How child welfare costs accumulate?

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Introduction

In Finland, interest in the wellbeing of children, adolescents, and families with children has increased significantly since the beginning of this millennium.[1] The welfare system for children, adolescents and families in our country has been organized in a manner typical of the welfare state model in the Nordic countries. In practice, this means extensive universal services guaranteed by the public sector. Municipalities and joint multi-municipal organizations are obligated to arrange these services. Furthermore, the Finnish child welfare system and protection emphasize strong welfare orientation.[2] Recent troublesome events in our society, such as shootings by young people and family killings, have made us reconsider the functionality of the welfare system and the availability of the services. Discussion on child welfare intensified in 2012, when the service system failed and an 8-year-old girl died, abused and neglected by her family members, despite being a child welfare client. This case highlighted the key challenge of child welfare: working between protection, care and control. Child welfare intervention is sometimes considered too lightly justified, but sometimes intervention should have happened much earlier and more forcefully.

The current child welfare legislation came into force in 2008 (Child Welfare Act 417/2007). The act defines child welfare in broad terms and it refers to activity that takes place in the sphere of basic preventive child welfare services for both children and families as well as child-specific and family-specific child welfare provision (Child Welfare Act 417/2007, Section 3). In Finland, the total number of clients in child-specific and family-specific welfare services has grown for several years. Even though the number of children taken into care has remained nearly the same in recent years (excluding one year), the situation in child welfare cannot be defined as good. When examining the number of children who have been placed outside their home and the number of children and families receiving support in community care[3], it is clear that the growth of the number of clients has continued. In particular, the number of emergency placements has grown significantly in recent years, as has the number of child welfare actions carried out against the client's will, which is alarming. The growth of the number of clients is significant especially among 13–17-year-old adolescents (Child Welfare 2010; Child Welfare 2012[4]). The growth of the number of emergency placements and involuntary actions probably indicates that child welfare often helps children and families too late, perhaps only when the situation has already turned into a crisis. Even if nothing else, the growth of the number of involuntary actions suggests that working closely enough with adolescents and/or parents, while simultaneously looking for jointly agreed on child welfare solutions for the situation, is not always possible.

The current legislation has aimed at clarifying client processes in child welfare. Access to child-specific and family-specific services is preceded by the assessment of the need for child welfare interventions. Children or adolescents become clients of child welfare only if their needs cannot be met through the measures of basic and preventive services. The number of children and adolescents in child-specific and family-specific child welfare services in recent years indicates, however, that the available preventive services have not

been sufficient. Therefore, we now need to change the focus of child welfare from reactive work towards preventive work. Child-specific and family-specific services cannot cope with the high number of clients that they are currently responsible for.

So far, Finnish research-based information on factors that lead to people becoming child welfare clients is scarce. However, in her study on this topic Tarja Heino (2007) has found out that the need for child welfare services is often tied to the problems of the parents, such as parents having difficulties in coping with everyday life, conflicts in the family, parents' helplessness or lack of sufficient parenting skills, or parents struggling with substance abuse and/or mental health problems. According to a report by Annina Myllärniemi (2006), substance abuse and mental health problems are often the underlying reasons for becoming a child welfare client. As a specific problem she draws attention to mothers' substance abuse. Thus, it is important to note that adult services and providing support for parents are often the best forms of child welfare.

Kestilä et al. (2012) have studied the risk factors of placing children and adolescents outside their home, by analysing record database data that covers all children born in Finland in 1987. The results of the study support views on the significance of the connection between the parents' economic problems, mental health problems, single-parenthood, parents' divorce, the low level of education and the placement of children and adolescents outside their homes.

For every fifth adolescent, problems related to the adolescent's own behaviour can be detected as the reason for their becoming child welfare clients. The shortcomings of child welfare seem to exist in services targeted to adolescents and their families and in how quickly the adolescents and their families can receive services suitable to their situation.

Thus, it seems that children and families need services for coping with the big and small problems of their everyday lives. People working with children and families need suitable methods and enough resources. Combining the resources of the families and the authorities is the best way to help children and families to cope with the challenges of the children's growth and development. When developing services for children and families, we should pay attention to the children's, adolescents' and families' own voices, engagement, participation and agency. To find shared goals and practices, we need collaboration between all the actors, including the clients and the public authorities, on both local and national level.

Promoting the wellbeing of children and families, and offering support at the right time requires shared responsibility for the wellbeing of children, adolescents and families from all the involved actors and authorities. We must also recognize the significance of preventive work and provide sufficient resources for it. When we discuss and develop child welfare we must remember to ensure adequate means for both community and alternative care. For a large group of children in our society respectful and safe everyday life exists merely with the support or by the actions of child welfare and protection. Therefore, it is important to invest in providing quality child welfare, in addition to preventive work.

In 2012 The Central Union for Child Welfare in Finland launched a project to examine the costs of child welfare service paths, to contribute to the discussion on services that would best serve the needs of the families from a humane point of view, and that would be cost-effectiveness from the point of view of child welfare. By dividing service paths into smaller parts, we can draw attention to the kinds of decisions made on the selected services for children, adolescents and families. In addition, this approach allows us to evaluate whether child welfare applies the principle of the least intrusive intervention possible, or whether the lack of alternatives leads to offering families heavy support actions too easily. Thus, while evaluating humane viewpoints, we also assess the costs of preventive work. In addition, political decision makers are provided with material for setting future policies for child welfare in a situation where child welfare is considered to be in a crisis. Decreasing economic resources require a thorough examination of the welfare services for children, adolescents, and families. For some reason, the political value of child welfare is modest, even though the total budgets of municipal social and health care services include huge amounts of money spent on child welfare, either directly or indirectly; this becomes evident if we take a closer look at services available to children and families in need of support. It is difficult to understand why resource allocation to child welfare or child protection is currently not considered politically more significant than this. To decrease the growth of child welfare client numbers and to offer families help at the right time, the available services need to be reformed. We may need to evaluate and reform the functionality of the whole child welfare system and to increase collaboration over administrative boundaries. In addition, we must promote the strengthening of the personal resources of children and families.

The National Institute for Health and Welfare (THL) and the Central Union for Child Welfare conducted the study in collaboration. The study is based on fictional client cases, which enable examining different support services for different families, how services are chained into service paths, as well as the costs of these paths. The client cases were created by experts, based on existing research and experience on child welfare clients and the kinds of problems these children, adolescents and their families have. Because child welfare services are always constructed on a case-by-case basis, it is impossible to pinpoint so-called typical cases. The diverse nature of child welfare services has been emphasized by presenting various alternative ways of helping the family in different situations in every case description. Therefore, we cannot describe typical costs; they always accumulate case by case, depending on the required services. The fictional client cases allow us to count the costs of services per client and the different service paths.

The growth of the number of child welfare clients in Finland

In 2010, child welfare social work and community care had 78,500 children and adolescents as clients. The number of clients increased 11 % in 2010 compared to 2009. In 2012, the number of child welfare clients was 87,200 and the growth was 7 % compared to 2011. In addition to the number of clients in community care, the number of child welfare notifications has been growing. In 2010, the total number of children and adolescents placed outside their homes was over 17,000 (including both old and new placements). This was approximately 1.3 % of the population younger than 18 years. In 2012, there were altogether 17,830 children and adolescents placed outside their homes (approximately 1.4 % of adolescents under 18 years of age). (Child Welfare 2010; Child Welfare 2012.)

In 2010, altogether 2,830 children aged 0-17 years were taken into care or placed urgently in alternative care for the first time, and 3,079 in 2012. Of these, the portion of urgently placed children was 86 % in 2010 (2 426) and 89 % in 2012 (2 726). In recent years, particularly the number of emergency placements has increased. In 2012, however, the number of urgently placed children decreased for the first time since 2011, by 3.1 %. When looking at age groups, particularly the growth of the number of teenagers in need of urgent placement stands out. Ever more often preparations for taking a child into care begin as a result of a situation, which has required an urgent placement of the child. In addition to the growth of the amount of emergency placements, the increase in the number of involuntary actions is an alarming development. (Child Welfare 2010, 5; Child Welfare 2012.)

Generating statistics on work in preventive child welfare is challenging, because preventive child welfare is understood very broadly as municipal basic and special services that promote and secure the growth, development and wellbeing of children, and support parenthood. Therefore, it is difficult to estimate the costs and cost impact of preventive work.

