal space was closed for a long time. When the nights got lighter and warmer, Helena again started staying out late. Jaana asked child welfare for help (e.g. a support person), but had not received a reply yet when the situation escalated into an emergency placement. This time, it resulted in Helena being taken into care, which was made legally final a few months later.

Helena completed ninth grade from an institution. Jaana found out that Helena had a substance abuse problem and may have had it for some time. Helena left the institution without permission on several occasions and she was not allowed home visits any more. Jaana did her best to balance the needs of Helena and her younger sibling.

Time after school and before adulthood

The facility in which Helena was living had solid neuropsychiatric expertise, but it alone was not enough for Helena's needs. Helena received treatment in a psychiatric hospital after a crisis during her placement. To her disappointment, she was not allowed to return to the same facility from hospital, and the new place was considerably farther from her home. The new place would have been able to cope with the neuropsychiatric disorders as well, but it was still not enough. Helena was continually moved from facility to facility, which exacerbated her problems. Jaana and Helena had trouble keeping contact due to the long distances and COVID-19 restrictions still in force. Helena was anxious. Jaana got help from open care child welfare services.

Helena's issues did not abate, so she was queued for a special care period. In time, she was admitted to a few weeks' special care period, but she or her mother were not informed of it in advance.

A relative offered to become Helena's supplementary custodian, and Helena tried living with the relative. She managed to do some schoolwork and took a few holidays at Jaana's place without trouble. She also started making music again, for a short time. In the summer, yet again, the situation nevertheless got worse. Helena's actions were deemed to constitute too great a risk to the family’s younger children in both Jaana’s and the supplementary custodian’s home.

It was time for another placement in a facility and more absences without leave. During those absences, Helena was involved with a group that committed crimes. She was put in queue for a special-needs facility and got a place there. After that, Helena was able to return to a familiar facility, which was a relief to both Jaana and Helena. The substance abuse got worse as spring went on. A period in another facility was tried to treat the problem, but it was not much help. When Helena returned to the facility, she was so close to adulthood that she in effect settled down to wait for her eighteenth birthday.

By Jaana’s count, she has dealt with 150 professionals and eight institutions regarding Helena’s issues. According to Jaana’s calculations, the state lost 40,000 euros in tax income because she was only able to work part time due to Helena’s circumstances. This amount could reasonably be added to the cost of the services. The calculation also included some costs that are not discussed in detail in this report.

The total costs of the above-mentioned process amount to approximately 760,000 euros. The majority, roughly 700,000 euros, was incurred from substitute care and other institutional services provided during that time, and from judicial expenses. School and tuition costs from special-needs education and student care amount to about 40,000 euros. The costs of open care child welfare services only constitute a fraction of the total, coming to around 12,000 euros. The psychiatry costs were of a similar magnitude. Other costs, such as therapy for the parents, have been estimated at less than 10,000 euros.

A happier version of Helena’s childhood and its costs

Now, let us imagine a different course of events. Jaana has seen a number of similar cases play out, and this scenario is largely based on her assessment of situations in which timely and correct help would have made things considerably better.

We discussed how, when and where Helena could have gotten the best help and support at any given stage. We looked at the question from a variety of perspectives and did not limit our options to services alone.

Based on the various materials and discussions, we can draw a fairly relatable and credible picture of junctures that were critical in hindsight. At some points, the smallest nudge one way or the other could have made a difference.

There are a lot of what-ifs for such a short story. If Helena’s family would have received concrete support for the sleepless nights when she was a baby; if the people around her would have noticed Helena’s special characteristics and sensitivities in time; if school had not focused solely on Helena’s difficulties with specific subjects; if the responsibility for the children’s upbringing would have been divided more evenly in the family; if the COVID restrictions would not have made everyday life harder; if Jaana would have been better able to see the world through Helena’s eyes; if Helena had not been the firstborn, etc. It comes down to a lot more than just services or the lack thereof. Services can be crucial, but in the childhood of Helena and many others, completely ordinary support networks of friends, colleagues, family and neighbours would have done a lot to help.

Before school

This calculation diverges from the first one immediately at the beginning, as we imagine that Helena's family would have received help at home for the first three years of Helena's life. Such help eases the burden of sleepless nights, especially for the mother. The calculation includes a support family to offer the mother a break and some much-needed sleep. We do not assume that the support provided to the family would have stopped the parents from separating.

When Helena turned three, her mother would have enjoyed the benefits of a peer support group or a similar service that would have put her child's characteristics into perspective. Weekly peer group sessions for three years have been included in the costs. The peer group is also included because there is a price listed for it. We do not assume home help for this period. In our assumption, the peer group would have offered the chance to compare experiences of child care with other parents. The presumed benefits of a peer group could also have been provided by a group of friends or a family club, for example. We assume that Helena would have been in family day care, which she enjoyed due to the familiar environment, small group and low staff turnover (basic service, the costs of which have not been taken into account here).

Helena's behaviour demonstrated characteristics strongly indicative of a neurodevelopmental disorder. This calculation is based on the idea that preschool teachers would pay attention to Helena's special way of learning things. In this assumption, Helena receives special support in preschool and starts school as a supported pupil. When calculating school costs, we included estimated future costs in addition to a normal path through basic education.

Helena's family would have benefited a great deal from long-term support. The alternative cost accumulation includes 12 years of relationship-based support for the family, with a supplementary educator helping the family meet Helena's needs. In our calculation, the renewed lack of sleep brought on by the birth of the little brother would have been met with intensive family services. We assume that responsibilities and relationships took some time to form in the reconstituted family. The calculation includes a couple of hours of family therapy.

We have taken into account home services to help Jaana cope with preparing several versions of each meal. In this way, the calculation takes the possible need for special diets into account.

The assumption was that the family's sleep issues would be alleviated with the growth of the little brother and Helena's mother would go back to work. We thought that the father of Helena's little brother would have taken a longer family leave, the costs of which have not been taken into account in this calculation. The calculation estimates that special-needs education would continue throughout basic education, and the costs of a relationship-based long-term companion have been taken into account from preschool to adulthood.

Primary school

Each year of primary school includes the long-term costs of tuition and the costs of the educator companion. These provide a base annual cost of around 12,000 euros for the calculation.

In the alternative calculation, we thought that the neuropsychiatric disorder would have been diagnosed slightly earlier than in the case above. The costs of the referral and diagnosis are the same in both scenarios. The calculation is based on the assumption that Helena and her mother would attend four days of adjustment training after Helena gets the diagnosis.

Lower secondary school

In lower secondary school, Helena will continue as a supported student in a small class. She will still also enjoy the relationship-based education support begun in preschool. In addition, the calculation assumes that Helena would get a lot of help from the school youth worker, especially at the stary of lower secondary school. The shift to a subject teacher system is difficult even with support. We assume that an active lifestyle will now help Helena focus on school, and that her trusted support persons in relationship-based education will support her in the most tempestuous phases of her growth. Helena's home is supportive of exercise and sports, and this is not assumed to incur any additional costs.

The calculation takes into account a neuropsychiatry mentor who supports the family by facilitating the communication and interaction between Helena and the rest of the family. As a result, we assume that the adults in Helena's family will learn to see the world from her perspective.

From lower secondary school to adulthood

We assumed that Helena, her parents, student counsellors and other support persons would choose a field Helena likes in a vocational institution as her first preference in the joint application system. Helena is assumed to get into her programme of choice and study until adulthood. The calculation includes the minimum amount of rehabilitation allowance for one year. In addition, it is assumed that the COVID-19 pandemic affected Helena's life, and psychologist's costs have been added to the alternative calculation to address this.

Summary

The above-mentioned alternative scenario does not include any intervention by child welfare or major blows to Helena's mental health. She also stays away from illegal drugs, and the alternative calculation does not include any costs incurred by the police or justice system. This version can be considered optimistic. The alternative scenario is based on the idea that Helena's anxiety was based on her neuropsychiatric disorders and the inadequate response to them, and that her substance abuse problems stemmed from her anxiety. The vicious circle, in which things spiral out of control after taking a bad turn, could have been prevented.

Everyday financial considerations were not taken into account in the alternative course of events. They would naturally limit options in real life. We did not skimp on the services, and the final bill is not inconsiderable. The alternative case combines relationship-based support with shorter-term solutions, such as adjustment training. For primary school, the costs of special-needs education are equal in both versions.

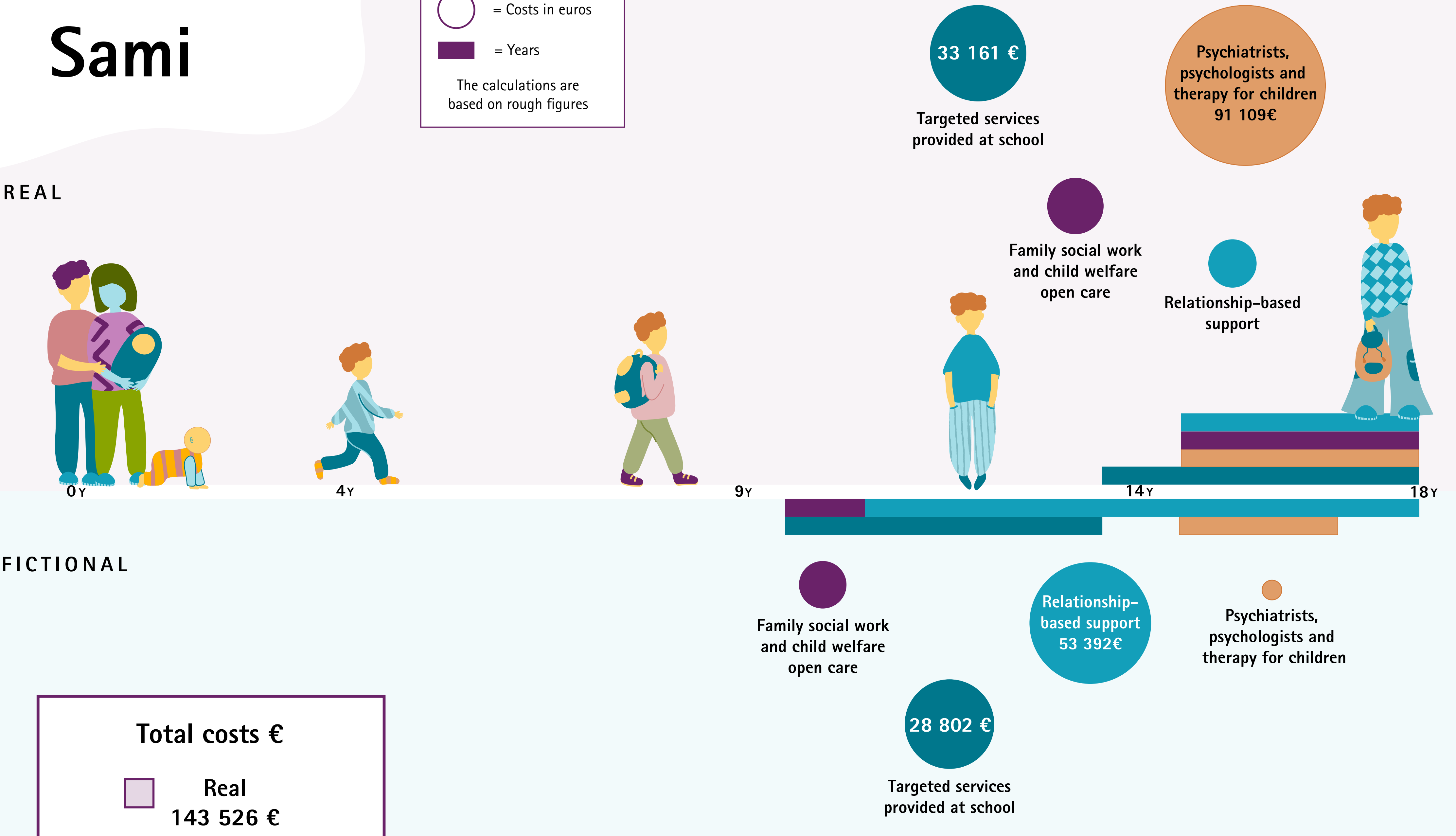
The costs of the second version of these events amount to approximately 264,000 euros. We calculated the costs related to school and tuition at approximately 70,000 euros (in addition to a normal path through school). The most significant individual item in the calculation is 80,000 euros for more than a decade of relationship-based support. The total price of early childhood support provided at home was estimated at just over 60,000 euros. The remaining 50,000 euros consist of the costs of rehabilitation support, the peer group, adjustment training and other smaller items. Helena could probably have made do with less. For example, we included a considerable number of neuropsychiatry coaching hours in the calculation. But even with this generous calculation, the costs only amount to roughly a third of the less positive alternative.

