Nederlands
Jeugd
instituut

Child and Youth Social Care Systems Abroad

Lessons on strategies and systems from England, Germany, Norway and Sweden

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November 2009

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1. Introduction

1.1. Aim of the quick scan

The Ministry for Youth and Families in the Netherlands is preparing a policy briefing on the future of the child and youth policy services and system. One of the main concerns is that more and more youngsters and their parents need highly specialized help and care. To underline the policy briefing there is an interest in seeking lessons that can be learned from other countries in relation to system and structural changes. It is also relevant to find out whether in these countries similar concerns and visions are being debated.

The Netherlands Youth Institute/NJi has therefore been asked to give an overview of some relevant developments in the countries around us. Almost five years ago a similar study was undertaken by EIM, Business & Policy Research, commissioned by the Ministry for Health, Welfare and Sports and the Ministry of Finance (July 2005). That study looked at five countries: UK, Germany, New Zealand, Sweden and Norway.

1.2. Approach of the quick scan

The EIM study is the starting point for the current quick scan on child & youth policy structures. However, the field of child and youth systems is constantly changing and many things have happened during the last five years. Therefore the current quick scan addresses the situation in the UK, Germany, Norway and Sweden1. The aim of is this quick scan is twofold:

1. To update the child and youth policy structures, describe processes and models of delivery
2. To identify key issues and messages for the Dutch policy briefing on the future of child and youth care

Due to the limited time, the EIM study was the starting point for the current quick scan. Various sources, in particular (policy) documents from the national governments of these countries and documents describing their child and youth policy services and systems, were used to write an updated country profile on the UK, Germany, Norway and Sweden. Within these country profiles, the access to mental health care and care for disabled children will be reviewed. Furthermore, the country profile will contain a unique approach concerning child and youth care. Experts of each of these countries were then asked to complement and/or correct this country profile. Their feedback was used to finalize this report.

[1] We have not included New Zealand. For pragmatic and time reasons we have only looked at European countries. Also, more direct exchange is possible with our neighbouring countries.

1.3. Outline of the report

These country profiles are the foundation of this report and are therefore included in the next chapter. These country profiles were used for the cross national analysis of the child and youth policy structures, processes and models of delivery in the UK, Germany, Norway and Sweden. This cross national analysis is presented in chapter 3. Chapter 4 describes the identified key issues and messages from the UK, Germany, Norway and Sweden for the Dutch policy briefing on the future of child and youth care. After further consultation with the Ministry as much information as possible has been added on the system of the care for disabled children and mental health care for children.

2. England

In 2008 England had 51,4 million inhabitants (84% of the UK population). Of these 11,7 million were children up to 19 years of age (23%). This chapter refers to the system in England. The systems in Scotland, Northern Ireland and Wales are subject to their respective laws and policies.

2.1. Is there a tendency towards medicalisation of care?

Children in England that are part of the social care system, are called 'looked after children[2]'. This term has been introduced in the Children's Act of 1989 and is intended to be less stigmatizing than 'in care'. England has seen a big overhaul of children's services since the introduction of the Every Child Matters (ECM) programme in 2004. ECM was introduced to ensure that no child would be outside the system and put a stronger emphasis on preventive, universal services. In 2008 – as the key figures below show – the number of children looked after were indeed decreasing. However, recently - especially after the death of Baby Peter who was known by the child protection system and the public inquiry that followed at the end of 2008 – more and more children are being referred to the social services, and therefore more specialised types of care. The question is whether this is a temporary 'Baby Peter effect' or a more permanent situation.

- There were 59,500 children looked after on 31 March 2008, 1 per cent fewer than last year's figure of 60,000 and a decrease of 3 per cent compared to 2004 (61,200).
- There were 23,000 children who started to be looked after during the year ending 31 March 2008, a decrease of 4 per cent from the previous year's figure of 24,000 and a decrease of 8 per cent from the 2003-04 figures of 25,000.
- There were 24,100 children who ceased to be looked after during the year ending 31 March 2008, a decrease of 3 per cent from the previous year's figure of 25,000 and a decrease of 6 per cent from the 2003-04 figures of 25,700.

2.2. The structure of youth care

Introduction

Every Child Matters

In 2003 the Government published a Green Paper called Every Child Matters. This was published alongside the formal response to the report into the death of Victoria Climbié, a young girl who was horrifically abused and tortured, and eventually killed by her great aunt and the man with whom they lived.

[2] The term 'looked after children' (LAC) refers to children in public care, who are placed with foster carers, in residential homes or with parents or other relatives. Looked after children are subject to some form of legal order, e.g. a care order (Children Act 1989, section 31), interim care order (Children Act 1989, section 38) or emergency protection order (Children Act 1989, section 44) where the local authority has acquired parental responsibility for that child.

This Green Paper built on existing plans to strengthen preventative services by focusing on four key themes:

1. Increasing the focus on supporting families and carers – the most critical influence on children's lives.
2. Ensuring necessary intervention takes place before children reach crisis point and protecting children from falling through the system.
3. Addressing the underlying problems identified in the report into the death of Victoria Climbié – i.e. weak accountability and poor integration.
4. Ensuring that the people working with children are valued, rewarded and trained.

The Green Paper prompted an unprecedented debate about services for children, young people and families. There was a wide consultation on these services with people working in children's services, and with parents, children and young people. The next step was the passing of the **Children Act 2004**, providing the legislative base for developing more effective and accessible services concerning the needs of children, young people and families. This Act provides the legislative foundation for a whole-system reform. It outlines new statutory duties of all services involved with children and clarifies accountabilities for children's services.

Every child matters: Change for children was published by the national government in November 2004, promoting a system locally and nationally where there is:

- Clear overall accountability for services for children, young people and families
- Integration of key services around the needs of children, in particular education, social care, health youth justice and family services.

The government's vision that was introduced is that of a system in which governmental and voluntary organisations, central government and local authorities and other public and private partners are enabled to work together, from their different perspectives and responsibilities, to enhance the lives of all children and young people.

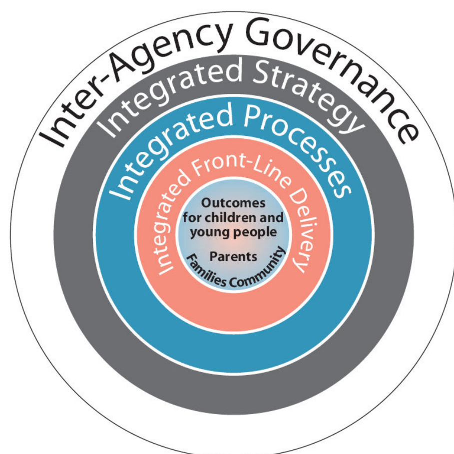
The Every Child Matters Framework is based upon the five outcomes that children and young people themselves identified during the consultations as key to wellbeing in childhood and later life. The outcomes were also consulted with the statutory, voluntary and community sectors. The 5 outcomes are:

1. **Being Healthy** so that they are physically, mentally, emotionally and sexually healthy, have healthy lifestyles and choose not to take illegal drugs.
2. **Staying Safe** from maltreatment, neglect, violence, sexual exploitation, accidental injury and death, bullying and discrimination, crime and anti-social behaviour in and out of school, have security and stability and are cared for.
3. **Enjoying and Achieving** so that they are ready for school, attend and enjoy school, meet the requirements of primary and secondary school, achieve personal and social development and enjoy recreation.

4. **Making a Positive Contribution** so that they engage in decision-making, support their community and environment, engage in law-abiding and positive behaviour in and out of school, develop positive relationships, choose not to bully and discriminate, develop self confidence, successfully deal with significant life changes and challenges and develop enterprising behaviour.
5. **Achieving Economic Well-Being** so that they engage in further education, employment or training on leaving school, are ready for employment, live in decent homes and sustainable communities, have access to transport and material goods, acquire income above subsistence level.

Every Child Matters has been the beginning of a number of activities regarding safeguarding children practices, children's services and family support. The initial emphasis was on the identification, referral and tracking children at risk and the provision of mainstream and specialist services to them. However, subsequent developments have broadened out to become what amounts to a 'whole-system change' and radical overhaul of all services working with children and families. Also, in the further stages of Every Child Matters, the focus has shifted from children at risk to looking at the whole family (Think Families!).

In Every Child Matters, the improved outcome for all children and young people is the responsibility of the local authorities. This will be driven by an analysis of local priorities, and secured through more integrated frontline delivery, processes, strategy and governance. This model of whole-system change, the Children's Trust in action, is illustrated by the 'onion' diagram:



The model is organised around the centre: achieving better outcomes for children and young people, which in the first place are delivered by so-called frontline services (integrated front-line delivery). These are universal services for all children and their parents. In general these are the children's centres (0 – 6 years old), extended schools (6 – 18) and youth work (12 – 18).

These services are organised around the children, but also provide services for parents, such as parenting advice and support, as well as job training in the children's centres. All staff working in the services for children and their parents work with integrated processes. This means that multi-agency teams and common instruments have been developed, the most important ones being the Common Assessment Framework (CAF) and ContactPoint (information sharing). All local authorities have to draw up a 3-yearly Children and Young People's Plan (CYPP). This integrated strategy identifies the needs of children and young people at the local level. It sets out priorities and policy for all partners involved in delivering services for children and young people. Children, young people and their parents are actively involved in the consultation process of the CYPP. Also at the level of governance, joint structures have been created to ensure better outcomes for children. In the next paragraphs these will be described both for the national as well as for the local level.

The national level

At the national level the **Department for Children, Schools and Families** (DCSF) has been created in June 2007. The DCSF is responsible for all issues affecting children and young people up to the age of 19 including child protection and education and is the lead for the Every Child Matters programme. DSCF is responsible for supervising the legal framework of Every Child Matters. DSCF provides both statutory guidance to local authorities (which local authorities must follow) and non-statutory guidance (which the DCSF suggests local authorities follow).