Hannele Forsberg and Aino Ritala-Koskinen have examined the growth of client numbers by taking a closer look at the change of the target group in child welfare social work, the working environment, and the expertise that characterizes this work (Forsberg & Ritala-Koskinen 2012, 154). The different explanation models have also been criticized, and the phenomenon cannot certainly be explained by any individual factor, as it is a consequence of many fairly simultaneous changes. As Forsberg and Ritala-Koskinen (2012, 157) note in their article:

> *”It is clear, however, that the channelling of the problem situations of children and families into the sphere of child welfare social work has increased.”*

In the 2007 Child Welfare Act, the threshold of making a child welfare notification was lowered considerably. Authorities are obliged to make a notification to a municipal body

responsible of social services, without delay and without being prevented by confidentiality regulations, if they have become aware of a child's need of care and treatment or circumstances endangering the child's development, or of a child's own behaviour that require an assessment of the child's need of child welfare (Child Welfare Act 417/2007, Section 25). Simultaneously with lowering the notification threshold, this Act increased the number of professionals, employees and persons in positions of trust with the obligation to notify the authorities.

The number of clients is partly considered the result of the enhancement of the discourse of concern, as well as that of focusing on the growth of child and adolescent ill-being and missing parenthood (Forsberg & Ritala-Koskinen 2012, 155). Recent more accurate and regular recording of child welfare notifications and clients may also have had an impact on the number of clients (Forsberg & Ritala-Koskinen 2012, 157).

In recent years, many municipalities have made cuts in family services, such as basic health care, school health care, home help service or day-care resources. Saving on these services increases the number of contacts to child welfare, firstly because the families' problems are allowed to develop for too long and secondly because these services are only available for child welfare clients. The significance of services for adults as a central element of child welfare work is often overlooked, too.

Child welfare services and paths

When discussing services targeted to children and families, quite often the contents of the work are labelled with diverse titles. Preventive work and preventive child welfare are often used as synonyms, but sometimes they are defined differently based on the actions they include. Nevertheless, preventive action always refers to measures taken before people become child-specific or family-specific child welfare clients, in other words, traditional child welfare and protection provided by social services.

Preventive work includes the promotion of health, safety and social wellbeing, preventive action, guidance, screenings, early care, supporting children's growth, the development and realization of their rights, as well as assisting individuals and families. The aim of preventive work, in particular, is to decrease the need of reactive services, insecurity and loneliness experienced by children, the poverty of families with children, inequality, lack of social networks, changes in family roles, and the overwhelming demands of everyday life. Good examples of preventive work practices include regular day-care activity, multi-agent family training model, substance education, health education, youth education work, promotion of everyday wellbeing, online outreach work, street work, guidance and tutoring in basic services, social work with families with children, and peer support.

Preventive child welfare has been defined in the Child Welfare Act (417/2007) as actions,

organized by a municipality, which aim to promote the wellbeing of all children and adolescents. Preventive child welfare promotes and ensures children's growth, development and wellbeing and supports parenthood. Preventive child welfare covers support and special support provided by education youth work, day-care, maternity clinics and child health centres, and other social and health care services. Good examples of preventive child welfare practices include, for example, the development of early support work models, meeting children in their school environment, targeted group activity, online outreach work, meeting adolescents in a commercial growth environment, surveys on attitudes toward wellbeing, support person activity, and peer support activity.

When preventive work or the support provided by preventive child welfare is not enough to help a child or a family, the family can be offered support through child-specific and family-specific child welfare services. 80 % of child welfare activities focus on helping people through community care, which means supporting the child and family at home. The provided child welfare community care services vary between municipalities. The Child Welfare Act (417/2007) mentions the following as community care measures:

Ensuring livelihood and housing; supporting solving a problem situation with a child and a family; supporting the child's education financially and otherwise, assisting in acquiring a profession and getting an apartment, finding work, hobbies, maintaining close relationships and meeting personal needs; support person or family; treatment and therapy services supporting the child's rehabilitation; family work; placement of the whole family under 37 § in family or residential care; peer group activity; holiday and recreational activity; and other services and support actions assisting the child and family.

If the support provided by community care at home is not enough for the child and family, the child can be placed in community care alone or together with a parent/parents. Placement as community care support has been defined in the Act as follows:

> *"Family or institutional care may be arranged as support in open care for a child together with a parent, custodian or other person responsible for the child's care and upbringing, in the manner referred to in the client plan and in the form of care in which the need for support is assessed or in the form of rehabilitative care." (Child Welfare Act 417/2007, Section 37.)*

The decision about support in community care is always made by a social worker responsible for the child's affairs. The necessary community care measures should be recorded in the client plan, which the social worker has written based on the child welfare assessment. The child, the parents, the parents' spouses, possibly the official who made the child welfare notification or a family member, as well as agencies who provide care for the child and the parent, their family members and other people who belong to the child's close network can all participate in the making of the plan.

The assistance for the child, adolescent and family provided by the social worker is one of the key elements of community care. The planned social work in community care can be divided into three phases, for example, which are the plan-making phase, the actual work and the evaluation phase (Muukkonen 2008). The phases related to the making and evaluation of the plan include many meetings between the family and the social worker that were easy to include in the service paths of this study through the individual assessment and other meetings. This report pays less attention to the guiding and managing tasks of the child welfare process, particularly concerning the cost calculation and the description of these service paths. Instead, the child welfare social worker's role as the process leader is emphasized, and the social worker's responsibilities, i.e. the coordination and organization of services as well as compiling information for the assessment and/or decision-making, which all are time-consuming processes. (Heinonen & Sinko 2009.) This phase involves several meetings with the child, the adolescent and the families, assessing the situation together with the client and a colleague or a team, as well as support, guidance and counselling (Muukkonen 2008, 94).

The child and their family are always primarily supported by the means of preventive care and community care. If these prove insufficient, children can be placed outside their homes through emergency placement or taken into care. A placement outside home can take place in a foster family or a residential care unit. When children are placed outside their homes, the decision is always temporary according to the Child Welfare Act (417/2007), and child welfare must work towards reuniting the families again. The best interests of a child should always determine this kind of work.

The choices of child welfare services are always the responsibility of municipal authorities; child welfare is work that is the responsibility of authorities, exercising public authority. Authorities can, however, buy child welfare services from other service providers, such as private service producers or non-governmental organizations. Private service providers play a significant role in providing alternative care services, but they have a central role in community care services as well.

In preventive child welfare services, the construction of service paths is not based on the contribution of any single worker. Often services offered to a child, adolescent or family are provided by the agent that notices the child's or the family's need of support. Moreover, service referrals between preventive child welfare workers are not always carried out in the best possible way. The distribution of information on available services should be carried out more efficiently than at present; the responsibility of information provision has not always been clarified to a sufficient extent in municipalities. In addition, in some places child welfare clients have to wait in line for an unreasonably long time. In child welfare, the construction of service paths always begins with the initiative of a responsible social worker, through the goals set for child welfare work. Providing clients of child-specific and family-specific child welfare with the services they need poses a special challenge – especially if the different agencies have different views on the kind of support the family can

be offered and, on the other hand, when services provided for adults should support the purposes of child welfare.

Total costs of child welfare

Child welfare costs have greatly increased in recent years, especially in alternative care. The costs of the placement outside home were 620 million euros in 2010, whereas in 2006 the costs were 430 million euros. This means over 500 euros per each child and adolescent under 18-years of age. When preventive child welfare and support in community care are added to this, the total costs reach nearly a billion euros depending on the method of calculation. (THL, Sotkanet/Kasvun kumppanit.) The costs of residential and foster care of children account for approximately 3.2 % of the total social and health care costs in municipalities. (THL, Sotkanet.) The costs have increased also in relation to other service groups. Only the costs of services for the elderly and the disabled are currently growing faster. The growth of costs can be explained by the increase in client numbers, the increase in the numbers of placements in residential care units, and the increase of the expenses of care, visible in the rising unit costs.

Placing a child outside home is a very expensive alternative regarding the costs. Foster family care costs about 22,000 euros annually, professional family home care c. 60,000 euros, and care in a residential unit over 90,000. (Kuusikko-kuntien lastensuojelun työryhmä 2011.)

There is no information on the costs of child welfare services in community care on the national level. The most comprehensive data can be compiled from comparison reports of the six biggest towns. The data from 2010 show that the costs of community care account for about 21 % of all child welfare costs. The costs of community care, however, decreased from 2009 by 2 %. The total costs of community care were divided by functions so that the costs of community care social work were 41 %, the costs of family work and family rehabilitation 30 %, and the costs of after-care 11 %. The portion of other functions was altogether under 20 %. (Kuusikko-kuntien lastensuojelun työryhmä 2011.)

Child welfare clients often need other services as well, especially mental health and substance abuse services. In our total cost calculations, we also took into account school and basic health care services as well as maternity clinic work to the extent that they were related to the client paths. Especially in mental health services costs increase when the care becomes more demanding. For example, adolescent psychiatric in-patient care costs 3,500 euros per week. Families become child welfare clients as a result of many changes and many service contacts. When problems are recognized early and intervention is carried out in the form of services and support, the immediate costs of municipalities increase. At a time of scarce resources, these investments may seem huge and there is no certainty about their effectiveness. Nevertheless, it is clear that as problems accumulate and become deeper, care costs also clearly increase.