Sami

○ = Costs in euros

▬ = Years

The calculations are based on rough figures



REAL

33 161 €

Targeted services provided at school

Psychiatrists, psychologists and therapy for children 91 109€

Family social work and child welfare open care

Relationship-based support

FICTIONAL

Family social work and child welfare open care

Relationship-based support 53 392€

Psychiatrists, psychologists and therapy for children

28 802 €

Targeted services provided at school

Total costs €

▢	Real 143 526 €
▢	Fictional 91 504 €

Examine the costs in more detail

Sami: first too little and then more than enough support

The main character of this case is Sami. The case is based on sources recording the services provided to Sami and his key interactions with them, along with some of the cooperation between the services. The material we used is based on nearly 200 pages of documentation, mostly from specialised medical care, family social work and child welfare. After Sami turned 18, he was interviewed about the accuracy of the records and his feelings during the time described in them. The people close to Sami were also interviewed when the original documentation was collected. Events have been added, omitted and altered according to our discretion.

The case examines a three-year period during which Sami meets approximately 30 different professionals. By “professionals” we mean the entire group of people who gave Sami help and support by virtue of their job or position, excluding his family. One of the key points of this case is that Sami’s psychologist and support person each worked on their own without cooperating with each other. The psychologist met Sami 87 times and the support person met him 98 times. Based on the records, their work shared many similar elements. In retrospect, Sami thought that it would have been enough to meet either of them once a week. Sami’s case also includes exceptionally detailed records of the communication between professionals, and some costs incurred from this communication have been included in the calculation.

Sami’s case is relevant because it illustrates the cooperation between social welfare and healthcare services in a concrete manner. Reading the case will probably leave you with the impression that Sami was alternately deprived of support and over-supported. The case does not indicate that this would have been due to any decisions made by an individual, but rather a systemic issue.

If avoiding placement in care is the measure of success for child welfare services, everything turned out well in Sami’s case. Sami did not end up in substitute care, nor were the costs of the services described as high as would have been incurred from placement in a facility.

Sami's childhood, bullying and mental disorders

Sami is from a city in Eastern Finland, large by Finnish standards. He was born into a normal-seeming family in the early 2000s. Sami was a conscientious and good child who was bullied in primary school. When he was 10, traumatic events occurred in his family, the details of which will not be discussed here. These events had a significant impact on Sami’s well-being. Sami’s parents got a divorce a few years later. Sami began having suicidal thoughts and attempted to harm himself already in primary school. According to Sami, he thought about suicide in the fifth grade. His need for help was only identified in lower secondary school, and not very quickly even then. Sami’s older siblings also reacted to the incident in their family.

His parents knew that Sami was cutting himself and brought it up with school health care in lower secondary school. It is highly likely that others too, such as hobby instructors, had noticed the marks. Sami’s issues and actions were partly seen as normal turbulence belonging to puberty.

In addition to cutting himself, Sami used both illegal and legal (to adults) intoxicants in lower secondary school, but continued practising sports. In the seventh grade, he had a few appointments with a psychologist. Sami said that he had been drunk at school more than once.

In the spring of the eighth grade, Sami was referred to an adolescent psychiatry clinic at his parents' insistence, even though the school did not consider it necessary. In the initial interview for his therapy, Sami told about his cannabis use. That constituted grounds for initiating family social services, which were informed by a child welfare notification. Both the psychiatrist and social workers assessed Sami's situation. At the end of summer before the start of ninth grade, the professionals did not have serious concerns and there were no major issues with Sami's feelings or health.

A sudden crisis

Not long after, Sami's situation escalated into a crisis. Sami was brought to the emergency room in bad condition after attempting suicide, but was discharged home from the hospital. This information reached a physician who filed a child welfare notification. Sami soon entered treatment in a psychiatric ward and went to hospital school. A significant part of the costs were incurred in this period.

He spent a few months in the ward and continued as an open care client after that. Sami completed the school year in hospital school. During that time, Sami received a special-needs education decision and returned to "normal" school, but did not go to school full time. The information about his entitlement to special support did not reach the school. Sami was discharged from the hospital with a diagnosis of anxiety and minor cognitive impairment.

Time passed and a new school year began. After his time in the ward, Sami continued seeing the youth clinic psychologist and child welfare arranged a professional support person for him. Open care services were initiated intensively, with Sami seeing professionals for up to four hours a day. Sami and his mother expressed a wish for more communication between the psychologist and support person, who were not in touch with each other at all. Sami cancelled some meetings because there were so many of them. He would have wanted one meeting a week. One extensive network meeting was held in the spring, but the person who was most in touch with Sami (the support person) did not attend.

A person close to Sami later commented that it would have been useful for the support person and psychologist to talk to each other. In other words, child welfare and the clinic should have communicated with each other about Sami's case.

In the spring, Sami spent a short period in the psychiatric ward at his own request because he had been feeling low and had started cutting himself again. The meetings with the psychologist and support person continued after Sami was discharged, sometimes on the same day. A psychiatrist again prescribed antidepressants for Sami (not included in the costs), but this information did not reach the other parties.

Sami was encouraged to get out of the house and "out and about". He spent a lot of time with his friends in the summer. Sami was open about his intentions to use intoxicants at a friend's birthday party, which led to a new child welfare notification. The notification did not result in any significant action, and Sami was feeling fairly well. Sami began improving his marks after the summer. He continued seeing his psychologist and support person.

Upper secondary education and adulthood, everything OK

The next spring, Sami submitted his application in the joint application system for upper secondary education. His certificate was reasonably good and he was admitted to upper secondary studies. When Sami was 17, two network meetings were held and his first client plan was drawn up.

At the end of summer, Sami was approaching adulthood. He started upper secondary studies in a new town. Sami kept seeing his support person on a regular basis but was not seeing a psychologist any more. He was granted a housing allowance but refused rehabilitation allowance. When Sami turned 18, his child welfare and youth clinic services were discontinued.

The information accumulated by the child welfare service and psychiatric clinic was not transferred to other services. Sami has successfully entered adult life, so this break in the flow of information has not harmed him.

The total price of the services described above amounts to approximately 140,000 euros. The costs were incurred from psychiatric treatment, hospital school and the psychologist's and support person's services.

More appropriately scaled and targeted forms of support for Sami

This section describes and calculates a different path through Sami's adolescence. In hindsight, it is easy to see where there was too little or too much support. In terms of the costs, the key issue is whether the treatment in the psychiatric ward and consequent hospital school could have been avoided. Another central theme is the initial underuse of open care services, i.e. the psychologist and support person, and their subsequent overuse.

In hindsight, we can say that the whole family should have received support sooner based on the actions of Sami and his siblings. With the same benefit of hindsight, it is easy to see that not everything Sami did was explained by the turmoil of puberty.

Crisis support for the whole family

This second scenario and calculation set out from the premise that Sami and his family would have received support immediately after the traumatic incident. The calculation also includes services provided to Sami's siblings, according to the logic that everything described in the case above could equally have happened to them. The costs have been calculated at school psychologist's rates. For the purposes of the calculation, it has been assumed that the entire family received four months of family social services for crisis recovery.

Bullying is naturally a significant issue. Putting a price tag on the prevention of bullying is slightly more complicated, and a school youth worker's costs have been included in the calculation with the logic that the youth worker could have intervened in the bullying.

According to the "early and long-term" principle, we calculated a long-term, relationship-based support service for Sami for eight years according to the base rate. A part of the costs of the professional support person is also included in the alternative scenario. These were thought to prevent the long period of hospital treatment and the expenses resulting from it. The number of psychologist's appointments was decreased to a few individual appointments. The reduction in services used is significant. This is based partly on the excessive service provision in the actual case and partly on a decreased support need due to the provision of other forms of support.

Sami was thought to manage school with light support. The calculation nevertheless also includes special-needs education expenses for the year of the family crisis. The actual case included a suspicion of cognitive impairment but also of alcohol and illegal drug abuse. Sami eventually did well at school, so the problems can be considered to have stemmed from intoxicants and depression.

Smaller costs even with redundancy

The assumptions made above result in roughly two thirds of the actual service path's costs. Some generous and optimistic assumptions were made in the calculation. On the other hand, the support was spread over a much longer period and some of it was allocated to siblings and the whole family, unlike in the original case.

If long-term support for the family and a support person are considered overlapping measures, the costs are on the high side. School youth work and relationship-based support are also implemented at the same time in the calculation. Neither case includes any costs from child welfare substitute care, so the costs are neither low nor especially high. A significant part of the realised path's costs were accumulated over a few months of hospital care. The alternative scenario does not put a price on the fact that Sami could more likely have gone to school five days a week.

In addition to hindsight, the alternative scenario includes a healthy dose of justified optimism. We have not saved on costs where they were assumed to generate impact. That is their ultimate purpose, after all. And when you do not hold back, costs will be incurred – in the tens of thousands in this case. In the calculations below, the support is distributed to several persons and it is assumed that Sami will have a normal path through school. The price of the services in the alternative scenario is approximately 90,000 euros. There probably are some redundancies in the calculation, and part of the support is allocated to Sami's siblings. Even so, the costs are considerably lower than in the first case.