Children's Plan

Shortly after it was created, the DCSF published the **Children's Plan: Building brighter futures**. The Children's Plan sets out the Department's goal for improving children and young people's lives. The Children's Plan sets out principles and is based on strategic objectives such as securing the health and wellbeing of children and young people and achieving world-class standards. DSCF has been asked why the Children's Plan has been structured around a new set of strategic objectives rather than the 5 ECM outcomes. Since these comments have been made, the DCSF has set out the links between the different objectives and outcomes, presenting a more coherent plan. The Department publishes an evaluation of the Children's Plan every year.

Legal framework

The legislative framework for Every Child Matters is found in the **Children Act 2004**. This Act provides the legal underpinning for the transformation of children's services and the duties of the local authorities regarding Every Child Matters. It makes the 5 outcomes the basis for all services to children and young people. It introduces the responsibilities and services for local authorities, such as the duty to cooperate between agencies and the setting up of the children's trust, the duty to share information, the duty to appoint one director for children's services and the requirement for a single Children and Young People's Plan for each local authority.

The Children Act 2004 is an amendment to the Children Act 1989. In this Act numerous Acts were consolidated into a single Children Act and it therefore became the basis for the child protection system, family support and other children's services in England.

Other administrative levels

Every Child Matters is a national framework for local change. The objectives of both the ECM strategy and the Children Act 2004 have been to change and improve the services at local level. At the local level, after the introduction of ECM all different services for children and young people (such as education, social services) have been administratively joined up in the local Children's Services. One councillor of the local council (governing body of the local authority) has been appointed lead member for children. This person has local political accountability. There are 150 local authorities in England.

As in many other countries, most services for children and young people are carried out by statutory (governmental) organisations. More and more these organisations are working together with voluntary organisations and charities.

Children's trusts

Following from the Children Act 2004 and the ECM guidance, in according with the duty to cooperate, all local authorities had to put into place '**children trust arrangements**', putting the 5 outcomes for all children and young people at the centre of all activity. The purpose of the children's trusts is to improve the well-being of all children and improving their outcomes. A children's trust is a local area partnership led by the local authority and bringing together key local organisations. Some have a statutory duty to cooperate and some do not. The concept of the children's trust fits in the English system of Local Strategic Partnership, which brings together public, private, community and voluntary sectors to work together more effectively to promote better outcomes for local people.

The children's trust is responsible for creating partnerships between all organisations that work for children and young people at the local level. At this moment mandatory partners are for example the police, the probation services, youth offending teams, the strategic health authority and primary care trusts (health). The national government is intending to increase this list with organisations such as housing cooperations, higher education and job centres.

Most Children's Trusts are already governed by a Children's Trust Board. The national government is preparing a legal basis for these boards, to make them more sustainable. The Board is responsible for 5 essential features of the children's trusts:

- Developing a child and family centred vision for all children and young people in their area through the Children and Young People's Plan (CYPP)
- Establishing inter-agency governance
- Developing integrated strategy: joint planning and commissioning, pooling and aligning budgets, and the CYPP
- Promoting integrated processes and shared language
- Developing integrated front line delivery organised around the child, rather than around professional or institutional boundaries

National government's vision on children's trusts:

"The children's trust should be at the centre of the cultural shift which unites all people working with children and young people around a common purpose, language and identity, while keeping the strong and distinctive professional ethos of different practitioners. It should enhance inter-professional trust and greater willingness to work outside traditional service areas and shared information.

Director of children's services

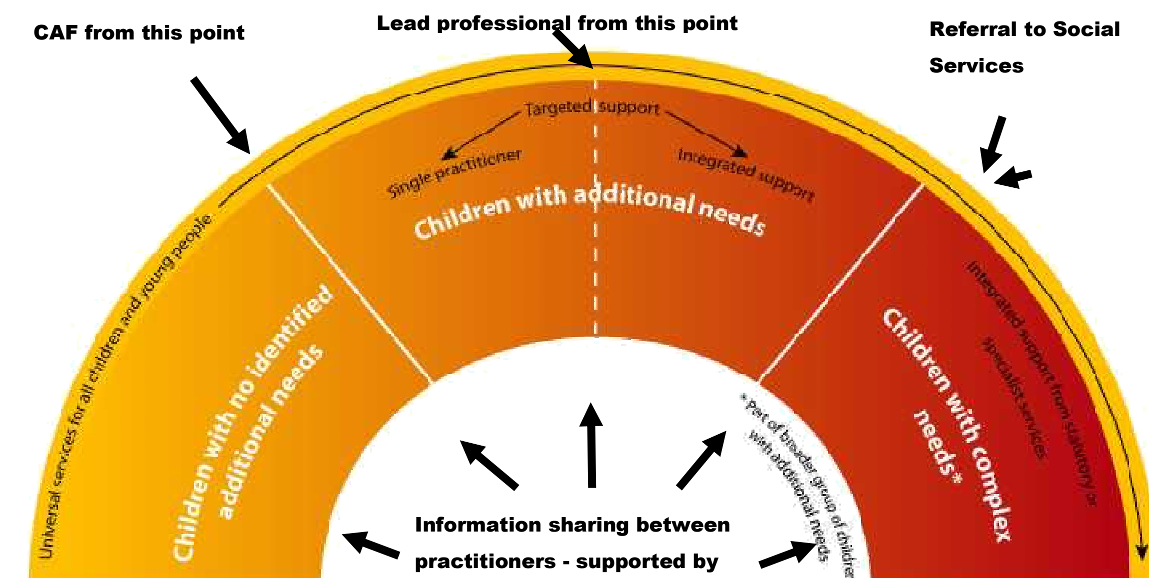
The Children Act 2004 requires all local authorities to appoint a director of children's services (DCS). The DCS is professionally responsible and accountable for the delivery of the local authorities' children's services. These include education, social services, services for parenting support and children's centres, including all the integrated working processes and information sharing. The DCS, together with the lead member of the local council, is also the chair of the children's trust. Until now, the DCS is also the chair of the Local Safeguarding Board (see paragraph 2.2.4), although this might change in the future.

2.3. Policies and approaches

Access to care

In England there is both a voluntary and an imposed route into care. With the introduction of ECM the focus has shifted to the voluntary route, with the emphasis on fulfilling additional needs as soon as possible. For this, most children's services use the so-called 'windscreen model'. This is a model of managed care. All services for children and their parents fit into this model.

The idea behind this model is that all children and their parents are reached by the universal services in each Local Authority, such as Children's Centres, Extended Schools and Youth Work. Through these universal services they can be guided through and referred to more specialised services. There is a continuum of support for children, young people and their families.



Windscreen model (managed care)

When a worker (e.g. at a children's centre or a school) detects an additional need, a **Common Assessment Form (CAF)** has to be filled out. This instrument allows a first analysis of the additional need of the child or family, such as housing or a special health service – without an immediate referral to a more intensive type of care.

In the case of child protection – the legal route – children can enter the system through care orders, voluntary accommodation arrangements or police protection or involvement with the youth justice system.

There are no mandatory reporting laws in England (or the UK) for professionals working with children. However, most organisations have internal procedures that they must follow if they have concerns about the welfare of the child. There are also guidelines from DCSF[3].

The entitlement to care/ a duty to offer care

The emphasis in England is more on a duty to offer care by the Local Authority through the children's services, rather than an individual entitlement to care. The duty to offer care has a legal basis in the Children's Act. This Act stipulates the services and structures that the Local Authorities should have in place, both for voluntary as well as for imposed care.

In case of the imposed measures for child protection; once a referral on child abuse has been made, the child protection team within a local authority has 24 hours to take action. The local authority has a legal duty to investigate concerns about any child who is physically present in their area, even is this child is a resident of a different local authority. If a child has been identified as being at risk, there is a period of 7 days in which an assessment has to be made (unless it is an emergency, then an emergency protection order can be issued, which allows the child to be taken out of the home for up to 8 days). If after the period of assessment the child needs further support from social services, the child is officially designated a **child in need**. In this case the local authority has a duty to provide services to safeguard and promote the welfare of the children involved.

If at this point the help offered is sufficient, the case will be closed when appropriate. If there is **significant harm** (defined by law) a child protection conference (attended by social workers and in some cases the police or hospital staff) will be organised and it may be decided that the child will be entered into the child protection register. At this point a child protection plan is made. The child protection conference might also decide on further care proceedings such as a **care order**. If children are the subject of a care order, children become 'looked after' by the local authorities. Data shows that most children with a care order are placed in foster care or in a residential institution. In some cases the child will remain with the parents with interventions taking place at home.

Current issues

During the past years there has been a lot of interest in the debates in England concerning the care for children and young people. There has been a great interest in Every Child Matters especially.

[3] Working Together to Safeguard Children: a Guide to inter-agency working to safeguard and promote the welfare of Children, DCSF 2006 – statutory guidance, What to do if you're worried a child is being abused, DSCF 2006 – non-statutory guidance

Particular regarding terms the direction and vision it has given to the children's services, not in the least for the workforce. Another – related issue – is the reform of the children's workforce. Especially the Children's Workforce Strategy 2020 is very inspiring for the debate on professionalization of the child and youth social care system in the Netherlands.

2.4. UK's unique approach: local safeguarding children boards

One of the 5 outcomes of ECM is 'Staying Safe'. This refers to a wider definition of child protection; it also includes safeguarding issues such as safe roads and decreasing traffic accidents. Implementing a strategy on safeguarding children is the responsibility of the Local Safeguarding Children Boards (LSCB). This is a statutory body in each local authority, required through the Children Act 2004. The local safeguarding board is an interagency forum, set up by the local authority, to agree how different services and professionals should cooperate to safeguard children and to ensure arrangements are working to bring about good outcomes for children.