Costs in this report

In this report, we go through four different stories of how a child or an adolescent becomes a child welfare client. Our aim is to describe how the child or the adolescent became a client, what kinds of service and expert contacts there were on the way towards becoming a client, and what kinds of decision-making situations there were along the path. Simultaneously, we map out costs related to different service combinations. Every story includes collaboration with child welfare and a personal social worker. The extent of this kind of work and the costs always depend on the case. However, we have aimed at paying particular attention to coherent service combinations related to child welfare social work. For every story, we have created different starting and ending points, as well as a couple of alternative paths. These paths form combinations whose costs we present in figures that describe the paths, separately for every story.

In addition to child welfare costs, we have taken into account services that are closely related to child welfare, such as mental health services and school health care. Some of the reported services are targeted directly at parents, but we have not counted these kinds of services, for example mental health services received by the parents, in the costs of different client paths. It is nevertheless worth mentioning these services in the stories, as much of child welfare social work involves the organization of services and support for a child's or adolescent's parents, and the responsibility of motivating the parents to use these services is also left for child welfare workers. The report includes a table as an attachment where we have compiled the unit costs of different services and examples of the costs of care periods.

The cost information has been compiled from various sources of information, especially from the unit cost reports of THL and the reports of municipalities in the Kuusikko project. The single most important source has been the 2006 unit cost report of THL (Hujanen et al. 2008). The cost information of the report is based on information gathered from municipalities and health care districts, and the national average unit costs have been calculated on the basis of this information. The reports also include information on the mean deviation of the costs, so that it is also possible to calculate confidence intervals for the mean costs. Therefore, the cost information gives a comprehensive description of the service costs in Finland in 2006. Because new updates to the cost information are not yet available, the figures have been changed to correspond to the value of money in 2010 by using the price indexes of social and health care functions, provided by the municipal finances unit of the Association of Finnish Local and Regional Authorities.

In 2010, THL finished a report on the unit costs of social welfare (Väisänen & Hujanen 2010), which has also been partly used as an information source on costs. This report includes data from 2007 and, therefore, this data have also been deflated to match the 2010 information.

The third significant information source consists of the reports of the so-called Kuusikko municipalities, the six biggest towns in Finland, which have provided cost information on

actual child welfare services, in particular (www.kuusikkokunnat.fi). The information in this report is from 2010.

In addition to the above-mentioned reports, cost information has been gathered from different sources and experts depending on the need of information. Because the information often pertains to one agency or municipality only, the generalizability of this data must be handled with some reservation. On the other hand, the information is as recent as possible and, therefore, depicts the current situation quite well.

This report does not give detailed calculations of how the costs build up, but justifications for the costs are available from the authors. The stories are fictional, so the cost information has been modified to suit the stories. Nevertheless, the point of departure has been to describe cost items that are as traceable and repeatable as possible. We must also note that many service combinations have been individually tailored, so it is not even possible to present detailed cost information. The information sources and the unit costs used in the calculations are presented in the attached table. The stories have a set beginning and end. The after-care following the placement, for example, has been left out. The ends of the stories can be situations where the child welfare clientship continues. It is therefore possible that costs that accumulate after the story's end are significant. For example, costs related to permanent marginalization and disability are manifold in comparison to those of the services examined in our report. However, we will not estimate these costs in this report. Nevertheless, it is still clear that the risk of marginalization is greater for children and adolescents who have been in alternative care for a long time or who suffer from mental health problems.

We hope that this report will bring insights and raise discussion on the actual sources of extensive cost items. Smaller investments in early support or targeted services for those who need them can help avoid the most robust and most expensive actions.

Four stories and a couple of paths

We decided to describe the different helping paths of children and families through fictional stories. Although the stories are fictional, the service paths that they include are possible and the services written into the stories are real. They are based on research and experiences in social work. The research sources include Heino's (2007) study on the kinds of problems families have according to social workers when the child welfare clientship begins, and Myllärniemi's (2006) study on the kind of community care support that was offered to families before their child was taken into care and what kinds of reasons there have been for it, and finally Kestilä et al.'s (2012) study on factors that increase the risk of placement outside home.

It would have been impossible to find families with similar problems and comparable co-

ping methods, which would have enabled comparisons between the costs of different paths. Choosing fictional alternative service paths turned out to be an apt solution. This report is not a study of the effectiveness of the services but it aims at opening discussion on the kinds of alternatives that exist and the kinds of service choices that we should pay attention to.

The purpose of the alternative service paths is not to claim that a change for the better in the child's or the family's situation would depend merely on early intervention. The child's situation is certainly affected by many factors, starting from the child's own temperament, coping methods and network as well as the parents' and the family's own networks and coping resources.

We understand that there are family situations where support in community care is not sufficient, suitable or possible. If necessary, the child has the right to be taken into care and receive quality care and caring outside home.

Regarding services, children have unequal access to them in different parts of our country. Some municipalities have cut children's and families' services to the minimum, whereas some municipalities offer numerous different alternatives.

The stories describe the starting situation, how the child's story progresses and at what points possible service choices are made.

1. A Girl who ended up in adolescent psychiatric inpatient care

The girl is in psychiatric inpatient care at the age of 15, after she has tried to harm herself. After a two-week period as a psychiatric inpatient, she is given care in outpatient clinic. Child welfare work is also initiated as a result of this crisis situation.

In an interview conducted about a year before the incident, the school nurse had stated that the girl might be depressed. The school nurse suggested that the girl should visit a physician so that the physician could make a referral to psychiatric examinations in an outpatient clinic if necessary. The girl did not consider this necessary and she refused to meet a physician. The girl also refused to see the school nurse again. The school nurse contacted the girl's parents. The parents disagreed with the school nurse and they did not take the girl to see a physician. In the meeting with the school nurse, the girl had talked about her childhood and how her parents argued a lot during that time. Her parents divorced when she was six years old and she recalled that some kind of violence had taken place in the divorce process. The girl stayed with her mother and started school. She recalled being a sad child for the first few years of primary school and she had difficulties in making contacts with her schoolmates. The parents got back together after a couple of years and the divorce or arguments were no longer spoken about.

The child welfare work included an assessment of child welfare need; the social worker met the girl together with a colleague, during two meetings at a hospital and a home visit. The parents were met individually at the hospital and during a home visit. The concluding meeting was attended by the whole family. At the same time, the adolescent psychiatric outpatient clinic evaluated the girl's situation. Since her commitment to psychiatric care was uncertain, it was decided that her status as a child welfare client would continue. In addition, several problems emerged during the assessment regarding the girl's home situation and her social relationships outside her home.

In a meeting with the social worker, her status as a child welfare client was continued, for the purpose of making a client plan in five network meetings at the adolescent psychiatric outpatient clinic and in three meetings at hospital wards. Family care work was initiated for the family after a while. The work was intense on the part of the two family workers who worked as a pair, but the commitment of the girl and the parents varied. At the same time the girl began weekly therapy visits at the psychiatric outpatient clinic. After three short, 1-3 weeks long hospital periods, it was decided that the girl would be placed with urgency in a youth reception centre. Her situation was evaluated in the centre during two months. The parents hoped that she would be placed in alternative care. The physicians suggested that psychiatric inpatient care would not improve the girl's situation or give it a better direction. The parents felt that the situation was very hard and said that it had caused arguments between them and problems in their relationship. The parents attended couples' therapy as suggested by the social worker.

After a year of child welfare work, preparations for taking the girl into care begin. The social worker arranges a meeting with the girl and has several discussions with the parents before the actual hearing. The whole family attends the hearing simultaneously. The parents and the girl accept that she is taken into care. Therefore, the matter is not taken to administrative court[5]. The girl waits in the reception centre for two months until a suitable place in alternative care is found. The girl is placed in a child welfare residential unit where the personnel have psychiatric expertise. The institution continues working with the parents.

THE JUSTIFICATIONS OF THE STORY AND THE SERVICE PATHS

In Heino's study, "Keitä ovat uudet lastensuojelun asiakkaat?" (Who are the new clients in child welfare?), the reasons for becoming a child welfare client related to the adolescent's own action were: the child's/the adolescent's poor psychological health in 14 % of the cases; difficulties at school among 20 % of the children/adolescents; and difficulties related to friendships among 9 % of the children. (Heino 2007, 59.)

Factors causing the need for taking into care have been listed in Myllärniemi's study. The reasons have been classified into factors describing the family's living circumstances and

the parents' situation, factors related to the child and the child's operational abilities, factors describing the adolescent's problems or self-endangering behaviour, and factors describing the child welfare clientship and community care work (Myllärniemi 2006, 63). The need for taking a child or an adolescent into care has also been justified by the following: ensuring the evaluation of the child's psychological condition; the investigations and care; the view that the care offered by the parents is insufficient; the view that the parents and the child are not committed to the care; the duration of the placement in community care was considered insufficient for the parent's substance abuse treatment or rehabilitation; or the parent's wish that the adolescent would be placed in care (Myllärniemi 2006, 77–78).