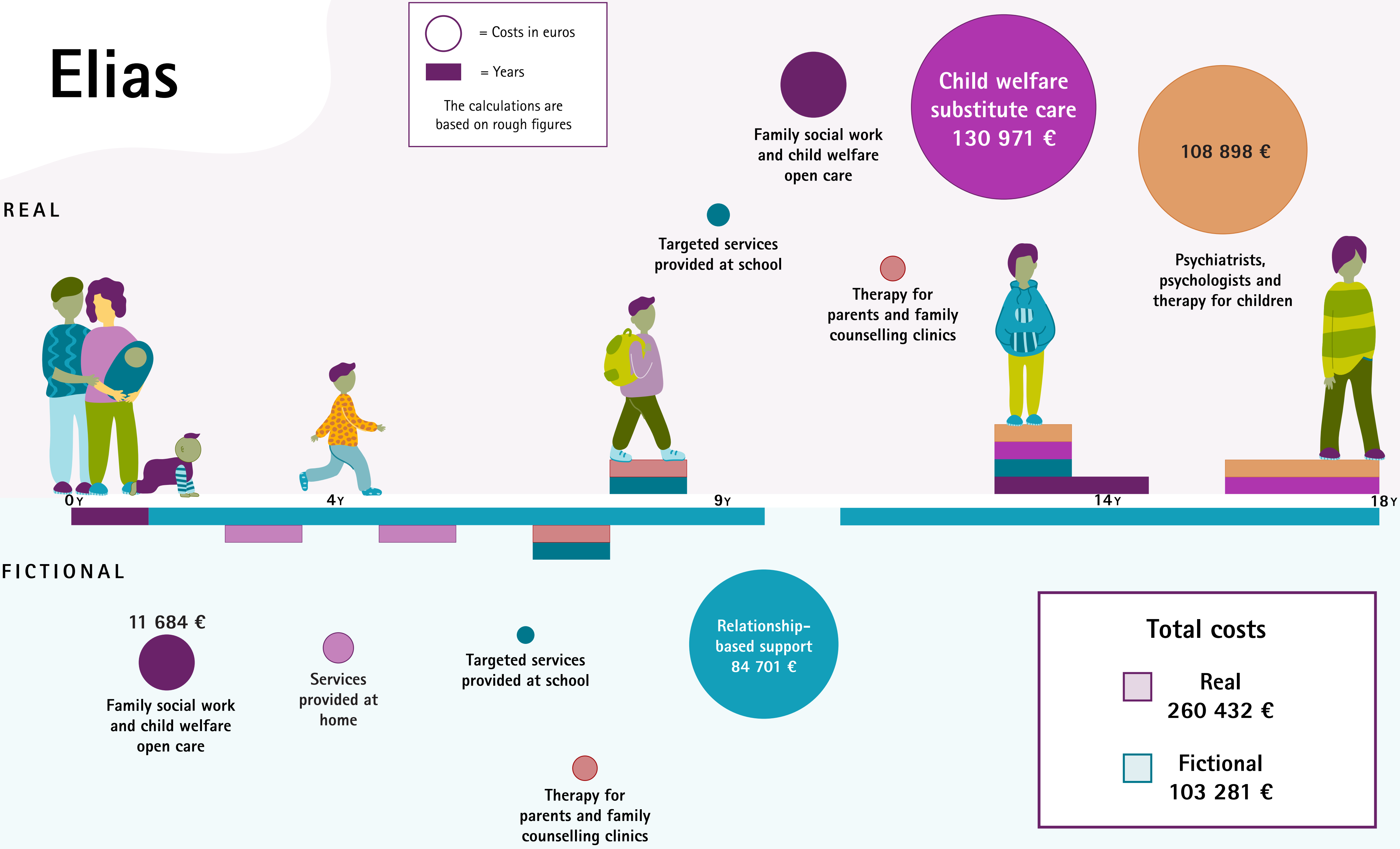
More than half of the costs are incurred from long-term relationship-based support. The various forms of support provided at school amount to 30,000 euros. This includes support from the school psychologist. The remainder of the costs, roughly 10,000 euros, consists of psychologist's services after school and family social work.

Elias

○ = Costs in euros

▬ = Years

The calculations are based on rough figures



REAL

Family social work and child welfare open care

Child welfare substitute care 130 971 €

108 898 €

Targeted services provided at school

Therapy for parents and family counselling clinics

Psychiatrists, psychologists and therapy for children

FICTIONAL

11 684 €

Family social work and child welfare open care

Services provided at home

Targeted services provided at school

Relationship-based support 84 701 €

Therapy for parents and family counselling clinics

Total costs

☐	Real 260 432 €
☐	Fictional 103 281 €

Examine the costs in more detail

Elias: better too early than too late

Elias's family has been burdened by the parents' mental health issues since he was born. His mother also contracted a somatic disease, and Elias's little brother was frequently and seriously ill for the first year of his life. Elias's parents divorced when he was young, but the problems continued with the mother's new partners. All of the family members were frequent healthcare clients during Elias's entire childhood and youth.

The services recognised that Elias was forced to take responsibility and become independent from a very young age: he received special permission to walk to preschool by himself and went to his dentist's appointments by himself all through school because none of his family members were capable of going with him. He also took his little brother to the school physician's appointments.

According to Elias himself, the long-term counselling and other intensive support he received at school were his only lifeline throughout his childhood and youth. They were practically the only services provided to Elias or his family.

When Elias was 13, his mother became well enough to work and his little brother had regained his health. When the other family members got better and the family's situation stabilised, Elias collapsed. It led to suicide attempts, psychiatric hospital treatment and finally taking into care and placement in substitute care. At this stage, Elias feels that he was supported by the workers responsible for his case.

Elias's history shows that, even though the family's circumstances were extremely challenging even when Elias was born, they only got help when Elias started school. No one reacted to the family's difficulties for nearly 10 years, even though the mother had asked for help from the child health clinic and family counselling clinic. Regrettably, help only got to Elias when he had attempted suicide.

From birth to primary school

Elias's mother was 20 years old when Elias was born. She suffered from somatic and mental health issues and disciplined her children physically. The relationship between Elias and his mother became fraught. There were frequent arguments at home, mostly due to the family's financial difficulties and the parents' inability to cope.

Elias's parents divorced in quarrelsome circumstances when Elias was less than one year old. According to Elias, cooperation between his two homes was difficult after the parents' divorce. At times, he had to carry messages between his parents. Even though the father was frequently in better condition than the mother in many respects, the mother remained the primary custodian. Elias feels that there is a ”default pattern” for these decisions, which is followed inflexibly regardless of the actual situation. Elias feels that the child welfare supervisor's decisions were unfair and that he had no chance to affect the situation.

When Elias was two years old, his mother graduated from an institute of higher education. His father already had a degree, but was struggling with his mental health and life management. While Elias's mother was studying, a lack of money and mental health challenges were constant features of the family's life, the atmosphere at home was unsafe, and Elias was disciplined physically.

Elias's mother had a second child when Elias was 5 years old. His little brother was frequently ill in his first year of life. Elias remembers that his mother's time and energy were spent on caring for his little brother. Elias's aunt moved in with the family to help out but was not someone to whom Elias could confide. Elias had to manage many things without help from a very young age. He also got special permission to walk alone to preschool.

When Elias was six, his father got a lady friend whom Elias remembers as a cold and cruel person, making the father's home unsafe. Elias recalls that his father did not react to this because he could not leave his lady friend for financial reasons. The relationship lasted two years and Elias was too afraid to tell anyone about the problems in his father's home.

Elias did well in primary school, which Elias credits to his teacher, who was a good listener and gave him much support. The teacher was consistent and strict. Elias does not know how he would have managed school without this important person. His home was gripped by a constant fear of death due to his little brother's serious illness. All attention was focused on the little brother, with Elias's needs being neglected.

When Elias was eight, he told the school psychologist about the situation at home. The school offered him the opportunity for long-term counselling. In Elias's own view, the intensive support he got at school was the only thing that kept him going through childhood and adolescence. It was practically the only support given to him or his family. According to Elias, his mother had asked for help from the family counselling clinic at this point. The contact with the family counselling clinic lasted for roughly six months but did not change the situation at home. Elias or his family did not get any other services to support the family at the time. When Elias was 11, his mother contracted a somatic disease and Elias had to take responsibility for his little brother as well. Elias also took his brother to the school physician's appointments and remembers that he was praised for his initiative.

Lower secondary school

By the time Elias was 13, his mother had recovered and was able to work again and his little brother had gotten well. Elias did well at school, where he feels that he got intensive support from both his teacher and the school psychologist. This support was not enough, however, and Elias collapsed immediately when his family's situation had stabilised. He attempted suicide, was hospitalised several times for psychiatric treatment, became a psychiatry outpatient, and the psychiatry clinic filed the first child welfare notification on him. The notification resulted in a brief (three months) placement in open care. There was a risk that Elias would have to keep going back into the psychiatry ward going forward. Elias had asked to be taken into care, but he was discharged back home. After his discharge, the family got crisis support and family services in open care. The support was provided to the mother's family even when Elias was spending more time at his father's place. Elias feels that he got support from the school, adolescent psychiatry worker and his child welfare workers during the crisis. When his situation stabilised, Elias recalls that not a single adult paid attention to his intoxicant use or even knew where Elias was spending his time. Elias feels that his life lacked boundaries at this stage and the professionals did not have a comprehensive picture of his circumstances despite the intensive support given to him.

Time after school and before adulthood

Elias again attempted suicide when he was in vocational college and entered the psychiatry ward once again, was placed in a reception facility and started a period of intensive outpatient treatment at the psychiatry clinic. Taking him into care was proposed at this point, but it did not happen because Elias did not want it any more. According to Elias, the situation in his family was tense and he was worried about his little brother. Elias felt the situation at home to be unsafe and did not live there, but stayed with relatives and friends. He was taken into care at the age of 17 and placed in a housing trial unit. His protracted psychiatric outpatient treatment ended and he began a long period of psychotherapy, which in the end lasted three and a half years. At the age of 18, he started receiving after-care support.

The total price of the services described above is nearly 260,000 euros.

Alternative scenario and calculation basis

The following scenario is not based on real events but on Elias's retrospective assessment of the junctures at which the right type of help given at the right time would have improved his situation considerably. In our discussions, we considered from a variety of angles which services, provided at which time, would have given Elias the best help and support.

In terms of costs, the key question in Elias's story is whether his multiple treatment periods in the psychiatry ward and placement outside the home could have been avoided. If his challenges had been addressed in time, could Elias's suicide attempts have been prevented?

Elias's family received hardly any support until the situation came to a head. The alternative calculation assumes that the family's challenges would have been identified and addressed in time and comprehensively. In an optimal scenario, the child health clinic and the parents' mental and somatic healthcare services would have noticed the whole family's challenges when Elias was born, made child welfare notifications and directed the family to the appropriate services. They would have been offered home services, and the family's financial situation could have gotten help for its financial situation in connection with the child welfare assessment. The alternative narrative calculates that long-term support would have been initiated for the whole family immediately after Elias was born and continued throughout his childhood. In this scenario, the calculation also includes intensified family services, after which the family would receive home services and long-term support. The family's support would be increased in difficult circumstances, such as during a divorce.

If child welfare concerns had been raised by primary school at the very least, would the family have received the long-term support it needed? Studies show that long-term support can improve the situation of children and families.

From the age of three, Elias would also certainly have benefited from a support family where he could have gotten attention from adults and space to process his emotions. According to this calculation, Elias could have gotten a support family for six months, which would have cost approximately 13,500 euros. The idea is that timely support could have prevented Elias's placements outside the home and periods of hospital treatment, which would have saved roughly 100,000 euros from the realised costs.

In other words, it seems like all of the services were consistently a few steps behind, and Elias was only placed outside the home when his mental health issues had persisted for years and had perhaps become chronic. When we need to resort to expensive and intensive services in a crisis, it carries a significant price tag for society, and there is no clear evidence of the effectiveness of such services.

As in the previous cases, more than half of the costs in this calculation are incurred from long-term relationship-based support. We added a generous amount of long-term support to this calculation as well. Stronger or more intensive support has been included in the calculations for the turning points in life in which risk factors multiply – such as the birth of a child or starting lower secondary school.