SAFEGUARDING is about keeping children safe by:

- protecting them from harm
- supporting their health and development
- making sure they grow up in a safe environment

SAFEGUARDING is about knowing when a child is at risk or needs help to deal with problems so that they can be kept safe from:

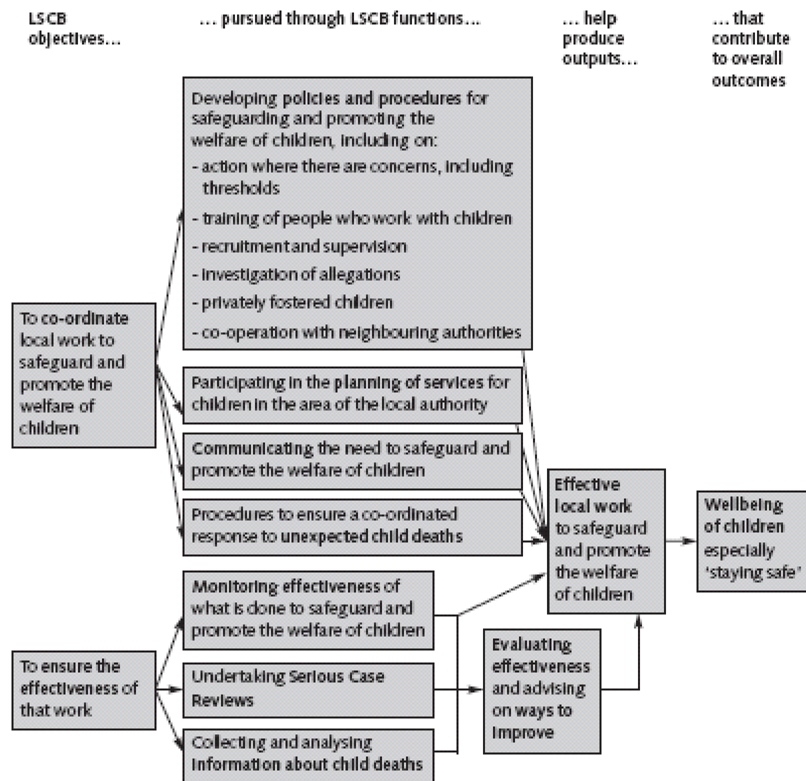
- accidental injury or death
- bullying and harassment
- crime and anti-social behaviour
- neglect, abuse or violence in the home

The LSCB sets out standards and guidelines how safeguarding is organised in the local authority. It is responsible for organising training to all staff of the children's services and partners in safeguarding children in general and in child protection in particular. They are also looking into vetting and barring (screening) issues of staff of children's services. If a child dies or is seriously injured and abuse or neglect is thought to be a factor, the LSCB is required to carry out a **serious case review** to find out what went wrong, learn lessons and improve interagency working. These findings also have to be made public.

In the Children Act 2004 there is a list of organisations that have to be presented in the LSCB (overlapping the membership of the Children's Trusts), but a lot of LSCB's include voluntary and charity organisations working on safeguarding children.

At this moment the Director of Children's Services (DCS) chairs the LSCB's. However, at this moment – after evaluation of the LSCB's – there is a suggestion that independent chairs to LSCB's should be appointed to avoid conflicts of interest and provide independent scrutiny.

Figure 1: LSCB objectives and functions



2.5. Summary

- England’s model demonstrates a continuum of care in which the universal services are organised around ‘meeting places’ for children, young people and their parents. Every Child Matters is the common framework of all services, focused at common language and integrated working. Through the system of universal services children and parents can be referred to more specialised services. All services for children and young people at risk are part of the children’s services.
- Every Child Matters and the children’s services are organised through the Children Act 1989 and 2004. This Act describes the duties and services of both the national government and local authorities.
- An interesting, unique approach in England is the Local Safeguarding Board in each local authority. This inter-agency forum is responsible for safeguarding children.
- The ‘voluntary’ and ‘ imposed’ route for families, children and young people at risk are both the responsibility of the children’s service of the Local Authority. There is also integrated working for the children’s service and the services for children with disabilities and the mental heath service for children.

3. Germany

In 2007, Germany had an overall population of 82.2 million. Approximately 19% of the population was under 20 years of age.

3.1. Is there a tendency towards medicalisation of care?

The term medicalisation is not used in Germany, but data over the period 2005-2008 show that there is an increase in certain interventions regarding child protection.

In the first place, in this period the number of *Inobhutnahmen* (children placed under custody) of the *Jugendämten* (youth welfare offices) has increased by 26%. Whereas in 2005 around 25.400 children were placed in custody, in 2008 this was the case for approximately 32.300 children. Not only the number of the children in custody has increased, but so has the proportion of children less than three years of age relative to all children taken into custody. This has doubled from 5% in 2000 to 10% in 2008. For three to eight year olds, it increased from 9% to 14% in the same period. According to the *Statisches Bundesamt Deutschland* that publicizes these data, these data show that the youth services pay more attention to the protection of younger children. In general, the purpose of this intervention is the direct protection of the young person. They are placed in custody on their own wish or on the initiative of others, such as *Jugendämter* or police if there is imminent danger to the child's welfare. The children or juveniles are usually put in an adequate institution like a home for a short period, i.e. some hours or a few days.

In the second place, the number of partial or full *Sorgerechtsentzüge* (revocations of child custody) from parents by German courts - because there was no other way to avoid a threat to the children's well-being - grew by approximately 40% in the same period. The exact number increased from around 8.700 in 2005 to 12.250 in 2008.

According to an expert from the *deutsches Jugend Institut*, the increase in the use of these interventions can not be described as a medicalisation of care as it is not related to the medical system. The increase is probably due to a more cautious way of operating by the people working at the *Jugendämter* under the motto 'it is better to intervene too much than too little'.

3.2. The structure of youth care

Introduction

In Germany there is no such term as 'youth care'. Rather, the relevant term in Germany is *Jugendhilfe*. This is usually translated in English as child and youth services. This encompasses both youth work and youth welfare services. More specifically, *kinder- und Jugendhilfe* supports children and young people in their development and helps young adults in particularly difficult situations. Furthermore, it advises and supports parents and other guardians in educating their children. It also has to participate in proceedings held before guardianship or family courts. Furthermore, one of the missions of the *Kinder- und Jugendhilfe* is to protect children and adolescents from threats. It does so by prevention via education about potential sources of risk to child welfare and as well by interventions when such a risk has already occurred. As to be discussed in more detail in paragraph 2.2.3, the past German legislature was characterized by a growing awareness in society and politics concerning child protection, partly because the government was faced with a number of serious cases of child neglect. Among others, the federal government in Germany took several steps to address the issue of child protection from a preventive angle.

The national level

In Germany, several ministries are responsible for questions that could be relevant for children and young people or deal with support to them. This among other includes the Federal Ministry of Labour and Social Affairs, the Federal Ministry of Health, the Federal Ministry of Education and Research and the Federal Ministry of Justice.

At the national level, the *Bundesministerium für Familie, Senioren, Frauen und Jugend* (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth) is responsible for central programmes of the Federal government's children and youth policy and important youth policy interfaces with other policy areas. Furthermore:

- it supports and sponsors national and inter-regional voluntary organisations of child and youth welfare in their diversity of values, contents, methods and working processes.
- it issues a *Kinder und Jugend Plan* (KJP; Child and Youth Plan of the Federation) which is a central instrument of child and youth support.
- it uses evaluations of model projects and their outcome to further develop child and youth services and sponsors independent experts to do research to provide information on the situation of young people in Germany. This includes the four-yearly *Kinder- und Jugendbericht* (Child and Youth Report).
- It has the lead responsibility for existing federal laws, such as the *Sozialgesetzbuch Achtes Buch, Kinder und Jugendhilfe* (also called SGB VIII; Social Code, Book VIII – Child and Youth Services). This law will be discussed in more detail in the paragraph about the entitlement to care/ a duty to offer care as it contains the duties of child and youth services.

Other administrative levels

The Länder

The Federal Republic of Germany is a federal state consisting of 16 so-called *Länder*, each of which is a state in itself**.** The Länder are responsible for all their internal administration and for the implementation of most federal laws and regulations. Regarding child and youth services, all *Länder* have to set a *Landesjugendamt* (Youth Office of the Land) that:

- support the local child and youth service providers by advice and further training
- give financial support to the bodies and organisations that are responsible for child and youth services with the objective of further developing and evenly balancing the expansion of provision
- are involved in the protection of children and young people in institutions

The Gemeinden, Kreisen und Städte

The SGB VIII gives the overall responsibility for child and youth services to the administrative districts (counties) and towns which are administrative districts in their own right.

According to the same law "*die Träger der öffentlichen Jugendhilfe werden durch Landesrecht bestimmt*" (providers of statutory youth services are determined by state law).

Because of this recent change in the law, it is thus no longer the case at the municipal/county level that all *Gemeinden, Kreisen und Städte* have to set up a *Jugendamt* . In theory, several counties can thus create one together. However, this has not happened yet.

The *Jugendamt* consists of two parts:

1. The *Verwaltung;* this is the administration that carries out the resolutions and laws
2. The *Jugendhilfeausschuss* (Youth Service Committee) which can be considered the part that locally exercises the management function of the child and youth services. This committee consists of representatives of youth and welfare organizations, associations, religious communities and the local council. It deals with all matters of child and youth welfare, in particular with:
    - youth service planning
    - the funding of *freie Jugendhilfe* (non-statutory/ voluntary youth service providers)
    - suggestions and proposals for the further development of *Jugendhilfe*

3.3. Policies and approaches

Access to care

Parents and adolescents can contact providers directly for short-term assistance to *Beratung (*counselling). However, ambulant or residential care are only accessible after an assessment and the design of *Hilfeplan* by the *Jugendamt.* Furthermore, a ruling by a judge is needed for restraint measures.