> *"The emergence of self-destructive thoughts is a very serious message about a child's psychological ill-being. A child's suicide talk and attempts always lead to an immediate reaction and emergency psychiatric actions." (Kataja 2012, 127.)*

In Anniina Myllärniemi`s study, services offered before taking children into care were: support actions by child welfare social work, referrals from child welfare, family work, collaboration with parties working with the child, other special services (family clinic, child or youth psychiatry, intensive family work). (Myllärniemi 2006, 83–84.)

Costs

The story starts from the parents' divorce when the girl is six years old. The first decision concerns the parents' divorce situation, regarding whether the situation of the child and family will be determined in the middle of divorce in a family counselling office, for example (1st decision).

Path 1

The mother and the child visit a family counselling office immediately during the divorce situation. A family counselling office visit can be considered more demanding and more expensive than a visit to an ordinary child clinic. The costs of a visit of 1.5 hours are approximately 220 euros. In this example, we have estimated the family counselling office costs for a combination of three visits, altogether 670 euros.

Years go by and then the girls experiences difficulties at school and with friends. The teacher notices this and helps the girl in group situations and encourages her to get to know other pupils. There are possibly visits to a school nurse (54 € per visit) and visits to a school social worker (88 € per visit). With small support, the girl's situation is improved.

Path 1 is the top-most path in the figure where the *costs include 670 euros from family counselling office visits alone and approximately 1,000 euros altogether, if we include two visits to a school nurse and two visits to a school social worker.*

Paths 2, 3, 4, and 5

The parents got divorced when the girl was six but got back together later on. Eight years

pass by. The girl's problems come up during a visit to a school nurse at the age of 14. The girl visits the school nurse several times (54 € per visit, e.g. 4 visits 216 €). The school nurse suspects that the girl is depressed and suggests that she could visit a physician. The girl does not commit to this idea. At this point, the path becomes divided (2nd decision).

- The parents are contacted, they do not want to acknowledge the girl's problems and the situation deteriorates (paths 2 and 3).

- The school nurse makes a child welfare notification (path 4).

- The parents commit to taking care of the girl and take the girl to a physician (path 5).

Paths 2 and 3

The school nurse contacts the girl's parents but they do not want to acknowledge the girl's problems. The girl's problems become worse, and after a year (at the age of 15) she tries to harm herself. She ends up in adolescent psychiatric inpatient care, and a child welfare notification is made about this. The inpatient care costs are 507 euros per day, so the costs of a two-week care period are 7,100 euros. The social welfare office receives the child welfare notification and initiates an assessment of the need for support. The costs from this consist mainly of costs from the social worker's work time (24 € per hour). Because cases vary, we cannot give one generalizable total cost covering the reception of a child welfare notification and the assessment of the need for support. In the example paths of this report, we have considered the nature of the different cases and the number of children involved in the notification.

In the case of the girl, who ended in adolescent psychiatric inpatient care, we estimated that the reception of the notification and the assessment of the need for support would take about 20 working hours, costing about 480 euros (3rd decision).

Path 2

After the initiation of the child welfare process, the parents, the girl, the psychiatric outpatient clinic and the social worker collaborate. A plan for her care is made in the network meeting. The costs of the network meeting depend on the number of authorities present. For example, if social workers or psychiatric workers participate in the event, the costs are approximately 176 € per meeting. In this case there were five meetings, so the costs are approximately 880 euros. The family participates in intensive family work for a year. The girl commits to visiting the adolescent psychiatric outpatient clinic once a week for a year. The costs of intensive family work are about 1,000 euros per month and 12,000 euros per year. The costs of a visit to an adolescent psychiatric outpatient clinic are 206 € per visit. The costs of a care period for one year are therefore 10,700 euros. With the support of child welfare and the services provided, the girl is able to set her life straight again. *The costs of Path 2 are altogether 31,300 euros.*

Path 3

The path proceeds as above, the girl's problems become worse, and at the age of 15 she tries to harm herself. She ends up in adolescent psychiatric inpatient care for two weeks (7,100 €). A child welfare notification is made while she is there, costs being 480 € (3rd decision).

A child welfare process is initiated, but it is difficult for the girl to commit to the provided care and her parents do not support her. The situation deteriorates and the girl spends three 10-day care periods in adolescent psychiatric inpatient care. The costs are 15,200 euros. An emergency placement is arranged for the girl for two months. She is placed in the children's residential care unit. The costs of residential care are 256 euros per day on the average. The total costs of the two-month placement are 15,400 euros. The social welfare office starts to prepare a decision for taking her into care. The costs consist of the social worker's working hours, which always depend on the case. In this case, the estimated costs are 770 euros. The girl is taken into care and placed for two years, until the age of 18, in residential care where psychiatric expertise is available. The costs of the placement are 187,000 euros. The social worker assigned to her case meets the child and the parents and monitors the placement over the year, altogether 96 hours. The costs of this work are approximately 2,300 euros. This path ends when the girl turns 18. The possible costs of after-care are therefore left outside this report. *The total costs of Path 3, which ends with the girl being taken into care, are approximately 231,400 euros.*

Path 4

At this point the girl has visited the school nurse, who has contacted the parents. The parents do not believe the school nurse, and the nurse decides to make a child welfare notification, which leads to an assessment of the need for child welfare. The costs of the child welfare notification reception and assessment of the need for care are 480 euros. During her period as a child welfare client the girl's becomes motivated to receive care in an adolescent psychiatric outpatient clinic. She receives therapy once a week for a year. The costs of this are 10,700 euros. If the therapy helps, her need for child welfare can be re-evaluated and perhaps she no longer needs to be a client. *The costs of Path 4 are altogether 11,800 euros.*

Path 5

After the contact by the school nurse, the parents are committed to taking the girl to a physician and there is no need for a child welfare notification. The costs of an examination by an adolescent psychiatric specialist are 246 euros. The specialist prescribes visits to an adolescent psychiatric outpatient clinic for the girl once a week for a year, which costs 10,700 euros. The therapy helps and child welfare does not have to intervene. *The costs of Path 5 are altogether 11,300 euros.*

A figure of the service paths of a girl who ended up in adolescent psychiatric inpatient care

2. A high school boy battling with substance, crime and truancy problems

The 16-year-old boy became a child welfare client at high school when he was 13 years old. His best friend moved to another town and most of his friends went to a different high school. He found it difficult to adapt to the new group and he was also bullied. He found new friends outside school. In the new group, he experimented with substances and quickly became a regular user. The boy consumes alcohol about four times a week, smokes cannabis and has started to use sedative drugs. He funds his substance abuse by selling and buying his personal items and his family's items and by stealing.

He has not completed some seventh grade courses and has therefore not been admitted to the eighth grade. The school has organized special teaching for the boy. At times he is able to attend the small group for a while, but then he completely drops out of school. He has not been to school for several months.

The parents have participated in some school meetings, but they have been away from home for long periods due to work-related travel.

The assessment of the need for child welfare was initiated by the end of the year when the boy was on the seventh grade, and his teacher made a child welfare notification about him. Before making the notification, the teacher had met the boy's parents and advised the boy to visit the school social worker. The school social worker met him twice, but he no longer attended the meetings after the school social worker suggested a joint meeting with this parents. The boy was also advised to participate in a project organized by youth work, where his problems would have been solved by operational/functional methods. He was not included because he did not come to meet a worker from the project. In December the same year, a social worker received the first notification from the police. The boy had stolen beer. Notifications from the police came in almost on a regular basis. The nature of the notifications also changed. Shoplifting became thefts, then robberies, and finally the boy was suspected of felonious assault.

The social worker has met both the boy and his parents during a period of three years. Six meetings have been organized during one year, two of them personal meetings with the boy. His parents have been present in the other meetings or one of them, as well as a school representative. The meetings have included discussions on the child welfare notifications and the boy's situation and his family's life situation. Different interviews have been conducted with the boy and attempts have been made to motivate him in different ways to become active in taking care of his matters himself.

A district court process on the boy's criminal issues is up-coming.

During an emergency placement, the boy's abuse of amphetamine also comes up. He is guided to an adolescent outpatient clinic for substance abuse treatment where he has a meeting with an occupational therapist every week. The boy meets a physician once a month and preparations for taking him into care are made. His parents have asked for a placement from the social worker for a long time. The boy begins visiting an outpatient clinic with the support of the reception centre. The boy finally agrees to the decision on taking him into care, although he says in the hearing that he will not accept placement in substance abuse treatment. His social worker has changed four times over the three years and as the placement begins a new social worker has again been assigned to work with him.