The price of the services in the alternative scenario is approximately 100,000 euros, which amounts to roughly 160,000 euros less than in the actual case.

3.2

Niko, Aamu, Ella and Aava – sufficient support for the family from preventive services

Niko

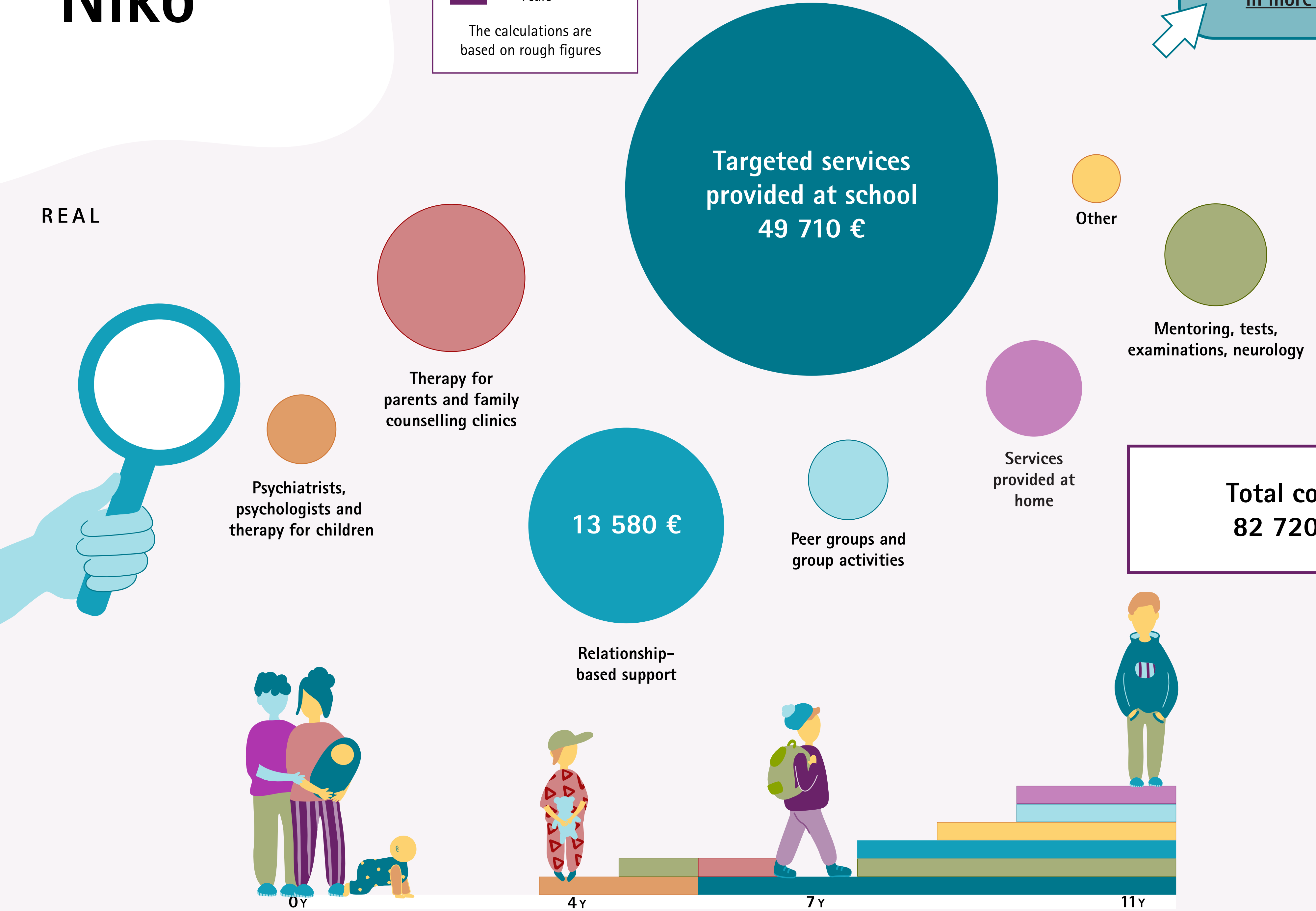
○ = Costs in euros

▬ = Years

The calculations are based on rough figures

Examine the costs in more detail

REAL



Targeted services provided at school
49 710 €

Other

Mentoring, tests, examinations, neurology

Therapy for parents and family counselling clinics

Psychiatrists, psychologists and therapy for children

13 580 €

Relationship-based support

Peer groups and group activities

Services provided at home

Total costs
82 720 €

Niko: a service path for a NEPSY kid and his family

Niko is 11 at the time of writing. This case is based on real events related by Niko's mother in a telephone interview, as well as on facts checked and related by his social worker. The essential part of the case is the last two years, when the family felt that it was getting the right kind of support for its challenges and things gradually began to turn

better. Costs had been incurred before this positive phase, however.

We assume that the family will continue receiving certain preventive services, and more expensive corrective services will not be required going forward.

Family background

Niko's family consists of a mother, father and three siblings. His parents have only completed basic education. The family's financial circumstances are tight, but the parents are not entitled to social assistance. The father is employed, while the mother has been unemployed or on sick leave for the past 10 years or so. The mother had a traumatic childhood due to her parents' alcohol abuse. She has mental health issues that have limited the life of the whole family. The family has found it difficult to commit to support services, and the parents do not trust services in general.

Niko's childhood from birth to primary school: the challenges mount

Niko had trouble with many things from when he was very small and had always been a particularly sensitive child according to his mother. His emotional regulation skills were not great and the parents were not equipped to develop them. The parents were also concerned about Niko's ability to concentrate, both at home and at school. In the parents' view, their children had problematic relationships with their siblings, and the parents felt everyday life to be difficult.

Niko was given speech therapy at the age of four and a few sessions of occupational therapy when he was five. He was also assessed by a children's neurologist before starting school, but his difficulties were still minor and Niko was young, so the assessment was not followed up.

The mother saw a psychiatrist for a time, but the therapy was discontinued when Niko was still in day care. The mother felt that she had been "thrown out of the psychiatry clinic".

Just before Niko started school, the family was offered support by the family counselling clinic, but the mother felt that it was not helping the family and a relationship based on trust did not form. According to the mother, the meetings were too infrequent (approximately once a month) and she always had to repeat what she had told them about the family's and Niko's circumstances. The family counselling clinic gave some advice but, according to the mother, they perceived that the problem was in the parents' relationship, even though the parents did not share this view. The parents felt that neither they nor Niko's challenges were being taken seriously. They felt that they were not being listened to.

According to the mother, the problem with all of the services was that the people always changed and no-one understood what they needed help for. The parents needed help and advice for their everyday life from the start but felt that they did not get any.

Primary school: comprehensive support for the family begins

Niko and his family received more concrete and comprehensive support when Niko was starting second grade. The family was granted comprehensive support because Niko had difficulties with self-regulation and his mother had mental health issues. There was a risk that the family's difficulties would increase and their service need would be greater going forward. When comprehensive support for the family began, the other services were discontinued.

The family's issues were addressed one at a time, taking the whole family into account. Relationship-based work was started with the parents and the family was assigned its own worker, i.e. a companion. The companion had frequent support discussions with the family and encouraged and helped them with managing their affairs. The meetings and telephone discussions were more frequent for about a year, after which the need for them decreased and meetings were held less often.

Help for Niko's challenges from neuropsychiatric examinations

Niko's challenges with self-regulation made both schoolwork and the family's life more difficult. These challenges manifested as difficulties in concentrating at school, when boundaries had to be set for Niko, in his relationships with his siblings, and as lying. The companion helped the parents get a new neuropsychiatric examination for Niko. That cleared matters up and Niko got a diagnosis and medication. Annual follow-up meetings were also scheduled with a children's neurologist and a physician.

Things also moved forward at school. Niko had a few meetings with the curator and school nurse. He received a special-needs support decision after his neuropsychiatric disorder was diagnosed. Before that, Niko had received general support in preschool and intensified support in first grade. As a result of the decision, Niko was transferred into a small group halfway through primary school and found it easier to focus and study there. The change also improved Niko's opinion of school and overall well-being.

Support for parenthood

The companion helped the parents adjust to the situation and directed them to counselling for the parents of children with neuropsychiatric disorders. The companion also helped the family deal with Kela (the social security institution of Finland), such as with their application for a disability allowance.

The parents had not had any significant time for themselves without the children for roughly ten years and were at the limit of their endurance. The family had some networks of its own, but they were not enough to carry the parents. A support family was sought for the family for a long time and finally found when Niko was ten. The family is now being supported by a support family who they trust and are comfortable working with. The support family is helping the parents cope, and the monthly breather has been much needed by them. This form of support has empowered the family by letting all of the children stay with the support family roughly once a month. The parents were also granted family therapy. They have weekly appointments and are highly committed and motivated to attend the therapy.

When the comprehensive support started, the mother was extremely tired and was not getting support for her difficult mental health challenges. After a long period of consideration, she once again sought treatment at the psychiatry clinic. Therapy was arranged for the mother in the day ward for a few days every week, which she attended for around six months. She also had appointments with her own nurse, physician and occupational therapist. She now has appointments roughly once a month. The mother is still on sick leave, but her situation is being assessed on a regular basis.

The power of peer support

Before the start of intensive support for the family, there were challenges in the relationship between Niko and his father. Niko often ignored his father and was aggressive and difficult when boundaries had to be set for him. The father has attended a dad group, which has helped him interact with Niko and his siblings. The change has been drastic, and the father's empowerment has contributed significantly to the improvement in the family's situation.

Now that things have gotten better, the family is also attending peer group meetings for the families of children with neuropsychiatric disorders once a month. They also attend events for such families every now and then. The whole family is welcome in the peer group. These group meetings are active, interactive, free-form gatherings. This peer support means a great deal to the mother.

The situation now: intensive preventive support made a difference

Niko and his parents were given long-term companionship-based support for a year and a half. The support was more intensive at first, when they were charting the family's overall situation and looking for suitable forms of support. Today, the support is occasional, but the family knows that help is only a phone call away if needed.

According to the mother, relationship- and companionship-based support helped Niko and his parents get over the worst time. The whole family is now within the scope of remote support, i.e. under monitoring. They can always call their support person if the need arises. The mother feels that the remote support is helpful, although more distant than the intensive support provided by their companion. All things considered, the mother is happy that they have a contact person they can reach out to.

In the parents' opinion, the counselling and support provided by their companion was extremely helpful to the family. *”We got a lovely/competent companion who listened, helped, encouraged and always knew what to do next.”*

Niko and his family are better now. According to the mother, the most important thing was that the family was given advice and information and was supported by the same familiar person from start to finish. After Niko got the services he needed, his schoolwork has improved and he is not as burdened by studying as before. His parents feel that peer support was important to them in addition to individual services and the support provided by the companion. The family's life is now easier. The mother is also feeling better: her mental health issues have abated and she is now going through preparation for working life.

”Back then, I felt that no-one was taking us ”seriously” and things were not going anywhere. And I didn’t even really know where to go for help any more. That’s why I think that, even if things had gotten better, definitely not by this much.”