The entitlement to care/ a duty to offer care

Several German laws mention the role of the parents and the state regarding the care of children:

- The *constitution* states that :
    - "Care and upbringing of children are the natural right of the parents and a duty primarily incumbent on them. The state watches over the performance of this duty" (Article 6: 2)
    - "Separation of children from the family against the will of the persons entitled to bring them up may take place only pursuant to a law, if those so entitled fail in their duty or if the children are otherwise threatened with neglect" (Article 6: 3)
    - "Every mother is entitled to the protection and care of the community" (Article 6: 4). This concerns the time during pregnancy, birth, the time of breast-feeding or rather the first months after birth and in later phases of her life, if the mother suffers negative consequences of pregnancy and birth.

- Furthermore, according to the earlier mentioned *SGB VIII*:
    - Every young person has a *Recht auf (*right to*)* assistance in his or her development and to an appropriate upbringing so that he or she can become a responsible and socially skilled personality (§ 1: 1).
    - Care, upbringing and education of children are the natural right of parents and their primary duty (§ 1 : 2). The state polity monitors the fulfilment of that duty (§ 1: 2)
    - For the realisation of this right, child and youth services shall:
        - further young persons in their individual and social development and help to avoid or remove disadvantages,
        - provide educational counselling and assistance to parents and other persons having parental powers
        - protect children and young persons from harm to their welfare
        - help maintain or create positive living conditions and a favourable environment for children, young people and their families

The *SGB VIII* contains the duties of child and youth services; this means that the supply of youth care is regulated by law. There is a distinction between:

- other tasks (called *andere Aufgaben* in the law) that have to be provided by *öffentliche Jugendhilfe*. As in practice, the *Jugendämter* carry out these Aufgaben, they will be discussed in the paragraph about Germany's unique approach that deals with these *Jugendämter*.
- Services (called *Leistungen* in the law):
    - Services offered by youth work, youth social work and socio-educational child and youth protection

- Promotion of education and upbringing within the family. This includes family education, family counselling, family holiday schemes and separation and divorce counselling.
- Help in raising children and supplementary benefits
- Support of children in day care facilities and day care
- Help for young people who have reached their majority and follow-up support.
- Help for children at risk of mental disabilities
- Help for mentally disabled children and young people as well as supplementary services. This is also called socio-educational services. These services assist children and young people with emotional/mental/ psychological disabilities in their integration by promoting school and vocational/ professional education, their transition to employment and their integration into society. It is thus a bridge in the transition between school to employment and can be offered in a foster home, in residential homes for young people and in non-residential settings such as and training projects or counselling centres.

This list shows that these German *Leistungen* contain services that in The Netherlands are provided by youth work as well as services provided by youth care providers. Furthermore, the *Bundesministerium für Familie, Senioren, Frauen und Jugend* is involved in these services as it has the lead responsibility for the law they are outlined in.

In Germany, according to *SGB VIII* everyone who is entitled to these *Leistungen* - children, young people and parents - have the right to choose among the facilities and services of various providers and organizations. These wishes will be fulfilled unless it involves disproportionate costs.

Most *Leistungen* can be provided by two types of *Jugendhilfe* (child and youth services)*:*

- *öffentliche Jugendhilfe* (statutory youth service providers). These public bodies belong to the public administration (most often the *Jugendamt)*.
- *freie Jugendhilfe* (non-statutory/ voluntary youth service providers). These voluntary agencies display a multitude of organizational forms.

The *SGB VIII* outlines the cooperation between the statutory and non-statutory/ voluntary youth service providers:

- Basic principle: *öffentliche und freie Jugendhilfe* shall co-operate as partners.
- Subsidiarity principle: the *öffentliche Jugendhilfe* shall refrain from activities when they can be provided by *freie Jugendhilfe*
- Overall responsibility of the *öffentliche Jugendhilfe*: The *öffentliche Jugendhilfe* has the overall responsibility for child and youth services
- Funding for and promotion of voluntary youth service providers: the *öffentliche Jugendhilfe* are obliged to promote *freie Jugendhilfe* by providing non-material and financial support.

Current issues

Early Support and Prevention for Children at Risk

According to the publication "*Aktiver Kinderschutz- Entwicklung und Perspektiven*" (More active child protection- development and prospects), the past German legislature was characterized by a growing awareness in society and politics concerning child protection.

The federal government in Germany then took several steps to address child protection from a preventive angle and to strengthen the cooperation between youth welfare, health care and justice, partly because the government was faced with a number of serious cases of child neglect.

In the coalition agreement of the former government, the government's priorities of child protection and *frühe Hilfen* (early assistance) were outlined: "children facing health and social risks need targeted support from the very beginning. This means that more dependable and better-networked support for socially disadvantaged and affected families must be provided earlier on, in the local community or district. The state's guardianship role and the community's duty of care must be strengthened and social early warning systems developed. Youth welfare, preventive health services and civil-society engagement should be integrated to create a new quality in the early childhood support services provided for families. For socially disadvantaged families in particular, the classic "drop-in" structures which are the basis for a wide range of services must be improved and geared more specifically towards the target group, and new outreach services developed. The objectives of this project are:

- to improve child protection through the establishment of early warning systems and through early intervention,
- to coordinate health services, youth welfare services and civil-society engagement,
- to strengthen the state's duty of care,
- to reinforce parenting skills and responsibility"

On basis of its coalition agreement, the former government among others, developed the action *Programme Frühe Hilfen für Eltern und Kinder und soziale Frühwarnsysteme* (Early intervention for parents and children and social Early warning systems). The objective of this programme that is carried out from 2006 to 2010 is to identify risks for children as early as possible and to improve the parenting skills of their parents. The focus of the programme are especially children up to about three years, pregnant women and young mothers and fathers in stressful situations. Furthermore, the *Nationale Zentrum Frühe Hilfe* (National Centre Early Intervention) was installed in 2007 . The centre supports the cooperation of maternity hospitals, midwives and counselling for pregnant women with child and youth services. It provides professional advice and good practices of local and regional networks.

In the coalition agreement of the current German government that was issued at the end of October, the coalition mentioned its desire of an “active and effective child protection”. To this end, it will introduce a Child Protection Act. However, according to the expert at the *deutsches Jugend Institut* most people believe that no new legal measures regarding child protection are necessary. Furthermore, according to the current coalition agreement the earlier mentioned *Nationale Zentrum Frühe Hilfe* will be used to help create and intensify initiatives for an active child protection.

3.4. Germany’s unique approach: Jugendamt

As mentioned earlier, “*die Träger der öffentlichen Jugendhilfe werden durch Landesrecht bestimmt*” (providers of statutory youth services are determined by state law). Because of this recent change in the law, it is thus no longer the case at the municipal/county level all *Gemeinden, Kreisen und Städte* have to set up a *Jugendamt* . In theory, several counties can thus set one up together. However, this has not happened yet.

The *Jugendamt* consists of The *Verwalting* and the *Jugendhilfeausschuss* (JHA; Youth Services Committee). In practice, the Jugendamt most often provides the *andere Aufgaben* (other tasks of the statutory service providers) that are mentioned in the *SGB VIII*:

- The taking into care of children and young people. This means temporary accommodation with a suitable person, either in a facility or in some other supervised form of accommodation.
- The removal of a child or young person from a residential environment.
- Participation in proceedings held before guardianship or family courts.
- Giving counsel and instruction in proceedings regarding the adoption of the child.
- Participating in proceedings according to the Juvenile Courts Act.
- Advising and supporting carers and guardians.
- Official guardianship, assistance and supervisory co-guardianship of the Youth Office.

The *SGB VIII* also outlines some specifics tasks of the Jugendamt, including taking a child into custody when the situation demands this. In addition, the mandate of the *Jugendamt* regarding the protection in the event of endangering a child’s well-being was structured and defined by the *Gesetz zur Weiterentwicklung der Kinder- und Jugendhilfe* (KICK; the Act on the Further Development of Child and Youth Services). KICK was one of the last amendments to *SGB VIII* and enhanced the protection of children and young people in the field of child and youth services pursuant to *SGB VIII.*

The primary task of KICK (that came into force on 1 October 2005) is to improve the protection of children and young people from danger in order to preserve their well-being. Regulations include the responsibility of the *Jugendamt* to set the direction to ensure the provision of services and to limit the self-provision of services.

3.5. Summary

- Germany's model of child and youth services outlines a holistic approach, including services such as child day care, preschool activities, youth work and recreational activities, while at the same time providing the child protection system. These services are coordinated at the local level through the *Jugendamt*, with a strong national legislative framework and innovation programmes from the federal government.
- Germany is very similar to the Netherlands in the way in which non governmental institutions and organisations provide a lot of services.
- It is unclear to which extent children and young people can claim child and youth social care based on the *Kinder und Jugendhilfe Gesetz*. It seems more a right to welfare rather than a right to services.
- The *Jugendamt* in Germany in the municipalities has a long tradition and solid central role in the provision of child and youth services. It can carry out what in The Netherlands is considered youth work as well as more youth social care related tasks, such as taking children and young people into care. The Jugendamt is also responsible for the system of the voluntary as well as the imposed 'route' into social care. It would be interesting to look into evaluations of how parents in Germany perceive the Jugendamt in relation to children and young people social care.
- The Germany system has seen a focus shift towards earlier intervention. Like in other countries, such as the Netherlands, this has (also) been a result of certain critical incidents involving children known to the child protection services. However, the shift is too recent to see any results of the focus on 'fruhe Hilfen'.