The boy is placed in a residential care unit that specializes in substance abuse treatment.

THE JUSTIFICATIONS OF THE STORY AND THE SERVICE PATHS

Background factors of child welfare clients related to the adolescent are, according to Heino, usually the adolescent's conflicts with a parent and difficulties at school (Heino 2007, 4).

The factor analysis of Heino's study brought up the profile of an adolescent experiencing many difficulties: this adolescent has difficulties at school, problems related to crime, substance abuse, difficulties in friendships and conflicts with parents, and additionally, poor psychological health (Heino 2007, 62).

In Anniina Myllärniemi`s study, services offered before people are taken into care were: support by child welfare social work/referrals from child welfare, collaboration with parties working with the child, outpatient clinic for adolescent substance abusers and a special project of the youth services (Myllärniemi 2006, 83–84).

Costs

The story begins when the boy goes to high school and his old friendships end. In addition, he has learning difficulties, which he previously worked on with his own teacher (1st decision).

Paths 1 and 2

The boy makes new friends and substance abuse enters the picture. This starts to have an impact on his school performance. He meets the school social worker altogether four times. The costs of a visit to a school social worker are 88 euros, which includes planning and the making of records in addition to the actual meeting. The costs of the visits to the school social worker are altogether 350 euros. The school social worker also contacts the parents. The parents do not commit to the meetings and the boy also stops attending them. The problems keep growing and his teacher makes a child welfare notification (2nd decision).

Path 1

The boy's teacher makes a child welfare notification which leads to an assessment of the need of child welfare. The assessment consists of the efforts of the social worker (24 € per hour), altogether 340 euros in this case. However, the boy does not commit to the planned support actions. New crimes come to light. He is placed with urgency in a child welfare residential care unit (256 € per day). The emergency placement lasts two months, which costs 15,400 euros. Additionally, the boy visits a psychiatric outpatient clinic for substance abuse treatment (8 visits to an occupational therapist and two visits to a physician). The costs of a visit to an occupational therapist are 138 euros and the costs of a visit to a physician are 175 euros. The costs of the psychiatric substance abuse treatment are altogether about 1,450 euros. The social worker starts to prepare the decision on taking this child into care. The costs of this, including the efforts, are 770 euros. The boy is taken into care and placed in a residential care unit with substance abuse treatment expertise. The placement lasts 1.5 years. The costs are calculated according to the costs of child welfare institutional care, thus the costs of the placement are 140,300 euros. Path 1 ends with the boy being taken into care and the placement, and *the costs are altogether 159,000 euros, of which the portion of the long-term placement is 140,300 euros.*

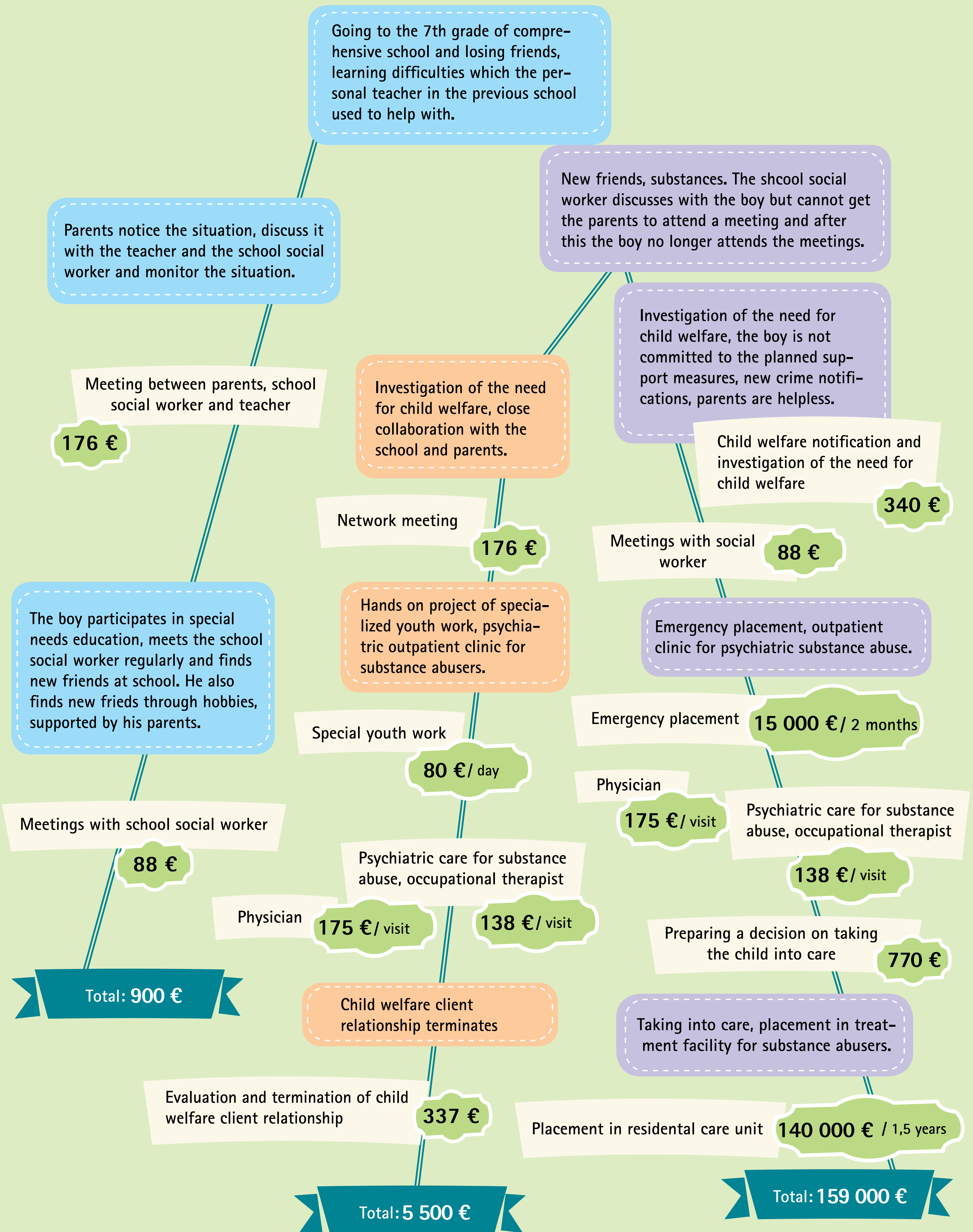
Path 2

A child welfare notification made by a teacher leads to an assessment of the need of child welfare (340 €). Child welfare actions lead to close collaboration between the school, parents and social welfare. The costs of four network meetings and the boy meeting with the social worker are 900 euros. The boy is directed to special youth work services (80 € per day) and a psychiatric outpatient clinic for substance abuse treatment (once a week for four months, 2,900 euros). The actions lead to results. The need for child welfare is re-assessed and he is no longer a client (340 €). *The costs of Path 2 are altogether 4,600 euros.*

Path 3

The parents notice the boy's problems when he goes to the new school, and they discuss the issue with a teacher and a school social worker (e.g. three joint meetings, 530 euros). The boy is included in special education provided by the school and starts visiting the school social worker (88 € per visit). He gets new friends and hobbies. *The costs of Path 3 are altogether 900 euros.*

A figure of the service path of a boy with substance, crime and truancy problems



3. A family with an immigrant background

The family has four children. The mother has always been at home taking care of the children. She does not speak Finnish and it is difficult for her to take care of matters with different service providers and officials. The father of the family is an entrepreneur who works long days and weeks. The mother practically raises the children alone.

One of the children says in day-care that his father has hit him. The day-care centre director makes a child welfare notification and the issue is immediately investigated. The child is taken to see a physician with his mother. The physician notes that there are no physical signs of hitting on the child. During the assessment for the need of child welfare, it comes up that the family's upbringing methods involve physical punishment[6]. In all four assessment meetings for the need of child welfare, an interpreter is present, and for this reason the meetings take twice as long. A report of an offence is made to the police about the physical punishment. Several discussions are arranged with the parents about the fact that physical punishment is illegal and it is not in the best interests of a child or necessary in parenting.

The parents are guided to a family counselling clinic. The father does not participate in the meetings and the mother attends them alone once every two weeks for three months. The care of the other children is organized by a home help service for the duration of the meetings. The family counselling clinic ends because the mother stops attending the meetings reserved for her.

The family does not pay their rent and they get an eviction notice. The issue is discussed in a meeting with a social worker from the social welfare office, but the family's father is not ready to commit to the agreed payment plan. The family decides to move in to the apartment of the father's mother and they have to live in very tight quarters, the whole family in the same room.

Child welfare has supported the family financially, acquired day-care places for the children as a measure of child welfare community care, organized a language course for the mother and arranged home help service for the mother during the lessons. The mother and the children have attended a family camp for immigrants organized by child welfare.