Costs

The costs of the services used by Niko and his family have amounted to roughly 83,000 euros, of which around 66% have consisted of special-needs education costs (general support, intensified support and small class). But the family also needed other support. The parents felt that the greatest change was effected by comprehensive and relationship-based support. Its significance was great but cost relatively small – around 13,000 euros. Without the change achieved, the family could have needed more expensive forms of support. The costs have been calculated up to Niko’s eleventh year. If these less intensive forms of support would be sufficient until he turns 18, they would incur 31,000 euros in additional costs. By adulthood, the total cost of Niko’s realised and presumed services would amount to 114,000 euros.

Research has shown that children with neuropsychiatric disorders are often over-represented in child welfare and their families are not successfully supported with timely and effective services.

Aamu

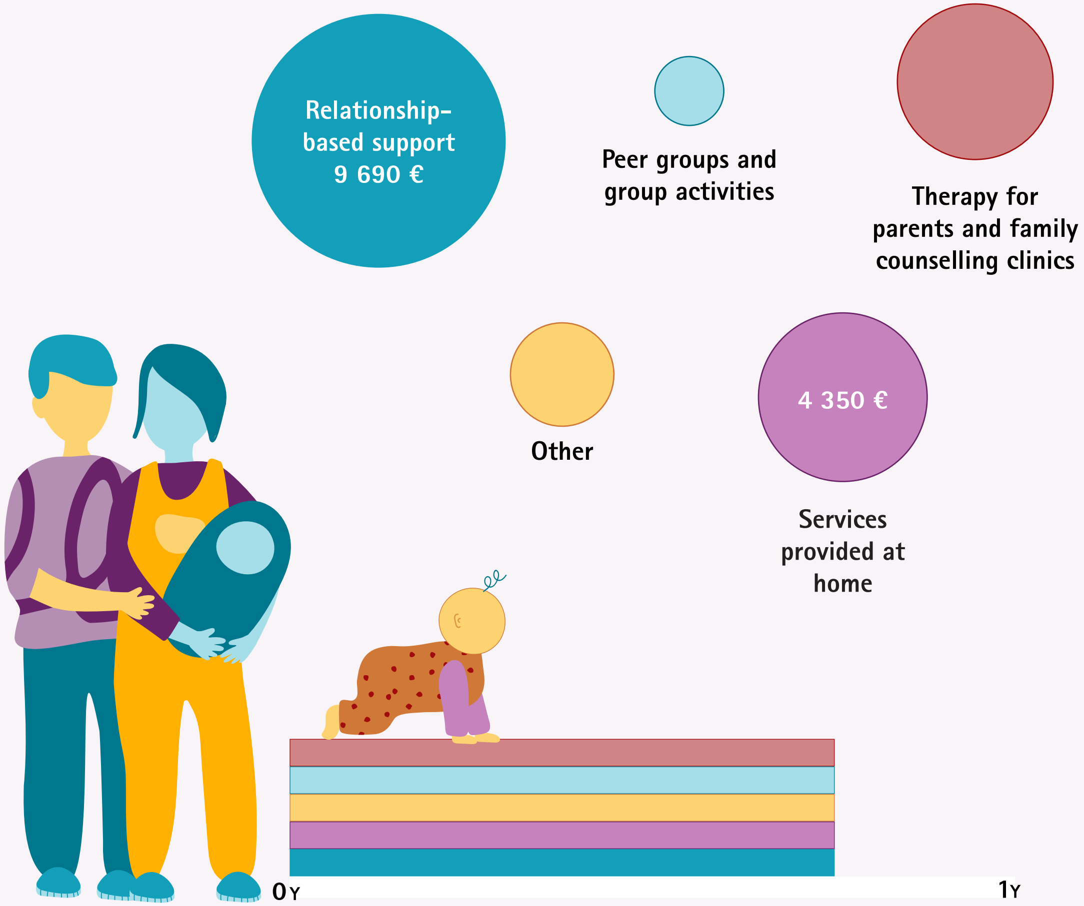
○ = Costs in euros

■ = Years

The calculations are based on rough figures

Examine the costs in more detail

REAL



Total costs
20 100 €

Aamu: the mother's mental health issues posed challenges from pregnancy onwards

Aamu is nine months old at the time of writing. This case study is based on discussions with Aamu's mother and facts checked and related by her social worker with the mother's permission. Her mother went through major changes after Aamu was born, and the family's situation gradually improved. Costs had accumulated from the mother's service use even before Aamu was born, but these are not taken into account in the calculations.

We assume that the family will continue receiving certain preventive services, and more expensive corrective services will not be required going forward because the root causes of the problems have been addressed and the family has received intensive support, which it has found to be effective.

Family background

Aamu is her parents' firstborn. Her father is employed, but the mother is mostly incapable of working due to her mental health problems.

Aamu's mother has suffered from serious mental health issues since youth. She contracted depression at the age of 20. The severe depression eventually required roughly nine months of treatment in a psychiatric ward. In a few years, the situation deteriorated again. She was suicidal and again received treatment in a psychiatric hospital for about nine months.

Serious mental health issues complicated Aamu's mother's life for ten years or so. She was still hospitalised for two brief periods at the age of 30. She has received psychiatric care for her entire adult life. These challenges with mental health have also affected her physical health.

Gradually, Aamu's mother began to realise that the bullying she had experienced at school and, especially, a serious childhood trauma lay at the heart of her problems. She summoned the courage to tell a professional at the psychiatry clinic. When she started processing these issues, her gradual rehabilitation began and she was able to decrease her medication.

Support for a difficult pregnancy

Pregnancy was an unexpected and wonderful surprise for Aamu's mother. But it was also a difficult time for her. The mother suffered from serious insomnia, her trauma evoked fears related to pregnancy and motherhood, and she had serious physical challenges as well.

During her pregnancy, the family heard about relationship-based comprehensive support and hoped that they could qualify for it. The service was only available to children and families at risk of facing broader challenges and needing special services later. The family had multiple risk factors – the mother's traumatic history and mental health challenges, difficulties in the relationship between the parents, the mother's long-term unemployment and the family's lack of support networks – and were thus found to qualify for the service.

The family was assigned a companion who gave the parents comprehensive assistance. The family's issues were addressed one at a time, taking the whole family into account. Relationship-based work was started with the family, and the companion held frequent support discussions with the family and encouraged and helped them with managing their affairs. The meetings and telephone discussions were more frequent for about a year and a half, after which the need for them decreased and meetings were held less often. At the same time, Aamu's mother explored her past traumas with psychiatry professionals.

Intensive support continues during infancy

Aamu cried a lot as a baby because of stomach complaints and needed special care. The crying would not abate no matter what, so it was decided to try zone therapy for Aamu. The mother was also offered ten sessions of osteopathy. The mother felt that the osteopathy had a major impact on her well-being and sleep during pregnancy and Aamu's infancy. Without this change, her insomnia would have continued and caring for Aamu would have been difficult.

The parents' relationship was fraying by the start of relationship-based support for the family. The parents started couples therapy but nevertheless separated when Aamu was a few months old. It has been agreed that the father spends some weekends with Aamu, but the mother is her primary parent and carer.

The mother has received home help services through the child health clinic for a few months to improve and maintain her ability to cope. A child care service was also arranged for the family when the home service ended. The purpose of the child care service was to support the mother's ability to cope and make it possible for her to continue her therapy.

The mother has been getting psychiatric treatment all through Aamu's infancy. Now that Aamu is 9 months old, her mother goes to EMDR therapy – a therapeutic approach commonly used to treat psychic trauma.

The situation now: relationship-based support "saved my life"

Aamu's mother says that she used to get anxious very easily and things like going to the grocery store were impossible for her. She also got flashbacks from her traumatic past, especially at night. The situation had improved a little just before the start of the relationship-based support provided by a companion. According to the mother, the support provided by the psychiatry clinic alone would not enabled her to achieve such progress, however.

For Aamu's mother, the important thing in relationship-based support is that you can always call someone. She has kept close touch with her companion and they have met on a weekly basis. At the time of the interview, she had been getting intensive comprehensive support for about a year and a half, and it had made a huge difference. She now feels that she is a mother. She feels stable and well. Aamu has given her life motivation and meaning. The mother is now more open about her trauma as well. Before, she felt like she was watching her life from the outside.

The same companion has supported the mother and whole family since pregnancy. Aamu's mother feels that it is important that you can call the companion when you are having a hard time. The mother says that her situation would be considerably worse without the companion. She would not have been able to manage, but would have suffered a meltdown. The mother thinks that she would have gotten suicidal and been hospitalised again. In that scenario, Aamu's circumstances and the family's service needs would have been completely different. According to the mother, the companion "saved her life".

Comprehensive support has made Aamu's mother trust people and the authorities more. She has also found new friends from a peer group for people in similar circumstances.

According to the mother, all support has been important, but the relationship-based companion service has had the greatest significance and impact. She feels that the EMDR therapy has also played a major role in the processing of her trauma.

After the parents' separated, Aamu is spending more time with her mother who is also responsible for her. The parents have joint custody, however, and Aamu's father is also present in her life. The mother's health has improved and she now experiences motherhood as a positive thing. Her mental health is also better. She has found herself again and begun to heal, but will still need trauma therapy for a long time.

Based on her own experience, Aamu's mother hopes that services would always target the root cause of the problems. That would prevent many issues but requires enough counselling, and possibly also alternative forms of treatment.

These changes have made a positive impact on Aamu's life and she will now get a much better start to life.

Costs

The costs of the services provided to Aamu and her family have amounted to approximately 20,000 euros, mostly from the costs of the companion. Aamu's mother felt that it was precisely the comprehensive and relationship-based support provided by the companion that made the greatest difference to her. The mother has been a psychiatry patient since adolescence, and these costs have not been taken into account in Aamu's calculation.

The costs have been calculated for Aamu's first year. If these less intensive forms of support would be sufficient after the early intervention and continue until Aamu turns 18, they would incur roughly 49,000 euros in additional costs. The assumed costs include the companion until age three, less intensive support until the start of school, some child care and home help services, as well as peer support for the whole period. By adulthood, the total cost of Aamu's realised and presumed services would amount to 69,000 euros.

Families with babies seldom receive risk-based support like Aamu and her family. Such families often say later that they wanted help and asked for it already during their child's infancy, but did not get enough. Intensive proactive support can nevertheless avoid later costs incurred from more expensive services.