4. Norway

In total, around 4.8 million people live in Norway. Around 1, 1 million of the population (23%) are children and young people below 18 years of age.

4.1. Is there a tendency towards medicalisation of care?

There was and still is a shift in resources in the Norwegian Child Welfare Services toward increased use of measures in the home. The data on the use of care also show an increase in the actual use of these measures: the number of children who receive assistive measures(in the home) from Child Welfare Services increased more than the number of children under public care. For example, from 2003 to 2006, the amount of children receiving assistive measures increased from 29,300 to 33,200, whereas the number of children under public care increased from 6,700 to 7, 300.

The Norwegian government continues to make resources available for these home-based measures and foster care rather than for placing in institutions. As mentioned earlier, the use of assistive measures increased (by 9.0%). Furthermore, from 2005 to 2006 the number of children placed in foster homes grew by 3.7%. In addition, in the same period the number of children and young people in institutions was reduced by 2.8%.

Furthermore, there is an increase in the use of mental health care by children and young people. For example, in the period from 1998 to 2006 the number of outpatient measures more than tripled, whereas the number of children receiving treatment in specialist health services more than doubled. According to the Norwegian government, the strong growth in the resources for mental health care for children and young people has contributed to the latter trend.

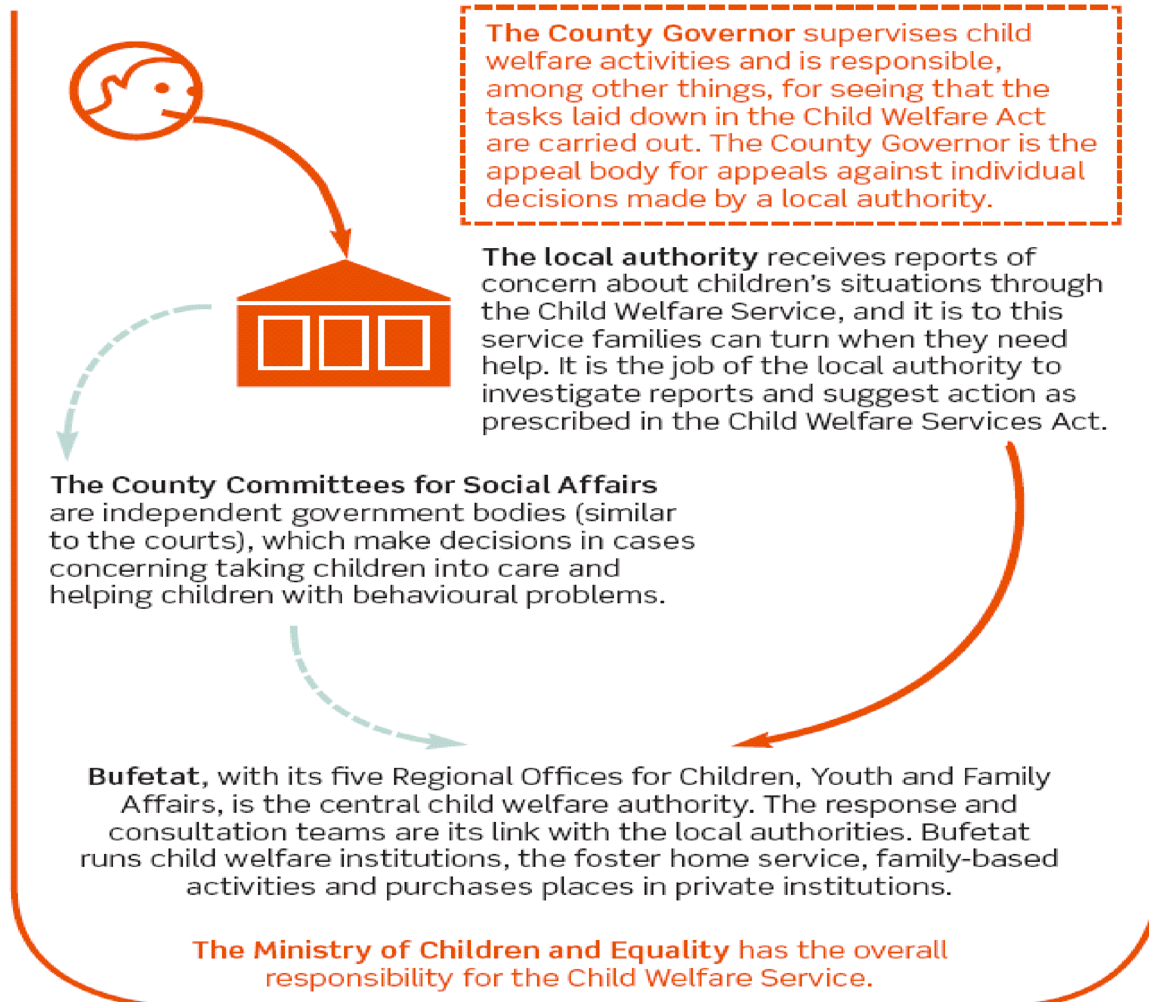
4.2. The structure of youth care

Introduction

In Norway, the term child welfare is used for what in The Netherlands is considered ‘youth social care’. In Norway, raising children is primarily the responsibility of parents. However, parents encountering difficulties may need short - or long-term parenting help. In such cases the Child Welfare Service could aid children and families so that children have opportunities for development in sound living conditions. All different levels of government are involved in child welfare and in 2004 the central government took over county responsibilities in the fields of child welfare and family welfare in order to - among others - ensure more equal, coherent services in all regions of Norway. This will be discussed later.

The national level

In Norway, currently municipalities and the state have duties and responsibilities related to child welfare, as is obvious from the following graph. As the county committee for social affairs is involved in the access to care, this committee will be described in the next paragraph about this topic. Furthermore, the Response and Consultation Teams are discussed in the last paragraph of this chapter as Norway's unique approach.



The Ministry of Children and Equality

In Norway, the central government has the overriding authority. The Ministry of Children and Equality is responsible for multi-sectoral policies directed toward children and youth. This includes topics like 'parents and children', 'children and youth', 'adoption' and 'child welfare'. In relation to child welfare, it is this ministry that has overall responsibility for managing the Child Welfare Act; it provides supervision to ensure that this act and associated regulations are properly enforced. Its responsibilities also include developing the overall policy regarding child welfare, providing instructions and guidance, arranging for child-welfare information to be generally available as well as initiating research and developing overall policy.

The government authorities at the regional level

In Norway, the central government includes central government agencies at the regional and the local level. Regarding child welfare, *Bufdir* (the Norwegian Directorate for Children, Youth and Family Affairs) is the government authority at the regional level. Its main objective is to provide services of accurate and high quality to children, young people and families needing assistance and support, no matter where they live in Norway. It is not only responsible for child welfare, but for example also for family counselling, adoption, youth exchanges and youth information. Furthermore, on behalf of the ministry of Children and Equality, it administers a number of grant schemes, for example for relationship-building projects with the purpose of promoting lasting family relationships and a secure and stable home environment for children.

Bufdir thus is the central governmental office under the Ministry of Children and Equality that is in charge of child and youth welfare services. It supervises five regional offices in Northern, Central, Western, Eastern and Southern Norway as well as a variety of services spread across the country. These regional offices (called *Bufetat*) are responsible for the more intensive services for children and young people, as according to the Child Welfare Act they have the following tasks and responsibilities:

- they assist the municipal Child Welfare Service in placing a child in care at the request of a municipality
- they are responsible for the recruitment of and placement in foster homes
- they are responsible for ensuring that foster parents receive general guidance and the required training.

Furthermore, *Bufetat* is responsible for:

- the accreditation of private and municipal institutions
- the establishment and operation of institutions called care centres for minors
- any associated specialised services for the care and treatment of children
- as mentioned earlier, making rules for the procedure for deciding admissions and discharges concerning the last two types of services.

Bufetat has not always has had these responsibilities. In the fall of 2002, the Government proposed amending the Child Welfare Act and the Family Counselling Offices Act in such a way that as of January 1, 2004 the central government would take over county responsibilities in the fields of child welfare and family welfare. In particular (as to be discussed later in paragraph Norway's unique approach: *Bufetat's* response and consultation teams) the state took over the county's responsibilities for operating the family counselling offices, child welfare institutions and foster homes. The main reason for this was to be able to increase the competence and knowledge-based guidance provided to the municipal Child Welfare Service. Furthermore, another aim of this centralisation was to ensure more equal, coherent services in all regions of Norway. In 2003 *Storting*, the Norwegian parliament adopted this proposal and the next year, the reform was implemented. However, a review conducted by the Office of the Auditor General publicised in 2007 showed that Bufetat does not provide an equal

service level and programmes throughout Norway. Furthermore, a more recent investigation of this reorganisation of the state Child Welfare Service shows that *Bufetat* has been underfunded for several years. In addition, it did not carry out sufficiently good analyses of the need for various measures which makes it difficult to assess whether all children who need help receive it. However, in line with one of the objectives of the reorganisation of *Bufetat*, more children have been placed in home-based measures and in foster homes, while the use of child welfare institutions has been reduced.

Other administrative levels

In Norway, the local authorities consist of 19 county authorities and 430 municipalities. These municipalities and county authorities have the same administrative status.

The County Governor

The County Governor is the main representative of central government supervising local authorities. It also supervises the accreditation of private and municipal institutions and intervenes in them when improperly run. Furthermore, the county governor has the obligation to supervise the child welfare activities in the individual municipalities. It for example:

- sees to that they carry out their tasks according to and within the framework of the Child Welfare Act
- ensures that they receive advice and guidance
- oversees child welfare institutions including the care centres for minors.