In a crisis situation the mother is advised to come to a shelter with the children. The mother stays at home, however, and the children are subjected to witnessing and experiencing violence. As the situation lingers on, preparations for taking these children into care begin. The decision on taking the four children into care is made in administrative court because the parents object to it. The children are placed in two different crisis families for six months.

THE JUSTIFICATIONS OF THE STORY AND THE SERVICE PATHS

Seven per cent of the children in Heino's (2007) study were from immigrant or multicultural families. The children who were child welfare clients had smaller living spaces than Finnish children in general, and most of them were living in rental houses. "The life of about every tenth child is coloured by multiculturality." (Heino 2007, 65.)

In Heino's data, a couple of children had experienced occasional homelessness, the family had been evicted or the threat of eviction had been serious (Heino 2007, 30).

In Kataja's study, violence targeted at children emerges from the records on processes of taking children into care devised by social workers in the following way, for example: "The interpretations of violence targeted at children and physical punishment in the sense of raising a child seem to be ambiguous." "The parents may resort to corporal punishment if they cannot make the child to obey otherwise. The records mention e.g. flicking the child in the forehead with a finger, marks of being hit with a belt, punches and confinement in dark closets." (Kataja 2012, 109.)

In Anniina Myllärniemi`s study, services offered before taking children into care included: support by child welfare work/referrals from child welfare, collaboration with parties working with the child, home help service for families, family counselling office, special day-care, projects and placements into mother and child homes and shelters (Myllärniemi 2006, 83–84).

Costs

The family has lived in Finland for eight years. The parents have 4 children. One of the children says in day-care that his father has hit him. The day-care centre makes a child welfare notification. The cost of the child welfare notification and the assessment of the need for child welfare, 480 euros, consist of the social worker's contribution. The mother takes her child to a physician together with the social worker. The costs of the examination by the physician are 92 euros and the costs of the social worker accompanying them for about two hours are 48 euros. If an interpreter is needed in the situation, it affects the duration and the costs of the examinations considerably. The costs of the visit to the physician are altogether 280 euros. At this point the path is divided (1st decision).

Paths 1 and 2

During the investigation, the social worker meets each child and the parents. An interpreter is present in the meetings, which doubles the costs. The costs of these meetings are 700 euros. The family is directed to a family counselling clinic, and the mother initially attends the meetings regularly, but soon the parents are no longer committed to the visits. The costs of the family counselling clinic visits are altogether 1,300 euros. The violence continues

and the mother and her four children go to a shelter. The costs of staying in the shelter are 336 euros per day. The shelter costs include a portion that is paid by the family, but at this point we calculate the combined gross costs. The family stays in the shelter for 10 days, which costs 3,360 euros. In the shelter, they face a new decision-making situation and the path is again divided (2nd decision).

Path 1

The parents divorce. The mother starts to take care of the family's matters actively, gets an education and applies for jobs. The mother receives support from child welfare. The family is supported by the community care services of the shelter for the duration of ten visits, the costs being 750 euros. The costs of this social work are altogether 2,900 euros. The family's situation starts to improve but they are still child welfare clients. *The costs of Path 1 are altogether 9,400 euros.*

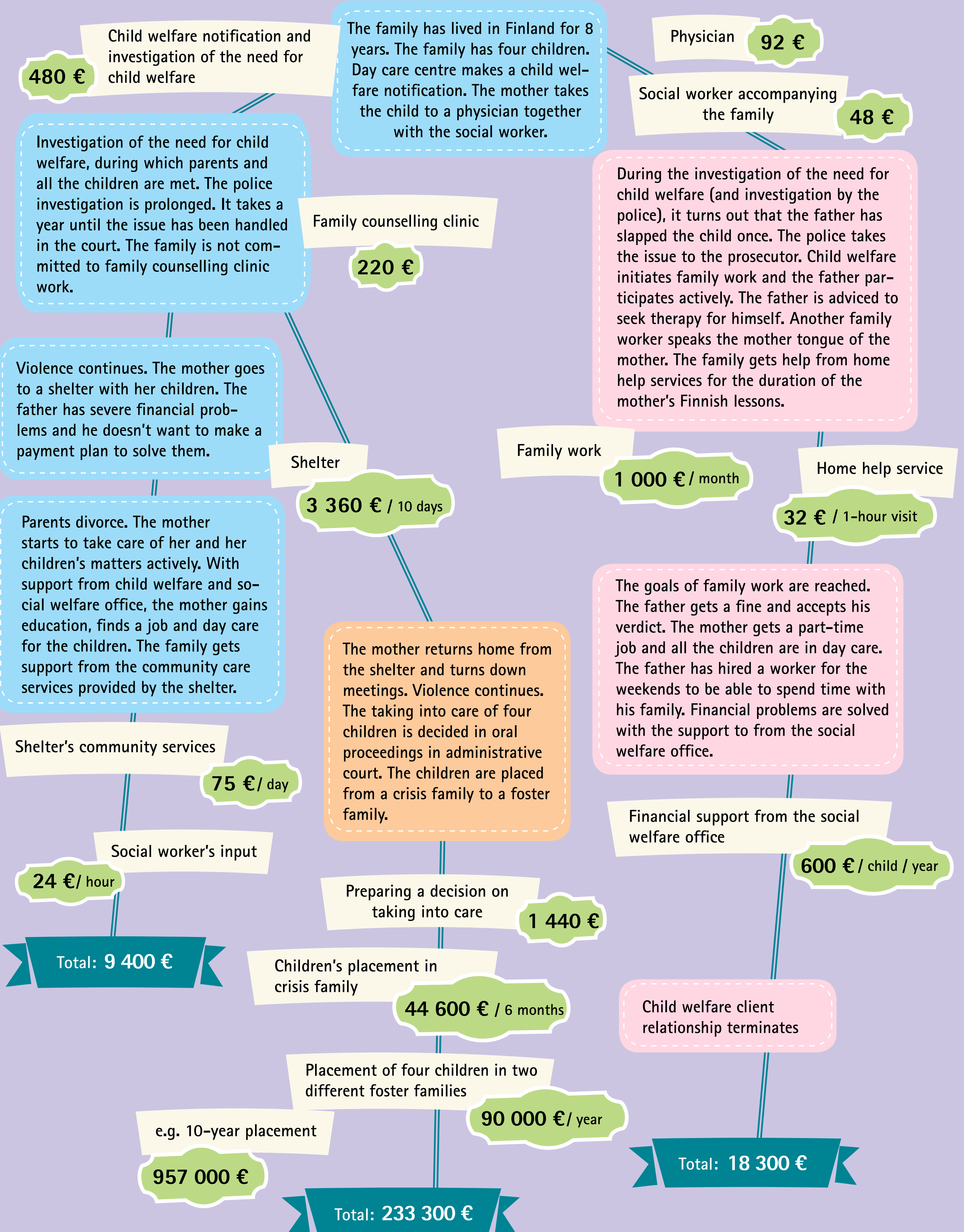
Path 2

The mother returns from the shelter to the father. The preparations for taking the four children into care begin. This results in costs of 1,440 euros. The decision of taking the children into care is made in administrative court. The children are first placed in crisis families, and then further placed in two different foster homes. The children stay in a crisis family for six months, and the costs result in 45,300 euros. The costs of taking the children into care and their placement in alternative care are 90,400 euros per year. *After the two-year placement, the costs of Path 2 are altogether 232,900 euros.* As the placement is continues, the costs rise considerably.

Path 3

During the child welfare investigation, it comes up that the father has slapped the child once and the issue is taken to a district attorney. Child welfare begins family work for a year. This results in costs of 12,000 euros. Home help service is arranged for the family once a week for eight months while the mother attends Finnish lessons. The costs of this are about 2,000 euros. The goals of the family work are reached. The father is fined and the violence ends. The family receives 2,400 euros of financial support from the social welfare office. Their situation is re-assessed (340 €) and their role as clients ends. *The costs of Path 3 are altogether 18,300 euros.*

A figure of the service paths of the family with an immigrant background



4. Single parenthood and poverty

A single mother lives together with her two children and she has raised them alone from their preschool age. The mother has been unemployed for a long time. The mother has become depressed and has been unable to recover her working capacity. The mother has attended a psychiatric outpatient clinic for three years and she is also on medication because of her depression. She has experienced financial difficulties because the rent, the price of food and other living costs have constantly increased. The income support she receives is more than 100 euros over the standard income support amount.

The children would like to have ice hockey and skating as their hobbies, but so far the mother has not been able to pay for such leisure time activities. Income support has been given to her to support the children's hobbies but the amounts are not sufficient for the children to participate in these hobbies regularly. The family goes to the swimming hall every once in a while. Child welfare has supported the children's hobbies during two years using child welfare funds. The family has also had a supported holiday with the financial support of child welfare. The children have friends in the neighbourhood, but at school both have been bullied and they have had difficulties in making friends in the school environment.