Ella

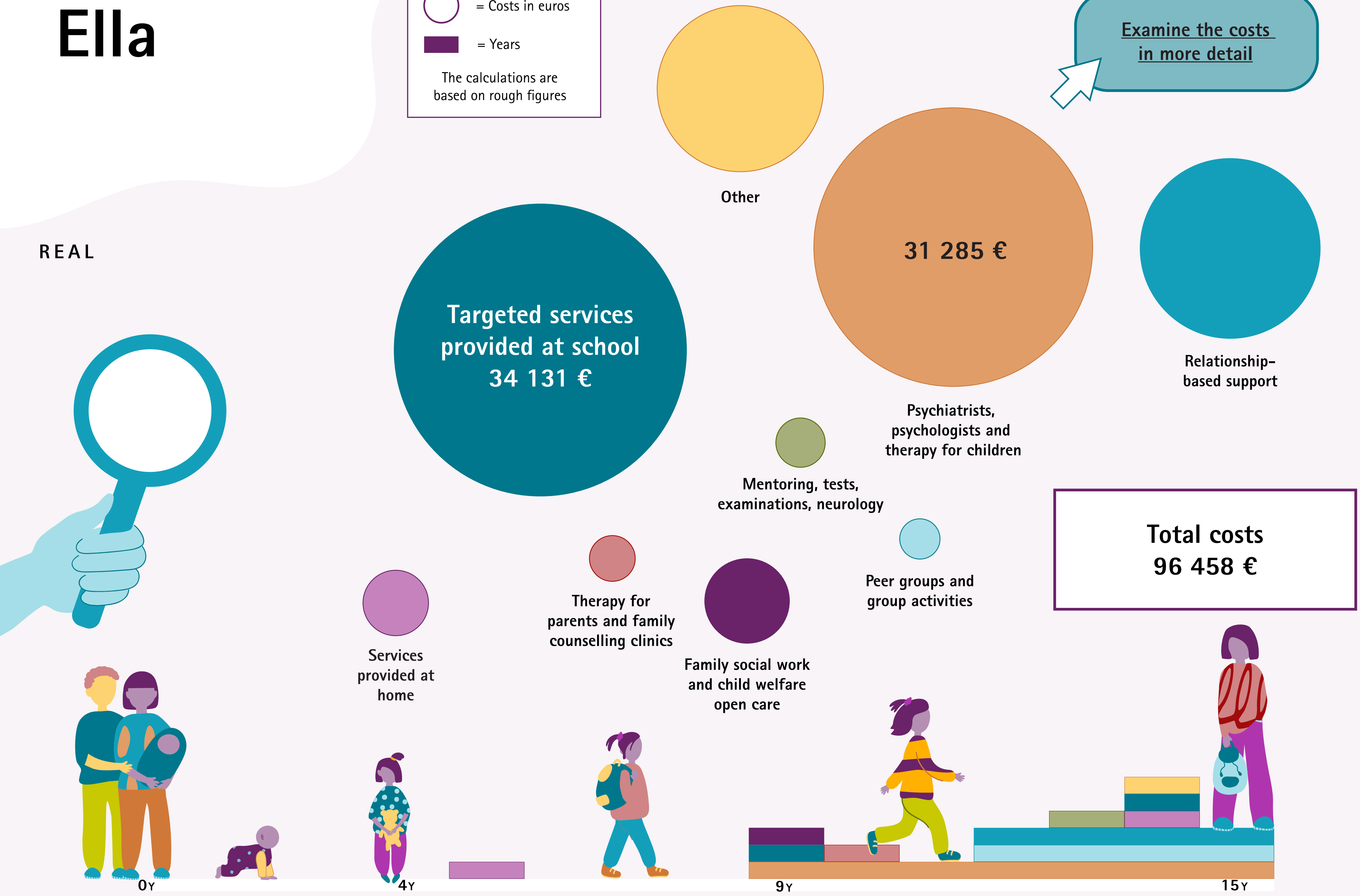
REAL

○ = Costs in euros

■ = Years

The calculations are based on rough figures

Examine the costs in more detail



Targeted services provided at school
34 131 €

Other

31 285 €

Psychiatrists, psychologists and therapy for children

Relationship-based support

Mentoring, tests, examinations, neurology

Peer groups and group activities

Therapy for parents and family counselling clinics

Family social work and child welfare open care

Services provided at home

Total costs
96 458 €

0Y

4Y

9Y

15Y

Aava

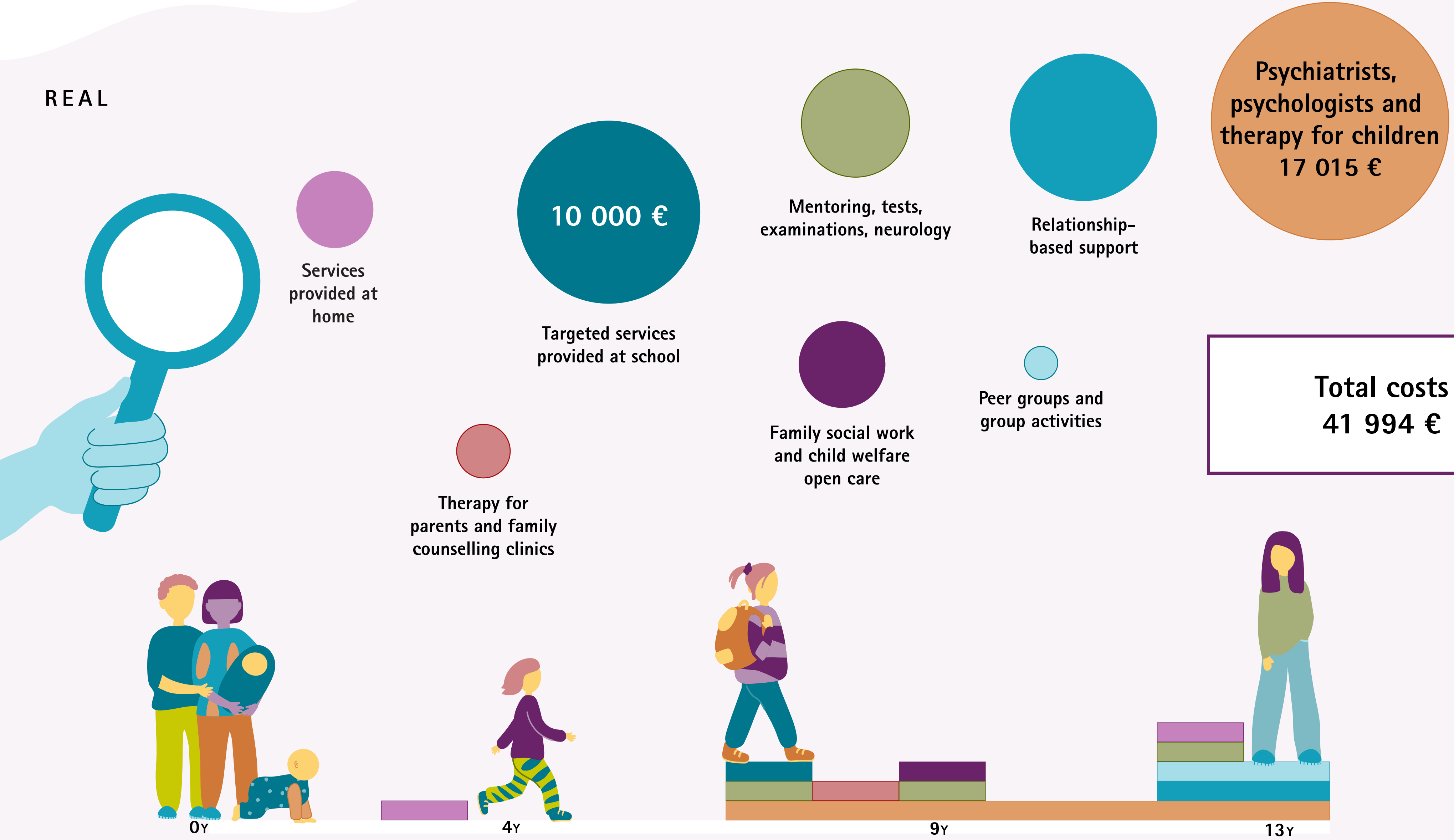
○ = Costs in euros

▬ = Years

The calculations are based on rough figures

Examine the costs in more detail

REAL



Services provided at home

10 000 €

Targeted services provided at school

Therapy for parents and family counselling clinics

Mentoring, tests, examinations, neurology

Family social work and child welfare open care

Relationship-based support

Peer groups and group activities

Psychiatrists, psychologists and therapy for children 17 015 €

Total costs
41 994 €

Ella and Aava: the whole family was suffering until the right type of support was found

Ella and Aava are sisters. At the time of writing, Ella is 15 and Aava is 13. This case is based on real events and separate discussions with Ella and the siblings' mother. Facts checked and related by their social worker have also been used for the case with the clients' permission.

The last two years are the key period in the case. In those years, the family felt that it was getting the kind of support that gradually turned things around for everyone. Costs had been incurred before that time, however.

We assume that the family will continue receiving certain preventive services, and more expensive corrective services will not be required going forward, because all family members feel that things have changed for the better.

Family background

Ella is in the ninth grade and Aava in the seventh. In addition to them, the family includes their mother. The parents are divorced and the father is not very involved in the children's lives. According to the mother, the sisters have faced many difficulties for their entire childhoods, and difficulties with their father have compounded the family's problems. The mother has a low income and the family's finances are tight.

According to the mother, Ella has been bullied, suffered from anxiety and depression, has cut herself and been otherwise prone to self-harm. The life of the younger sister, Aava, has been complicated by neuropsychiatric challenges and loneliness, and Aava suffered from many somatic symptoms until the start of primary school. Her serious allergies and reflux symptoms were a heavy burden on the family. In addition, the family's situation has been complicated by the parents' divorce and the mother's inability to cope. The mother also feels that the family has not been listened to or understood in the service system in the past.

Ella's issues lead to self-harm

The parents had marital trouble in Ella's early childhood and finally divorced when Ella was six. In addition to the divorce, Ella suffered from bullying in primary school. The mother sought many kinds of help for Ella and the whole family both before and during primary school but was granted hardly any support. And when granted, the support was inappropriate or inadequate. The family did get some assistance from home services to help them cope, however.

Ella had a few appointments with the school curator and psychologist in primary school. That was not enough for her, however, and Ella became a child psychiatry patient in the third grade when her symptoms got worse. This support continued later as adolescent psychiatry for depression and anxiety. Ella experienced psychological violence at her father's place after the divorce and also told about this in the child welfare needs assessment. According to Ella, she was not believed and her experiences were belittled, however. She did not become a child welfare client.

Ella says that she was timid and was bullied a lot towards the end of primary school. In the last grade of primary school, she was granted relationship-based comprehensive support. It included a companion who had meetings with both Ella and her mother. The service also included many group activities and events for young people, parents and the whole family. Ella made a lot of friends in the groups and gradually started feeling better.

Things moved forward in other ways as well, and Ella was referred to neuropsychological examinations. She had not been admitted to them before despite the mother's repeated attempts throughout primary school. As a result of the examinations, Ella was diagnosed with a neuropsychiatric disorder, was prescribed medication and received some occupational therapy. Ella did not get adjustment training due to the late stage in which her disorder was diagnosed, however. The mother feels that she should have been examined earlier.

Ella got drastically worse at the start of lower secondary school. She got serious depression, had suicidal thoughts and was too exhausted to go to school. According to the mother, if Ella had received support earlier, things would not have gotten so bad. Ella had almost given up already. She went to hospital school for approximately a year due to her suicidal tendencies and multiple challenges.

But her companion continued supporting Ella in the midst of these challenges, and her wishes were listened to and fulfilled. Ella stopped visiting her father on her own initiative. She felt that the authorities had not listened to her on this before. Ella's condition improved dramatically when the meetings were reduced and she was no longer forced to go to them.

Ella feels that she has been listened to and people have taken a genuine interest in her affairs in the relationship-based individual and group activities. According to Ella, people used to downplay her problems and she had lost faith in services and getting help. Now that Ella has felt that people trust her, she has found the ability and courage to talk about her problems and has gradually started feeling better.

Ella feels safe and at home in the individual and group activities. She has made a lot of friends through the activities, which has been an especially healing experience for a victim of bullying. According to Ella, the greatest change is that she now wants to live. She has started dreaming.