In addition, it is the appeal body for appeals against:

- individual decisions/orders of the local Child Welfare Service, including decisions in removal cases
- so-called follow up orders of the central government child welfare authorities at regional level
- when the matter in hand does not rest with the jurisdiction of the County Committee for Social Affairs

Municipalities

In Norway, the municipalities vary in size, but more than half of them have less than 5 000 inhabitants. All municipalities must have a child welfare administration that carries out day-to-day activities in fulfilment of the Child Welfare Act. This includes:

- the provision of advice and guidance
- ruling on matters assigned to it under this act
- the preparation of cases for consideration by the County Committee for Social Affairs ,
- the implementation and follow up of child welfare measures

In addition, the head of this child welfare administration (or the prosecuting authority) may immediately make an interim care order without the consent of the parents, if there is a risk that a child will suffer material harm by remaining at home.

The bodies that perform functions on behalf of the municipality constitute the municipal Child Welfare Service. All Norwegian municipalities have a Child Welfare Service that can be contacted during office hours4. According to the child welfare act, this municipal Child Welfare Service has to collaborate with internal and external partners; thus with other parts of the public administration and voluntary organizations that work with children and young persons (Ministry of Children and Equality, 2009). In addition, it has to provide a wide range of services:

- Preventive activities

  The Child Welfare Service carries out preventive activities in the sense that it is responsible for bringing to light neglect and behavioural, social and emotional problems at a sufficiently early stage to avoid lasting problems as well as for instituting measures to this end.

- Providing help and support

  The fundamental principle that is adopted by the Child Welfare Act is that children shall grow up with their biological parents. This entails that children shall primarily be helped in the home. According to the same act, the Child Welfare Service is responsible for implementing measures for children and their families in situations where the children have special needs due to conditions in the home. Help may be provided in the form of financial support, as advisory services, counselling or assistive measures. Such assistive measures seem to be directed at assisting parents in childrearing (by temporarily taking care of their child for them) as these measures include a personal support contact, enrolment of children in day care or kindergarten, providing a respite home or respite measures at home or other parental support measures. Thus, the Child Welfare Service has a number of instruments that can be used in an attempt to create satisfactory conditions for the child in the home. As we shall see later, this service adopted new and well documented methods in community-based measures such as Parent Management Training Oregon (PMTO) and Multisystemic Therapy (MST) the last few years.

  As a rule, assistive measures may be provided only if the family consents, but some of these measures (including supervision in the home, attending kindergarten or other daytime offering) may be enforced through an order to parents. Rulings requiring parents to accept assistive measures are only to be issued by County Committee for Social Affairs . In practice, more than 80 percent of all children coming in contact with the child welfare service accept voluntary assistive measures in the home.

  The use of these assistive measures has been stimulated. For example, there was and still is a shift in resources in Child Welfare Services toward increased use of to measures in the home. Furthermore, some examples of these assistive measures are mentioned in the Child Welfare Act to make them visible for caseworkers in child welfare services and for parents wishing for such assistance. This way the measures could reach more persons, and thus contributing to more children receiving a satisfactory care situation in the home.

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[4] Furthermore, so-called emergency child welfare units that work in accordance with the Child Welfare Act are standby in the evenings and at weekends. The availability of these emergency child welfare services varies from municipality to municipality.

Furthermore, it is the right and duty of the Child Welfare Service to make investigations when it receives reports of concern about children's situations

- Intervene when necessary – possibly against the will of the parents.

The Child Welfare Service is the agency that has the main responsibility for keeping track and intervening when children are subjected to violence and abuse. The child welfare act and other legislation oblige public authorities to disclose information to this service when a child has shown persistent, serious behavioural problems or when there is reason to believe that a child is being mistreated at home or is exposed to other serious failure of parental care. This is to ensure the Child Welfare Service of information concerning children subjected to failure of care or abuse.

The Child Welfare Service also has a responsibility to intervene if the earlier mentioned support measures implemented in the home are not sufficient to meet the needs of the child. In this case, the Child Welfare Service may arrange in consultation with parents to place a child in foster care, in an institution, or introduce specific parent-child measures for a period of time. Furthermore, according to the child welfare act, another ground for taking a child into care is "if the child is mistreated or exposed to other serious abuse at home". In general, taking the child into care must be the measure that is in its best interest. Removing the child from the home without parental consent is also possible, but as mentioned earlier this requires a decision from the County Committee for Social Affairs on the basis of a recommendation submitted by the municipal authority.

After these boards have determined that the child will be placed out of the home, the Child Welfare Service has some other responsibilities, including:

- selecting the placement location on basis of rules outlined in the Child Welfare Act
- monitoring the development of children who have been placed in care outside their homes as well as their parents. In practice, this service does not function satisfactorily; for example, deadlines are often not met, the required follow up of protection referrals are omitted and the service is under budgeted.
- if desired by the parents, the Child Welfare Service is obliged to offer parents guidance and follow–up a short time after the care order has been issued and as part of such follow-up, they should put them in contact with other assistance agencies.

4.3. Policies and approaches

Access to care

County Committees for Social Affairs

In Norway, there are 12 County Committees for Social Affairs (also called County Social Welfare Board). A County Committee for Social Affairs is a government body with an autonomous position in relation to the Office of the County Governor and to the ministry of Children and Equality. For each case, a board shall consist of a chairperson who is a lawyer, two professional experts, and two 'ordinary members'. This board is involved in Access to care as it makes decisions about the removal a child from the home without parental consent on the basis of a recommendation submitted by the municipal authority. Furthermore, it makes decisions concerning forcible intervention in the case of children with serious behavioural problems. The board's decisions may be appealed in the district court. Furthermore, regarding Access to care, *Bufdir*, the Norwegian Directorate for Children, Youth and Family Affairs, makes rules for the procedure for deciding admissions and discharges regarding institutions for children.

The entitlement to care/ a duty to offer care

The Child Welfare Act is concerned with children's need for protection. It has two purposes:

- ensuring that children and young persons who live in conditions that may be negative for their health and development receive the necessary assistance and care at the right time
- helping to ensure that children and young persons grow up in a secure environment.

Measures provided for by this act may be applied to children below the age of 18. If the child consents, measures implemented before the child has turned 18 may be maintained or replaced by other measures mentioned in this Act until it has turned 23.

As mentioned earlier, this act outlines the earlier discussed duties and responsibilities of the various governmental levels regarding child welfare. This act does not give legal rights to the child as it is based on the responsibility of the authorities which makes it more difficult for children and/or families to claim the services that are regulated in this legislation.

Current issues in youth care in Norway

Related to what is considered youth care in The Netherlands, there are some topics that also need to be reviewed here:

- Parent support

In Norway, the state has to provide parenting support and professional family counselling services. Currently, there are 64 family counselling offices, two-thirds of which are state-run and directly connected to *Bufetat* and one third is owned by church foundations and operated under an agreement with the central authorities. These offices may work together with several services, including local health centres and (nursery) schools. Parent guidance is available at these services. Here parents can get guidance about their children's needs and development, discuss questions relating to bringing up their children and exchange experiences and -if desired- be helped in finding other forms of assistance.

- Cooperation

As mentioned earlier, the child welfare act states that the municipal Child Welfare Service has to collaborate with internal and external partners; therefore with other parts of the public administration and voluntary organizations that work with children and young persons. In 2008 it was investigated whether the municipalities organize and follow up cooperation between health, social and child welfare services for children of school age and young people in the age-group 18-23. This study showed that when it comes to identifying children, who may suffer injury, and assessing and following up individual children, organization and coordination of Child Welfare Services are inadequate. This also applies to young people who will need help or support from child welfare or social services after the age of 18.

4.4. Norway's unique approach: Bufetat's response and consultation teams

As mentioned earlier, in 2004 the state took over responsibilities for operating the family counselling offices, child welfare institutions and foster homes. The main reason was to be able to increase the competence and knowledge-based guidance provided to the municipal Child Welfare Service. Then 26 so-called Response and Consultation Teams located across Norway were established.

This approach is unique as these teams are the central child welfare authority- Bufetat- link with the local authority Child Welfare Service and provide it with expert assistance in difficult child welfare cases. In particular, these teams:

- work to find local solutions in collaboration with local authorities
- render professional assistance to local authorities in difficult child welfare cases, including cases involving a suspicion of sexual and physical abuse
- provide expert assistance to the municipal Child Welfare Service for investigating the cases
- aid municipal Child Welfare Service with the use of support measures
- assist local authorities of children and young people with placement outside the home

4.5. Summary

- In short, in Norway the municipal child welfare service are responsible for a wide range of services, ranging from preventive activities, providing help and support in the home to intervening when necessary, possibly against the will of the parents. Furthermore, it has to provide services once it has been determined that parents will be deprived of the care for a child.
- These duties as well the duties of the county government and the national government level regarding child welfare are laid down in the child welfare act. This act was recently changed in the sense that as off 2004 the central government took over county responsibilities in the fields of child welfare and family welfare, therefore cutting out a tier of government.
- The main reason for this centralization was to be able to increase the competence and knowledge-based guidance provided to the municipal Child Welfare Service. This resulted in Norway's unique approach: the establishment of 26 so-called Response and Consultation Teams located across Norway. This approach is unique as these teams are the link of the central child welfare authority- Bufetat- with the local authority Child Welfare Service and provide it with expert assistance in difficult child welfare cases.
- Norway seems to have made a successful transfer of institutional care for children and young people to foster care and more home based help for families and children at risk.
- The municipal child welfare services are responsible for both the voluntary as well as the 'imposed' route into social care.