The children's father has not been able to pay the alimonies, so the mother receives maintenance payment. There are no grandparents and the family does not have adult friends. The mother has had to cut her earlier friendships because they were related to a time when she was abusing substances.

The assessment of the need for child welfare was initiated based on a child welfare notification made by a child psychiatric outpatient clinic. Altogether eight meetings were set up to assess the need for child welfare, four of which were not organized because the family did not arrive and did not notify about any obstacles to attendance. The children have been clients at the outpatient clinic for six months due to their neurological problems. The school physician has made a referral for the children. The outpatient clinic has been worried about the mother's coping and whether the outpatient clinic treatment would succeed. According to the information provided by the outpatient clinic, the children spent afternoons and evenings almost completely out in the yard or in the homes of neighbourhood friends. The mother does not know any more specifically as to where or with whom the children spend their free time.

Child welfare supported the mother's AA group visits by having a nanny visit once a week, two hours at a time, during the visits. Earlier the family used home help service for families with children, but due to the scarcity of resources, the nanny is nowadays recruited from elsewhere. Afternoon activity and support persons have been organized for the children.

The child psychiatric outpatient clinic has announced that they are unable to help the children on the basis of their needs. The outpatient clinic has suggested that the children need to be taken into care so that their therapy can be carried out on the basis of their needs.

THE JUSTIFICATIONS OF THE STORY AND THE SERVICE PATHS

In Heino's study (2007, 4), 43 % of children who were child welfare clients lived in families where one or both of the parents did not have any employment history. 45 % of the children lived in families who had received or are still receiving income support. In 2005, 25.2 % of income support receivers in the whole country were single-parent families (Heino 2007, 37).

Furthermore, 16 % of children living with one parent lived with the father (Heino 2007, 33). "Two thirds of children who lived with one parent were in contact with their distant parent, but one third did not keep in any contact." (Heino 2007, 33.)

In Anniina Myllärniemi`s study, services offered before children are taken into care were: support actions by child welfare work/referrals from child welfare, collaboration with parties working with the child, home help service for families, family counselling office, financial support justified by the need for child welfare and care in outpatient clinic (Myllärniemi 2006, 83–84).

Costs

This story is about a single-parent mother of two children. The mother has raised the children alone from their preschool age. The mother became unemployed and depressed, this situation has continued and the mother has not been able to recover her working capacity (1st decision).

Paths 1 and 2

The children have difficulties at school and they are bullied. The school physician notices the problems during an examination and makes a referral to a child psychiatric outpatient clinic. The costs of the examination by the school physician are approximately 92 euros. The costs of a psychiatric outpatient clinic visit are 294 euros for children and a little less for adolescents, 206 euros. Both children attend the psychiatric outpatient clinic five times, the total costs being 2,940 euros. The outpatient clinic makes a child welfare notification, which leads to an assessment of the need for child welfare (480 €) (decision 2).

Path 1

Child welfare begins with family meetings. At first the meetings are successful, but soon the mother stops attending the meetings and the situation with the children remains unclear. The costs of the meetings are 350 euros. According to the outpatient clinic, the children's problems at school and at home are becoming worse and the mother is not able participate in the AA clinic visits. Preparations for a decision on taking the children into care begin, the costs are 960 euros. The children are placed in a professional family home which costs 118,000 euros per year. The children also receive therapy (144 € per visit). The mother no longer keeps in contact with authorities and the placement continues. *The costs of Path 1 are altogether 127,000 euros after one year of placement.*

Path 2

The mother is committed to meetings with the social worker (700 €). With the support from child welfare, the mother is able to take care of the children's outpatient clinic visits once a week for a year (2 x 15,300 €). The mother also participates in her own AA clinic visits. The family receives financial support from child welfare, 1,200 euros per year, and home help service is organized once a week for the family for six months (1,700 €). The children have personal support persons (1000 € per year). The family's situation improves, but they remain child welfare clients. *The costs of Path 2 are altogether 48,600 euros.*

Path 3

The mother's depression caused by unemployment is recognized and she starts to visit a psychiatric outpatient clinic. The family gets help from home service once a week for six months (1,700 €). The mother also receives discretionary income support for the children's expenses. The teacher, the mother and the school's social worker meet three times and intervene in the children's bullying (176 € per visit). The mother receives peer support and the children join a sports group called Icehearts, which aims at preventing marginalization. In addition, the children are supported by the school to solve problems caused by attention deficits. *The costs of Path 3 are altogether 2 200 euros.*

A figure of the service paths of single parenthood and poverty

Divorce and the mother gets single parenthood. Mother becomes unemployed and suffers from depression.

The mother is treated in the psychiatric outpatient clinic, recieves help for taking care of her home and children from the home help services, and social assistance and discretionary financial support for the children's hobbies from the social welfare office.

Child welfare financial support

600 € /child / year

Meeting between parents, school social worker and teacher

176 €

The teacher, mother and school social worker intervene in school bullying together with other parents of the class. The mother is supported by other single parents and the children get to participate Icehearts program. The children's attention deficit disorders are diagnosed and sufficient support is arranged for them at school.

Total: 2 200 €

Child welfare notification and investigation of the need for child welfare

480 €

With support from child welfare (meetings with social worker, financial support, home help service), the mother is able to go to her own A-Clinic visits and to ensure that the children visit the outpatient clinic. The children create good and trusting relationship with their personal support persons, who help them to find hobbies and make friends.

Home help service

32 € / visit

Psychiatric outpatient clinic for a child

15 300 € / year

Support person

1 000 € / year

Total: 48 600 €

Children are bullied at school. The school physician makes a referral to child psychiatric outpatient clinic. The outpatient clinic makes a child welfare notification.

School physician's examinations

92 €

Psychiatric outpatient clinic for a child

294 € / visit

The mother does not participate in the meetings and the children's situation cannot be investigated throroughly. According to the outpatient clinic, the children's problems are getting worse both at home and at school. The mother does not have the energy to go to her own A-Clinic visits and appears tired. The children do badly at school.

Meetings with social worker

88 €

Preparing a decision on taking the child into care

960 €

Children taken into care and are placed in a professional family home. Children receive regular therapy. Mother does not want to work with officials or other support parties.

Placement in professional family home

59 000 € /child / year

The children's therapy

144 € / visit

1 190 000 € e.g. 10-year placement

Total: 127 000 €

Summary and conclusions

If the right kind of help is available for children and families at the right time, the need for taking children into care is smaller. We are in a situation where shifting the focus from reactive child welfare to preventive work and preventive child welfare requires efforts, but their results can be evaluated only after a few years. The results cannot be seen immediately, and adding resources to preventive work will not completely remove the need for reactive child welfare.

It is a regrettable fact that no matter how many services there are available, clients cannot always find the motivation to make changes in their lives, or the services may no longer be sufficient in a specific situation. Children who need reactive child welfare will always exist. Emphasizing preventive work and investing in it must not lead to ceasing the development and provision of good reactive services. Children and families who need reactive child welfare can be in a weak position in the society in many ways, so it is not justified to take the support network organized by the society away from their reach.

Nevertheless, the increase in the number of child welfare clients has to be tackled now. Child welfare preventive services, the sufficient availability of which should be ensured in municipalities, include e.g. home help service for child families, services of a psychologist and family counsellor at maternity and child health clinics, adult substance abuse treatment services, services of day-care special workers, different support persons and school care services (school nurse, school social worker, teacher, special teacher and school counsellor).

In this report, the described service paths illustrate the way the total costs of child welfare client paths are born. Reasonable cost units become large expenses when the need for a particular service becomes more demanding. It is not clear whether even large investments will help in the early phases of a child welfare clientship. Nevertheless, a client path ending in long-term placement raises the costs ten-fold, even when compared to extensive child welfare community care services. Having analysed the costs of the services along the paths, we can now compare the costs of the alternatives.

This report has calculated the costs of different client paths. The costs are example calculations based on approximate cost information. For some services, variation in the cost information was fairly large, so we can estimate that the figures presented can deviate 5-10 % in either direction. By examining average figures, however, we can get a good overall picture of the costs of the client paths and how they develop. A more detailed cost calculation would require a more long-term study that would be based on individual-level client and cost information. This would not have been useful for the purpose of this study.

When examining the fictional client paths, we can note that preventive work services often have very low costs. In the client paths described in this report, the costs were 12,000 euros per child in all service paths when mere preventive work services were sufficient, regardless of whether the process was long or consisted of short-term support for the family only. The

costs of community care ranged between 5,500–60,000 euros depending on how intense the support was and how many different support actions the family received simultaneously or consecutively to assist them in their everyday lives. When the service paths ended outside home, the costs of the placement increased greatly. 100,000 euros is a small amount when examining service paths ending in placement outside home. Figures of around 1 million euros may be closer to the truth.