Aava's neuropsychiatric challenges impede schoolwork

Aava is the younger of the sisters. Her parents got a divorce when Aava was still in day care, and her life has been characterised by a variety of somatic symptoms, especially in her early childhood. Due to these health issues, Aava was a regular patient at the paediatric clinic until she turned 13. She started child psychiatry before primary school and was diagnosed with a neuropsychiatric disorder after neuropsychological examinations. The diagnosis enabled Aava to get adjustment training in the first grade, and she spent her first school year in small-group tuition. According to her mother, Aava would also have needed occupational therapy, and she persistently tried to secure it for Aava. Occupational therapy was finally begun when Aava was in the third grade.

Due to its various challenges, the family was eventually referred to the family counselling clinic when Aava was in the second grade. The mother felt that the support given by the family counselling clinic was not appropriate and all the challenges were seen simply as parenting issues. The family later got neuropsychiatric mentoring, which the mother found helpful. Later on, the family also became a family social work client under the Social Welfare Act and was provided with family social services through that channel for a time.

According to the mother, Aava's school was not able to deal with her neuropsychiatric disorders. During primary school, Aava gradually lost the joy of learning, even though she had always loved learning according to her mother. This concerned the mother, who wanted Aava to be tested for learning disabilities, but this was not thought necessary. The tests were eventually taken when Aava was in the sixth grade, and she was diagnosed with dyslexia and a learning disability.

Towards the end of primary school, Aava was transferred to another school and started receiving the same comprehensive companion-based support that Ella already had. Aava and Ella also shared the same companion, with whom they could discuss things confidentially. Aava has also attended weekly group activities, where she has found a lot of friends, which she never had before.

According to the mother, the helpers have been able to look at Aava's situation as a whole and address the root causes of her problems. Relationship-based comprehensive support has brought about a change in Aava's situation. She now finds school easier. She has recovered her lost motivation to study. And Aava is not lonely any more: she has made friends and found a community where she feels that she belongs.

Effects of the family's circumstances on the mother

Both Ella's and Aava's circumstances have hindered their mother's ability to cope. The mother says that she has frequently taken long sick leave. Her symptoms have been somatic, and the stressfulness of her life has certainly not made them better if not worse.

The family has a low income. Medicines are expensive on top of the normal cost of living, because she still has to pay the deductible for them. At worst, the family has spent 300 euros per month per person on medicines as the deductible is calculated separately for each individual. Other continuous healthcare expenses, such as hospital and clinic fees, also increase the family's financial challenges.

According to the mother, managing her children's affairs is full-time work. She has had to cut back on her working hours, which has damaged the family's finances further. The mother is Ella's informal carer and works half time to be able to manage the family's meetings, doctor's appointments, schedules and bureaucracy.

The mother used to feel that her family was not being listened to. According to her, things were blamed on the parents and viewed as interaction issues. Because this had been the mother's experience for a long time, she started doubting herself. She says that she had been seeking support for the family for a long time, but getting services was difficult before the family was granted relationship-based comprehensive support. The mother feels that she has finally been heard and has received support for parenting.

The knot started to unravel once the family's situation was seen as a whole. The whole family has been provided with communal group activities and individual support from their companion, which has helped all family members. According to the mother, the children now feel that they can talk to professionals about their problems. The children have also made friends through the activities and also spend time with them outside the structured activities. The experience of being seen and heard had been important for the whole family.

According to the mother, both she and the children are highly committed to the comprehensive support and activities: in them, they have found a community. The family has gained shared positive experiences from the activities that they would not have been able to afford with their low income.

The situation now: relationship-based individual support and communal group activities helped turn things around

In the relationship-based individual and group activities, the family's situation has been seen as a whole. This has had a positive impact on the lives of Ella, Aava and their mother. According to the mother, the service system used to be against them, but now it feels like it is walking the same path forward with the family.

The mother feels that it has made a great difference. She thinks that she would have burned out without diverse support for the children's great difficulties with illness, school and the various demands placed on them. Even the other parent in the family did not provide any help or support. In the mother's assessment, without comprehensive care, the younger sister, Aava, would be lonely and spend all her time on the computer. Without the motivation to go to school, she could also have wound up in bad company. According to the mother, Ella could already be in substitute care. Sadly, the mother also acknowledges that she might not even be alive any more.

The mother feels that the family should have received comprehensive support much sooner. *“It would have been much more cost-effective if we had gotten support when the children were little, which I did ask for and even beg from various places, because we have been to so many appointments, emergency rooms and meetings with different parties over the years and relied on so many kinds of support... and the lives of many people would be easier too.”*

The mother boiled the change down to one sentence that says it all: *”I don’t have to be scared any more.”*

Costs

The total costs of Ella’s and Aava’s services amounted to approximately 138,000 euros, of which roughly 96,000 euros are allocated to the older sibling, Ella, and about 42,000 euros to Aava. It is noteworthy that, regardless of the mother’s requests, support often came to Ella a little late, allowing her problems to accumulate. This gradually increased her need for specialised services and consequently the costs as well. As an example, hospital school is a specialised service with an annual price tag of 33,000 euros.

All of the family members felt that relationship-based support and communal group activities were effective and significant in changing things for the better. The mother says that, without support, the family’s situation would be worse and both children would need more services. The total costs or relationship-based support and group activities for three years amounted to roughly 19,000 euros, which represents approximately 14% of the costs of all services used by the children.

Ella’s costs have been calculated up to the age of 15 and Aava’s up to the age of 13. If the current forms of support would suffice in future and continue until the age of 18 for both sisters, it would incur approximately 44,000 euros in further costs. By adulthood, the total cost of the sisters' realised and presumed services would amount to 183,000 euros. The costs would thus be 121,000 euros for Ella and 62,000 euros for Aava.

Both sisters were diagnosed with a neuropsychiatric disorder at some point of the service path. Children with neuropsychiatric symptoms are often over-represented in child welfare, and authorities do not always have the expertise to provide them with timely and effective support, which can lead to very high service costs.

4.

Conclusions, what can we learn?

THE CALCULATIONS IN THIS REPORT involve bold assumptions, some uncertainties and even a healthy dose of hindsight. We should not look for lessons in the specific events of the individual cases. The case studies serve their purpose if they are fairly representative of the conditions on the ground. We should instead think about how to catch the mirage of a union of the financial and the humane. Or perhaps, given that we are dealing with a cost survey, it would be more apt to compare the quest to finding the crock of gold at the end of the rainbow?

The title of our report is: how the costs of protecting children accumulate. We are thus not studying cost-effectiveness. Our intention is to follow in the footsteps of the previous report by presenting the accumulation of costs simply, but without compromising too much on accuracy. And the costs do accumulate, much faster than in 2012. The costs of social services are almost as great as those of healthcare and are growing at the same rate.

Browsing through the cost data is an adventure in itself. Prices appear to have risen rapidly. The different sources quote very similar prices for some services, but there is also considerable variation. Some of the prices quoted are suspiciously low, such as those for school psychologist services, which can partly explain the scarcity of psychologists at schools. As a stand-out exception from the general trend, the price of support person services has actually decreased.

Criticism of the one-size-fits-all solution can be justified

This report can be criticised of seeing relationship-based support as a blanket solution for every problem. We accept this criticism and acknowledge our guilt. This “blanket solution” does not refer to any single method or service provider, but only to a method of working. On the other hand, we did not pull this blanket solution from our hats. Rather, it was mentioned in its various forms by the people we interviewed (see also Hokkila, 2023, Rimpelä & Kirmanen, 2024). The idea is very similar to the key concepts of Itla’s collective impact model: prevention (act early and prevent), integration (work together) and continuity (work long enough).

The above-mentioned “blanket solution” of relationship-based support means support provided someone familiar to the recipient. The support will be continued for as long as necessary and can vary in intensity. Simply being available without performing any specific service is part of the concept. This is what we mean when talking about relationship-based support in this text.

Twelve years of such relationship-based support costs the same as a little over three months in the psychiatry ward or four and a half months in a special-needs child welfare facility. There were lower prices quoted for relationship-based support too, and we did not calculate an average but picked the highest price quoted. Our calculations thus do not overplay the difference – especially since the media has quoted higher daily prices for facilities than the ones used by us (YLE, 2024). Relationship-based support is also justified by the logical idea that once you know the family, you also know its needs better. And if commitment to services is the problem, that too will be easier to address.

The difference in prices was naturally already known based on the previous report. And we are still no wiser about allocating support after this report either. What we can say, however, is that even when proactive support is “wasted” (that is, provided to a family that is not in acute distress), the cost will not be ruinous. Let this be the first potential lesson for municipalities thinking about cutting proactive and preventive services. Relationship-based support is also affordable compared to child welfare open care services. As indicated by the case studies, relationship-based support can either increase or decrease the costs in the short term.

Conclusions of previous report confirmed

As much as we may be tempted, it is not useful to calculate a “cost-effectiveness ratio” for proactive services based on the case studies. In the, admittedly few, case studies in this report, the cost of the scenario based on proactive services would appear to be in the 40–60% bracket compared to the alternative. The horizon is also limited because the costs were only calculated to the age of 18 at best.

Furthermore, Sami’s case highlights the fact that, even with open care services, more is not always better. Based on Niko’s case, a combination of service use and availability would appear to be the most functional choice.

Even though the combination of open care services does not necessarily correspond to reality in some of the cases (Helena, Sami, Elias), their price nevertheless remains well below the prices of specialised institutions. The calculations stray farthest from reality when support is cobbled together when needed and with an open cheque. However, this still appears to be a more economic choice when presented in this way. In addition, in Helena’s and Sami’s cases, we listed services knowing that, in reality, less could have been enough.

Perfect timing does not exist in real life, and even good timing is often apparent in retrospect. Not all open care services are cheap but, as a rule, they need to be piled very high before their price equals that of institutional alternatives. The above-mentioned observation is nearly unchanged from the 2012 report: *”In purely economic terms, the need to decrease placements should be obvious. The other side of the coin is of course effectiveness, of which there is no conclusive evidence one way or the other, but with the cost structures presented, open care services can be provided generously for a long time before their costs would exceed those of placement.”*

In the cases of Niko, Aamu and Ella and Aava, support was provided based on risks and effectiveness targets. Their families received relationship-based support and group activities, for example, which do not feature in the costlier case studies of Sami, Helena and Elias. In the case studies of Niko, Aamu and Ella and Aava, the clients had positive experiences of relationship-based support provided by a companion and found it to be effective. Even though the costs have been itemised, such support actually consists of an interconnected system of services seeking to achieve the desired effect, including support from the companion, group and peer activities, as well as additional services. That is why the cases may contain more services like therapy, child care or zone therapy than normal. They may not be as readily available in public services, but the costs quoted in these cases are real. The costs of these cases are not very high, but there is still a cost to proactive and preventive support as well.

Self-harm is emphasised in the case studies, family care neglected

The reader may wonder why the case studies refer to self-harm so many times. We have not overemphasised the issue – on the contrary, we left out some incidents of self-harm and suicidal behaviour. Shorter or longer periods of hospital care in the psychiatry ward following suicide attempts occur again and again in the materials and interviews used to construct the case studies. The recurrence of suicide attempts may be a simple coincidence, or it may not.

Placement in family care plays a minor role in the case studies. We could have imagined and calculated such a case, but decided to leave it to future reports. Placement in a family is not especially expensive compared to open care services, never mind placement in a facility. Substitute care is not automatically expensive, and there are major differences between its various forms, including in their price.

Niko's case study refers to remote and digital services, but apart from that, they received regrettably little attention in this report. The next update to this report should possible be made from the perspective of digital and remote services, and sooner than in 12 years.