5. Sweden

In 2008 Sweden had an overall population of 9.3 million. In that year, 22 percent of the population was less than 19 years old. This comes down to 2, 1 million children and young people

5.1. Is there a tendency towards medicalisation of care?

In Sweden, the increase in the amount of children and young persons receiving 24 hour care[5] started nearly 20 years ago. The big rise occurred during the 1990s. This decade - in the period 2001 to 2008 - the number of children and young persons who at some time during the year received 24 hour care grew from 18,500[6] to 22.700. The children who received this type of care on November 1 of a specific year increased from 14.000 in 2001 to 15.800 children in 2008 in the same period. There are different causes for this increase in the use of 24 hour care. In the first place, there was a lack of institutions before the state took over in the middle of the 1990s. With the resulting increase in possibilities for 24 hours care for young people, the use of placements in institutions also increased. In the second place, the increase is also due to in the legislation, both in *LVU* (Swedish abbreviation for the Care of Young People Act) and in the legislation concerning young offenders. Because of the latter, the justice-system put a pressure on social services to act in a more powerful way. The discussion affected the national politicians. They highlighted the lack of measures towards young people that committed crime and used drugs and asked for more pro-active social work towards youth with behavioural problems. In the third place, several developments including these increasing expectations from professionals (and from society) lead to a specialization of the social services; this lead to the emergence of special social workers for working with children and young people. When the focus is on a group of people, often more needs are discovered. This also happened in the domain of children and young people. In the fourth place, the rise in 24 hour care since 2004 is also probably related to unaccompanied under age asylum seekers.

However, according to an expert of *Socialstyrelsen* (the National Board of Health and Welfare) this increase in the use of these interventions can not be described as a medicalisation of care as care consists of many things, ranging from education in small groups and social training and activities to treatment in order to - for example – reduction of behavioural problems of young people.

Within the group of children and young persons in 24-hour care, there has been a shift in the use of some particular interventions. Specifically, whereas the number of placements in institutional care levelled off during 2001-2005, the number of children and young people in foster care increased by 5-10 per cent during the same period.

[5] 24 hour care is also called 'The 24-hour measures'. These measures comprise: Care outside the home under the *SoL* (the Swedish abbreviation for the Social Service Act); immediate custody under the special provisions for *LVU* (the Swedish abbreviation for the Care of Young People Act) and Care under the *LVU*.

[6] Please note that the absolute numbers in this paragraph do not take into account the size of the youth population, whereas the data in the third paragraph do.

Furthermore, the placements in emergency foster homes have primarily increased and evidence suggests that they have replaced former emergency institutional placements. According to the Swedish government in its fourth periodic report to the Committee of the Rights of the Child, these last two trends show that the efforts of municipalities to reduce institutional care (for children, young people and families) have paid off in recent years. Municipalities undertook these efforts because of large debates about the high costs of institutions and their lack of effect.

Whereas there has been increase in the number of children in 24-hour care since 2001, the use of non-institutional measures[7] has remained more or less the same. On November 1, 2001 28.000 children and young people were subject to one or more of these measures and 7 years later in 2008 28.100 children. Examples of non-institutional care measures include contact persons and contact families, family education, family therapy, helpline support, processes to strengthen the bond between parents and younger children, structured treatment programmes for teenagers with behavioural problems and support accommodation for older adolescents and structured programmes for parental support.

5.2. The structure of youth care

Introduction

Unlike in the Netherlands where the term 'youth social care' is used, in Sweden the common term is 'children and youth care'. Children and youth care in Sweden is part of their welfare policy. All three levels of the Swedish government (national, regional and local) have responsibilities for that policy.

The national level

At the national level, both the ministry of Integration and Gender Equality and the ministry of Health and Social Affairs are in some way responsible for welfare policy. For example, the former ministry is responsible for coordination of the Swedish Government's youth policy that is aimed at ensuring that all young people between 13 and 25 have access to welfare as well as to influence. These aims of the Swedish youth policy were outlined in the youth policy bill "The Power to Decide – the Right to Welfare" that the *Riksdag* (Swedish parliament) adopted in 2004. Access to welfare means that young people are to have favourable opportunities for good mental and physical health. Young people are also to have access to a good material, social and cultural standard of living. They are to be protected from degrading treatment and from being subjected to bullying and crime. Access to influence means that young people have to be able to influence the general development of society's priorities, their own every day life (such as their housing, school and working environment) and immediate surroundings (in their circle of friends and family). The *Riksdag* has decided on five main areas for Swedish youth policy to clarify the scope and to define its boundaries: not only including health and vulnerability, but also education and learning; influence and representation; culture and leisure time. In The Netherlands, these areas are considered part of youth policy and not of youth care policy.

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7 The non-institutional care measures taken comprise: Structured non-institutional care programmes under the *SoL*; personal support under the *SoL*; a contact person/family under the *SoL*; Contact person and treatment under the *LVU*.

In Sweden, the Ministry of Health and Social Affairs is responsible for basic welfare issues, including issues such as social services, child rights as well as (public) health and medical care. One of the objectives of the Swedish social services policy is to strengthen the protection of children at risk, whereas some of the current priorities of the Swedish child rights policy are related to youth care issues. These priorities for the next five years include giving better support to parents, promoting children's mental health and combating violence against children and will be discussed in more detail in paragraph 2.4.3

The Swedish National Boards

In Sweden, there are around 300 government agencies. The task of these agencies is to implement the decisions that have been taken by the Riksdag and the Government. Three of these agencies are important in relation in to youth care:

1. *Ungdomsstyrelsen* (the National Board for Youth Affairs) is the government agency that supports municipalities in the development and implementation of youth policy. It works to ensure that young people have access to influence and welfare by distributing funding to local governments and youth organizations and by producing and communicating knowledge on the living conditions of young people. It is also responsible for the follow up of national youth policy by focusing on how the overall objectives are achieved in the earlier mentioned five main areas for Swedish youth policy.

2. *Socialstyrelsen* (the National Board of Health and Welfare) is one of the government agencies under the Ministry of Health and Social Affairs. It works to ensure social welfare, high-quality health and social care on equal terms and good health for the whole Swedish population. This board and the later to be discussed county administrative boards have a joint responsibility for supervision of social services in the municipalities. Whereas *Socialstyrelsen* has the overall national responsibility, the county administrative boards are responsible for operational supervision at regional level. As of January 1, 2010 these county's responsibilities for the supervision and observation of social services are taken over by *Socialstyrelsen* as the government wants the supervision to be more efficient and more equal across Sweden.

3. SiS (*Statens institutionsstyrelse*; The National Board of Institutional Care) is another government agency under the Ministry of Health and Social Affairs. It is responsible for the supervision of caring activities. It also has the task of developing methods of treatment and of developing the competence of residential treatment centre staff. It also conducts evaluations of various treatment methods. SiS offers various treatment options and in two types of special approved homes in various parts of Sweden it looks after young people who, in various ways, have "gone off the rails". It also helps the municipal social services to find the place and the form of treatment most appropriate to the needs of each child who is the subject of a care order. Concerning young people, SiS only has a role when the municipal social services are looking for a placement for a teenager with behaviour problems.

Other administrative levels

At the regional level, Sweden is divided into 21 counties that each have an administrative board and a county governor. The county administrative board sees to it that the decisions of the Government and the Riksdag have the best possible effects in that county. Regarding welfare, the county administrative board's responsibilities include the observation of the implementation of the social services act by the municipal social welfare committees. In particular, it is responsible for the operational supervision of social services in the municipalities. These boards are not the only ones responsible for this supervision; they have a joint responsibility for this with *Socialstyrelsen* that has the overall national responsibility. However, as mentioned earlier, as of January 1, 2010 the county's responsibilities for the supervision and observation of social services are taken over by The National Board of Health and Social Welfare.

Local level

Sweden has 290 municipalities. Municipalities in Sweden have extensive autonomy. This also applies to their youth policy as well as their policy concerning social services. For example, regarding youth policy municipalities can –if they wish- base their youth policy work on the national objectives, but the way it is executed in practice is shaped on the basis of the local conditions. This autonomy of the local government restricts the scope of the national Government for exerting direct influence on the outcome of its national youth policy. Furthermore, local authorities can organise their child welfare in the way they find most suitable, as long as the basic standards of the *SoL* (the Swedish abbreviation for its Social Services Act) are respected.

Each municipality is responsible for the social services within its boundaries. The municipal council is assisted in its work by a number of committees, such as the social welfare committee. These social welfare committees –that are formed by directly elected politicians- govern these social services. This means that the work of social workers in the municipalities is politically controlled at a local level and thereby dependent on the views of the political majority in each municipality.

Relating to youth care, two laws outline the (in a later paragraph to be elaborated) tasks and responsibilities of social welfare committee:

- *SoL* (the Swedish abbreviation for its Social Services Act). According to this act, the social welfare committee can offer parents and children support and help on a voluntary basis. Its tasks include "assuming responsibility for the provision of care and service, information, counselling, support and care, financial assistance and other assistance for families and individuals in need of the same". Furthermore, since April 2008 there has been a special section in *SoL* that states that this committee has to provide children and young people with the support they need after leaving care[8].

[8] However, according to an expert at *Socialstyrelsen* this is more a so- called policy role than a list of concrete rights. *Socialstyrelsen* published some guidelines last June that point out the necessity of planning before leaving care. It also recommends thinking of both practical support (e.g. accommodation) and psychological support (e.g. a contact person).

- *LVU* (Swedish abbreviation for the Care of Young People Act). This act applies to care without consent and is thus complementary to *SoL* in situations when the voluntary efforts that can be given with the support under that act are not sufficient. On finding that a young person should be taken into care under this act, the municipal social welfare committee will submit an application to the county administrative court. The duties of this court are discussed in paragraph 2.4.3 as they are involved in Access to care.