This report included an example of a girl suffering from mental health problems. The ending point of one path was her placement in a child welfare residential care. The costs of one day in a child welfare residential care unit are over 250 euros. In one year, the total costs will be over 90,000 euros. We can therefore ask what could have been achieved with the money spent on placement if it had been used at an earlier phase on the path. With 90,000 euros, we could organize intensive family work for seven years, for instance. On the other hand, with this amount of money the girl could attend a psychiatric outpatient clinic over 400 times, meet a social worker over 1,000 times, or the family could visit a family counselling clinic over 400 times or home help service could be organized for over 3,000 hours. These services could be funded with the costs of a one-year placement in a child residential care unit. Bearing in mind that over a half of placements last over a year and one third of them last over five years (Kestilä et al. 2012), the costs can be even larger.

It is of course clear that not all children, who are placed, end up in residential care, and the costs are more reasonable in foster care, approximately one fourth of the costs of residential care. The costs of foster care increase through different support services that are offered to foster families during the placement. The costs of foster care are also large when compared to child welfare community care services, for example. When considering the alternatives in purely financial terms, there should be an apparent need to decrease the number of placements. The other side of the coin is of course effectiveness, as there is no clear evidence in one way or another, but with the cost structures presented in this report, community care services could be offered for long time periods and in large amounts before the costs surpass the costs of placements. It is of course always important to ensure that the best interests of the child are realized, and it should be the key factor in defining services targeted at children and families, but in the end the effectiveness of services is also in the child's best interest.

Although these calculations aim at raising thoughts about the costs of different service paths and different alternatives, it is clear that there are no alternatives for all children and families. Sometimes emergency placement and taking a child into care is the only possible choice. Even if there were more investments in preventive services and community care, we must also remember that ensuring the quality and effectiveness of foster care demands resources as well.

So why the lack of investment in preventive care? In light of the above information it would be sensible, economical, and often also the right thing to do in humane terms? The resources of actors in preventive child welfare are scarce, even though they do not lack expertise or

knowledge in basic services. It is impossible to share information about services when such services cannot be offered. Are we hiding behind dwindling resources, as it is only corrective services that are often the only kind of legal services that cannot be postponed due to the economic situation or lack of resources or by keeping silent about issues? Increasing the availability of services in basic services should be one key goal when strengthening preventive work activities. Involving experts of reactive services in the group of actors in preventive services poses a special challenge. Breaking down the sector-based structure of work could be one way of developing child welfare.

When calculating the costs of service paths, we have included all obvious costs. Earlier we mentioned that we have limited our analysis by not including the costs of services for adults in the costs of the service paths. Another significant restriction is the diverse nature of child welfare social work and the long processes that do not have a set price in the report. This may narrow the picture of the contents and the processes of child welfare social work. In our opinion, these are important subjects for follow-up studies.

Examples of the costs of care periods

SERVICE FUNCTION	COSTS, COMMENTS	
Visit to a school nurse	54 €/visit	a
School nurse's input	23 €/hour. E.g. 2-hour meeting incuding preparations 70 €, can also be estimated as above (54 €/visit).	a
Visit to a school social worker	88 €/visit. The costs include planning, etc.	a/e
Visit to a physician at school health care/basic health care (incl. examinations)	92 €, one time visit	a
Visit to a school psychologist	103 €, information from YTHS	a
Meeting with a social worker	88 €/meeting, incl. time the social worker spent on tasks related to the meeting	a
Social worker's input*	24 €/hour. E.g. meetings with the child who has been taken into care and meetings with the parents, 48 hours a year, 1,150 €.	a
Receiving a child welfare notification and making a report	Consists of social worker's input, costs are case-specific, e.g. 20 hours 480 €	e
Social work with a client	Social worker's input 24 €/hour, the total number of hours always case-specific	a/e
Preparing a decision on taking a child into care	Costs consist of social worker's input, e.g. 32 hours 770 €	e
Immigrant visiting a social worker, accompanied by an interpreter	176 €, incl. time spent on preparing the meeting with an interpreter and a social worker	e
Adolescent psychiatric inpatient care	507 €/day, one week treatment period 3,550 €	a
Treatment in adolescent psychiatric outpatient clinic	206 €/visit, e.g. one visit per week for a year 10,700 €	a
Examinations by a specialist of adolescent psychiatry, first visit	246 €/visit, fee depends on the nature and the duration of the examination. The same for the infants.	a
Parent's visit to psychiatric outpatient clinic	153 €/visit, e.g. once a week for a year 8,000 €	a
Therapy for children	144 €/visit	a
A child's visit to psychiatric outpatient clinic	294 €/visit, more expensive for children than adolescents	a
Hospital inpatient care	Ordinary inpatient ward 217 €/day	a
Occupational therapist at the psychiatric unit for substance abusers	138 €/hour. This certainly varies greatly. The example costs have been estimated according to a visit to specialist in the adolescent psychiatric clinic other than a physician, e.g. 4 months 2,200 €.	a
Physician at the psychiatric unit for substance abusers	175 €/hour, visit to a physician at adolescent psychiatric clinic (40–60 min), e.g. 4 months 700 €	a

Examples of care period costs

SERVICE FUNCTION	COSTS, COMMENTS	
Visit to A-Clinic or youth clinic	81 €/visit	b
Family's financial support from child welfare	600–1,300 €/year/child (rough estimate)	f
Intensive family work	C. 1,000 €/month, 12,000 €/year	c
Family councelling office	112 € / 45 min. E.g. 1.5-hour visit 224 €/person.	d
Child health clinic	71 €/visit	a
Support person	420 €/year + 600 € assistance for hobbies	d
Special youth work	80 €/day, e.g. the Nuotta project	d
Network meeting (A-Clinic, social worker, child health clinic, day care)	350 €/meeting, depends on the number of officials involved and the duration. Usually four parties involved, costs include meeting and planning.	e
Home help service	32 € / 1-hour visit. Calculations based on 2-hour visits. Cost information has been calculated on the basis of all home help services, making distinctions between child families, the elderly or disabled persons was impossible. Home care is not included, however.	a
Family Group Conference (FGC)	C. 1,500 €/meeting	d
Shelter for a family	336 €/day, e.g. 3,360 € / 10 days, own risk payment 430 €	d
Community care services provided by shelter	70–80 €/visit, e.g. 10 visits c. 750 €	d
Emergency placement	Residential care 256 €/day, foster family 62 €/day. E.g. 2 months in a residential care unit 15,000 €.	c
Child's placement in a crisis family	62 €/day, e.g. 3 months 5,600 €	c
Taking into care, long-term placement	In residential care 256 €/day, foster family 62 €/day, professional family home 162 €/day. E.g. a year in residential care 93,000 €, in foster family 23,000 €.	c

SOURCES: a) Hujanen et al. 2008**, b) Väisänen & Hujanen 2010**, c) Kuusikko-kunnat 2011**, d) expert sources e) author's calculations, f) Kuusikko-kunnat 2006

* The costs of the hourly work of a social worker include the average gross salary, the employer's social security fees and holiday pay.

** Original information changed to the value in 2010.

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(Endnotes)

1 The first chapters of original Finnish report have been modified with the international readers in mind. The modifications were made by Hanna Heinonen and Susanna Hoikkala from the Central Union for Child Welfare.

2 On child welfare policies for children in Nordic countries, see Eydal & Satka (2006); on the definition of child protection, see Hearn et al. (2004), and on alternative care and child protection in Finland, see Eronen et al. (2011) and Pösö et al. (2010).

3 *Children placed outside their homes* refers to children and young people placed outside their own home as a support intervention in community care, through emergency placement, as taking into care (voluntarily or involuntarily) or as a form of after-care. In this report, the concept of *community care* is used instead of open care (see e.g. unofficial translation of the Child Welfare Act). According to the Child Welfare Act (2007, Section 34), the pur-

pose of these kinds of services is to promote and support the child's development and to support and enhance the upbringing skills and opportunities of the parents, custodians and persons responsible for the child's care and upbringing. Support in community care takes place usually in non-residential settings.

4 The report presents statistical information from both 2010 and 2012. The data from 2010 have been presented because they were used in the original Finnish publication. The latest national statistics are on year 2012 and they were included to describe the current situation.

5 The 2007 Child Welfare Act has strengthened the roles of regional administrative courts in the processing of child welfare issues. Administrative courts process, for example, taking into care orders if a child who has turned 12 or their custodian object to it.

6 In Finland, corporal punishment of a child has been legally forbidden for about 30 years (Act on Child Custody and Right of Access 361/1983, section 1).

LASTENSUOJELUN
KESKUSLIITTO