This report has not calculated the financial benefits of child welfare either. In Helena's case at least, we can confidently say that the placements improved the quality of life of those staying at home and enabled their full-time employment. Not placing the child in substitute care could have carried a high price too.

In a few years, all underage age cohorts will be small. This will reduce costs even if the percentage of child welfare clients in the age cohort remains the same. If we could bring the child welfare metrics to even the level of 2005, it would free up a considerable amount of resources. Those resources could be allocated in a way that would further decrease the need for child welfare.

The method we have chosen underscores the difference in costs between the different scenarios, but limits their examination to childhood. No service is unreasonably priced if it works, because the client will hopefully have decades of life ahead of them, during which the benefits or costs will multiply. On the other hand, the prognosis in the more expensive scenario is not necessarily very good compared to the more affordable one.

Sami's, Helena's and Elias's cases leave the impression that action could have been taken sooner. On the other hand, you could also say in the cases of Niko, Aamu and Ella and Aava that it would not have been a good idea to wait much longer. The key lesson is probably the same as in the 2012 report (Heinonen, Väisänen & Hipp, 2012): good timing is important and saves money. But if identifying children and families in need of support at the right time would be simple, there would be no need for this report because the issue would have been sorted out ages ago.

In conclusion: If not now, when?

Can the mirage of a union between the humane and the financial be made real? We should have plenty of opportunities to do so, but there are obstacles in our path too. We do have reason for optimism, however.

Firstly: the costs of child welfare have been growing sharply for a long time, and we have now reached a level where we really need to look at the amounts we are spending. Pouring more money into the old machine does not automatically translate to a better life for children.

Secondly: no one objects to getting something better for less money, so in that sense, we just need to get the job done. If we can steer the effectiveness boom gripping public services at the moment to the right track, we will be one step closer to making the mirage a reality.

Thirdly: as the child count gets lower, every child will get – or at least should get – more attention and support. Even more than before, we cannot afford to let a single life go off the rails if it can be prevented. This does not mean that the rights of the child can be compartmentalised or that we can compromise on them when many children are being born. Nor does it mean that childhood would not be precious right now. It is difficult to formulate this idea without flirting with kitchen economics, empty proclamations and cynical realpolitik. Thousands of our baby boomers once emigrated to Sweden without even shaking the age pyramid. It is not hard to see that things are different now.

Fourthly: calculations on the cost of young people being marginalised were already being made during the depression of the 1990s. This observation is thus at least a generation old. As long as there have been general public services, reforms have been made to improve them. Our report presents concrete descriptions of how effective timely support can be. It should not be impossible, and it will not be free, but it can be worth it. We hope that our report will be a small step from “we need to do something” towards “this is what we need to do”.

Fifthly: we hope that our report will also stop decision-makers from being too enchanted by the mirage. There is no miracle cure, and the principle “invest one euro and get 20 back” is unlikely to apply here. Proactive support also costs money, and we hope that this report can help with understanding that.

If the union between the financial and the humane is not realised soon, more and more people may decide that it was only a mirage after all.

5.

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Appendix 1
How costs accumulate and how they were calculated

The clarifications and descriptions of calculations presented here apply especially to the cases of Helena, Sami and Elias. In the other three cases (Niko, Aamu and Ella and Aava), the data is based almost entirely on data from the Lapset ja nuoret SIB (Children and Youth Social Impact) programme. The data consists of precise, realised expenses specifically related to the case being described. In other words, the costs in these cases are more accurate than in the others.

Based on the data collected for the report, prices have increased significantly in the past ten years or so. Nothing certain can be said on the basis of this sample, however. We should nevertheless note that there are two possible ways to calculate the costs: what were the costs in the 2010s, in the time of the cases described in the previous report. Because of inflation, the answer will be different if we pose the question like this: what would the costs be if all this happened now? The indexes may not capture all aspects of cost development.

This report used almost the same definitions in the calculation of costs as used in 2012. The costs were limited to childhood (age 0–17) for the time and the services stated in the case studies. In addition to the services, we also included income transfers, i.e. monetary support, in the calculations at our discretion (Helena, Aava and Ella).

We only took public costs into account. Income or tax revenue lost or gained is mentioned at times in the case studies but was not included in the calculations. All prices quoted are gross prices. The majority of the prices presumably consists of wages and salaries, some of which is immediately returned to general government finances in the form of taxes. The calculations sought to determine the prices of service provision without profit margins or subsidies. There is probably variation in our price data, such as in how real estate or administration costs have been included in the prices.

We have primarily calculated the direct costs related to the child, which results in a focus on social work and child welfare, healthcare services and (special-needs) education. Services provided to the child's parents or siblings can be mentioned in the case studies and have been included in the calculations where explicitly stated. The younger the child, the more justified it is to include the parents' costs in the calculation. If the cost of a parent/family is directly linked to the child's child welfare case, its inclusion is justified. The whole family's costs have been included because we cannot know which of the children would have had the strongest reaction.

We used the premise that any costs diverging one way or the other from the normal trajectory of things would be included. Child benefits, early childhood education and care, or normal primary school are thus not included in the calculations. The costs of special-needs education, school health care and school youth work have been included in the calculations. Defining and allocating school costs was not simple. We sought to leave the base cost of basic education out of our calculations. The sums we used more probably underestimate than overestimate the actual costs. We wanted to harmonise the sums used in the various case studies, even if they then no longer reflected the events quite accurately. The school psychologist has normally been calculated as part of student care and is shown in the education costs.

Services for the whole age cohort, such as vaccinations or physical examinations, were excluded from the costs of school healthcare. To a degree, we also used our discretion on a case-by-case basis in separating additional services from the costs of a normal school path. For example, school youth work is normally a group activity and not intended as an individual service for a single student. School youth work has been “allocated” by including a part of its presumed expenses in the calculation.

Nearly all of the services taken into account in the calculation are now organised and paid for by the wellbeing services counties. Of municipal services, we have included some school and youth work costs. Costs allocated to the state include the costs of the judicial system and, with regard to rehabilitation allowance, Kela (Helena).

In addition to these definitions, we took some liberties in the calculations. In particular, we did not let ourselves be overly constrained by realism when plotting the alternative scenarios. We are aware that every school psychologist has been responsible for around a thousand primary school pupils for years now. We have not let such ratios restrict us, but have included psychologist’s appointments in the calculations where they have been thought to be of help. Our calculations were based on a selection of support and services that is not available to very many people in very many places in the real world.

Calculation principles and practices

For the purposes of the calculation of costs this report, we used a unit price for every identified service if one could be found. At the most granular level, the unit was one hour or appointment, for example with a physician, psychologist or nurse. Days are typically used as the unit for substitute care and inpatient hospital treatment. These two services also accumulated the largest costs in the cases studied. In some sources, the unit is the school year. Some sources have also calculated unit prices for services such as processing child welfare notifications and peer group meetings.

The base formula is simple, unit price times the number of units, but we did not calculate the prices so straightforwardly in every case. Significantly different unit prices are quoted for some services. In some cases, we solved this issue by calculating the average of the prices quoted. If the available price data differed in age as well as amount, we put more emphasis on newer sources. For the daily price of substitute care in child welfare, we formulated two prices: the basic level and demanding/specialised level. We also used the latter price as the daily price for substance abuse rehabilitation and special care.

We could not find unit prices for everything and also wanted to specify and confirm certain prices from other sources. We used the municipal wage statistics published by Statistics Finland for assessing the costs of school youth work, special-needs education and school psychologists. In general, the costs of school, particularly those of the various degrees of support, were difficult to determine. Our assessments are based on a number of sources but are probably imprecise specifically with regard to additional costs incurred in addition to a normal primary school education (see also Heino et al., 2016).

Older price data was increased to 2023 prices with the municipal finances index. When comparing the older and newer prices, we could not help but think that the prices of the services examined in this report have increased faster than the index. This difference may be partly explained by the different calculation methods used in the sources.

We also looked at prices for support person services on the websites of companies offering open care services. Prices were also taken from reports and the data accumulated in the Lapset ja nuoret SIB programme, for reference if nothing else.

Of the older sources, the key publication is Terveyden- ja sosiaalihuollon yksikkökustannukset Suomessa vuonna 2017 (Unit costs of healthcare and social services in Finland in 2017, Finnish Institute for Health and Welfare, 2020). The report by Heino et al. (2016) as well as the previous version of this report provided good starting points and points of reference for all calculations.

We also used the child welfare report published by Finland's six largest municipalities (Kuuden suurimman kaupungin lastensuojelun palvelut ja kustannukset vuonna 2021) in calculating the costs of child welfare. Data from the Lapset ja nuoret SIB programme was used to confirm the magnitude of some school cost calculations.

The service price lists of the wellbeing services counties, retrieved with a search engine, were a key source. This price data is very recent, and these price lists have been used for nearly all unit prices for healthcare and psychologist's services. They also include information on the hourly rates of social workers and social counsellors. The differences to older sources are considerable, and we have assigned greater weight to more recent quotations. We were able to find a direct or indirect price for almost everything, as well as reference prices for most of the prices used in our calculations. The services for which we could not even find a good substitute price were rare indeed.

Helena's and Sami's case studies include relationship-based educational support. We also used the Owal-Group's assessment of SOS-Lapsikylä's family partners (Vaikuttavuutta kohtauspinnoilla, 2019) as a reference for our estimates. The actual price used was taken from Lapset ja nuoret SIB programme data (Helena, Sami). The case studies of Niko, Aamu and Ella and Aava use actual and realised costs.

The data for the rehabilitation allowance were taken from Kela's online service (Helena).

Jaana's calculation of lost tax revenue is not included in the calculations, even though it is mentioned in the text. Neither do the calculations for Niko and Ella and Aava include tax revenue lost due to the parent's absences due to illness or inability to work.

A significant part of the costs in the real version of Sami's case were incurred from the period of treatment in the psychiatry ward. We had access to precise data on its duration and calculated the unit price with an emphasis on recent sources, mainly information published by the wellbeing services counties. The price data for hospital school (Sami and Ella and Aava) are based on information from the Finnish National Agency for Education's website, with the assumption that the costs of hospital school would continue to accrue also during treatment in a ward. We deducted our estimate of the normal price of basic education from the cost of hospital school.

The psychologist's appointment rate is also significant for the total costs

(Sami). There is a fair number of different unit prices available. We resolved the issue by calculating an average from a few unit prices and leaving a few of the oldest prices out of the equation.

The support person was also a key factor. The price of this service differed from the others insofar as the more recent prices were sometimes lower than the older ones. We used the average of the figures we could find (Sami). The daily rate for a support family (Helena, Niko) was based on an old study (Heino et al. 2016) and a new website (Perhehoitoyksikkö Kanerva).

We also included the costs of meetings and discussions where available. These were priced at the social worker’s hourly rate (Sami).

In Sami’s case, we expanded the group of service recipients to his siblings in the alternative case. The price data for family social work was collected from recent wellbeing services county price lists.

The costs of companions, group activities and child care are based on actual realised expenses (Niko, Aamu, Ella and Aava). The costs of couples and individual therapy, zone therapy and osteopathy are also real (Aamu). The price of EMDR therapy is an estimate calculated from the average of data available online. Child health clinic services have not been taken into account in Aamu’s calculations, as it is a universal service offered to everyone.

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