5.3. Policies and approaches

Access to care

Concerning Access to care, there is a difference between *SoL* and *LVU*. According to *SoL* the municipality is ultimately responsible for ensuring that persons within its boundaries receive the care and assistance they need. The social welfare committee decides on Access to care offered under *SoL*. Most of its decisions can –this is a matter of choice for each individual municipality- be delegated to a social worker or to a supervisor of a group of them. For example the social worker can, after a referral, decide to start an assessment and if there is such a need offer the family voluntary support.

Both the social welfare committee and the county administrative court are involved in determining Access to care under *LVU*. Under this act, care may be considered when voluntary solutions (that are offered under *SoL*) are not sufficient and when this results in restrictions of the parents' right to make decisions about the child being. In particular, there are two main cases where care under LVU can be used:

- In so-called 'behaviour cases': when the young person exposes her or himself to manifest risks through some kind of socially destructive behaviour, such as engaging in criminal activity or substance abuse
- In so-called 'environmental cases': this is when deficiencies in care or some other circumstance at home involve a manifest risk that the young person's development or health will be harmed

The social welfare committee will submit an application to the county administrative court when it considers that a young person should be taken into care under LVU. This court will then consider the case and decide whether the young person is to be taken into care. An investigation that forms the basis of such a decision must be objective, impartial and worked through in accordance with the true facts. In emergency situations (i.e. when there is direct danger for the child's life and health) the chair of the social welfare committee can decide on an immediate taking into care, but this decision must be confirmed by the county administrative court within one week from the date when the decision was made. Appeals to a decision by this court about taking a young person into care can be made at the administrative court of appeal.

The entitlement to care/ a duty to offer care

As mentioned earlier, *SoL* and *LVU* mention the involvement of the municipalities and its social welfare committee regarding care for children. SoL stipulates general guidelines for municipalities concerning their social services obligations. As mentioned earlier, it also states the tasks and responsibilities of the social welfare committee concerning youth care. For example, their tasks include "assuming responsibility for the provision of care and service, information, counselling, support and care, financial assistance and other assistance for families and individuals in need of the same".

Furthermore, according to the section of *SoL* dealing with special provisions for children and young people, the social welfare committee among others ensures in close cooperation with families, that children and young people who have shown signs of developing in an unfavourable direction should receive the needed support and protection and, if necessary for the child's best interests, upbringing and care away from home. In addition, as mentioned earlier, since April 2008 there has been a special section in *SoL* that states that this committee has to provide children and young people with the support they need after leaving care. In short, all these responsibilities of the social welfare committee show that according to *SoL* social services are responsible for what is considered youth work as well for what in The Netherlands is considered youth care.

As mentioned in the previous paragraph, the county administrative court and the social welfare committee are involved in the decision-making process in access to care under *LVU*. This law outlines that this committee decides how the care should be arranged and where the young person should live during the period of care. It also has to issue an order for the termination of care when care under this act is no longer needed. In general, according to this law care should end at 18 in case of the earlier mentioned 'environmental cases' and at 21 in case of the 'behaviour cases'.

Current issues in youth care in Sweden

Related to what is considered youth care in The Netherlands, there are some topics that also need to be reviewed here:

Programmes for specific target groups

In Sweden, during the last couple of years, several actions for specific target groups have been initiated, including girls and young women and young unemployed people. The latter exemplifies the recent shift in perspective in Swedish youth policy; the Government and the Riksdag emphasize more clearly that the measures taken should pay particular attention to young people with fewer opportunities.

Priorities in child rights policy

In the spring of 2008, the Swedish government issued its communication 'Child policy - a policy for children's rights' to the *Riksdag*. This communication contains the priorities for the period 2008 - of which some are related to youth care issues.

Giving better support to parents
In Sweden, the government considers it is important that this support is offered continuously during a child's entire childhood. There is a legal obligation to provide parenting support; the responsibility for parenting support in various forms during childhood rests primarily with the municipalities and county councils. Nowadays, parenting training is given in groups during pregnancy and during the child's first year of life - essentially within the framework of maternity and child health care as well as via "family centres". Giving better support to parents is also one of the priorities of the current Swedish child rights policy; more precisely, "support in parenthood, comprising support and education initiatives for parents with children in different age groups and with different situations and needs". In particular, the government is implementing a family policy reform in order to strengthen the power of parents' over their lives and it plans to draw up a national strategy for parental support.

Combating violence against children
In Sweden, children are entitled by law to protection against all forms of physical and psychological violence inside and outside the family. Furthermore, the State has a responsibility to guarantee this right for every boy and girl living in Sweden. In addition, authorities whose activities affect children and young people have a duty to report to the social welfare committee of any matter that comes to their knowledge that may imply a need for the social welfare committee to intervention for the protection of a child. In particular, institutions which come into contact with children have a mandatory duty to report if they consider a child to be at risk and in need of support from the social welfare system.

Currently, combating violence against children is one of the priorities of the Swedish child rights policy. As the Swedish government believes it is important to enhance the protection of children against all forms of violence, it is taking several measures. This includes the development of a programme to coordinate the efforts of both the public sector and the non-profit sector to combat violence against children. It also concerns the implementation of an action plan against the sexual exploitation of children.

5.4. Sweden's unique approach: the contact person and contact family program

Sweden had a range of welfare interventions to support families under stress, including 'contact persons'. *SoL* requires municipalities to include contact persons/families in their repertoire of measures; according to this act: "the [social welfare] committee may appoint a particular person (a contact person) or a family to help the individual and his next-of-kin in personal affairs, if the individual requests or consents to such an arrangement. In the case of children under the age of 15, a contact person may be appointed only if the child's custodian requests or consents to the arrangement. If the child is aged 15 or over, a contact person may be appointed only if the child personally requests or consents to the arrangement". Furthermore , the *LVU* indicates that children aged 15 to 20 are "to keep in regular contact with a specially appointed contact person" without their consent as a result of their behaviour.

The contact person can help the children with their schoolwork, discuss problems with them, provide company for constructive leisure time activities or support in independent living and is expected to cooperate with the child's parents and provide support to them. "The term 'contact person' is used when a person, without involving his or her family, has contact with the child or young person on a daily basis". In contrast, "the term 'contact family' is used for a family that is visited by a child in need one or two weekends per months and perhaps for a few days during summer vacations, or when there is a temporary need for accommodation because of problems at home".

Everybody has a right to apply for a contact person/ family, but the social worker decides on the need. Following an assessment of the child and family's needs, it is common for the social services to suggest this service. The court can also appoint one, for example when it is considered in the child's best interest that a contact person is present during visits to (drugs abusing/ violent) a parent or when the divorcing parents are in conflict over access to the child. However, the contact person is not considered to be a solution if the family's problems are so severe or the home situation is so negative for the children that out-of-home placement should be considered. The social workers appoints the contact person or family, but the client family can also suggest a family or person known to them. Every six months, the service of the contact person is evaluated, however it can continue for years. Contact person/ families are not professionals, but they are paid and must officially be approved of and are supervised by social services.

When the Social Service Act was introduced, the contact family represented a shift to "comprehensive view", "voluntary services", "right of self-determination" and "normalization" and preventive measures. There were expectations that after a period the contact family would naturally transform and become a normal part of the client family's new network and that the service would be organized later by laymen in for example neighbourhoods. Nowadays, it is a very common non-institutional measure. On November 1st 2008 of the approximately 28,100 children and young people that were subjects of one or more of the reported non-institutional measures, around 21,200 children and young people received or were assigned a contact person/family. This being a very common non-institutional measure and the fact that both the contact person and their clients are pleased with this specific non-institutional measure that is carried out by non-professionals make the contact person and contact family programme a unique approach.

5.5. Summary

- In Sweden, municipalities have extensive autonomy. This also applies to their youth policy as well to their policy concerning social services that both encompass what in the Netherlands is considered youth care. For example, local authorities can organise their child welfare in the way they find most suitable, as long as the basic standards of the *SoL* (the Swedish abbreviation for its Social Services Act) are being met.
- According to this act, social services are responsible for what is considered youth work as well for what in The Netherlands is considered youth care.
- This act states that the social welfare committee can offer parents and children support and help on a voluntary basis. In contrast, the law on care for children and youths (LVU) applies to care without consent.
- The fact the that contact person/ family is a very common non-institutional measure and the fact that both the contact person and their clients are pleased with this specific non-institutional measure that is carried out by non-professionals make the contact person and contact family programme a unique approach.

6. Mental health services and services for disabled children

During the process of putting this quick scan together an additional question came up; to what extent are the mental health services and services for what are known as *LVG jongeren* in The Netherlands (slightly disabled children) related to or integrated in the system of social care for children and young people in the countries of the study? This is a crucial issue in the current debate in the Netherland. We have chosen to address this question in a separate chapter, because of its complexity. Describing the systems for disabled children or the mental health services in these countries is a study in itself. We therefore have concentrated on the link with the children and young people's social care system, where possible.

6.1. England

In improving the care for children with disabilities or mental health problems two recent developments in England have been very crucial. In the first place, the Every Child Matters programme that has been described in detail in the country profile on England. The services for children with disabilities and the cooperation with mental health services for children are an important part of this programme. The second important development has been the introduction of the 'national framework for children, young people and maternity services' by the Department of Health around the same time as ECM (2004). This children's NSF is a 10-year programme that aims for long-term and sustained improvement in children's health. The NSF comprises eleven standards. These standards have to be implemented by the national health service (NHS) and the local authorities. There are three categories of standards. The first category concerns the standards for all children. The second category concerns standards for children with mental health problems or disabled children. The third category relates to maternity services.

Mental health care for children

The mental health and psychological well-being of children and young people is mentioned standard 9 of the NSF:

"*All children and young people from birth to their 18th birthday who have mental health problems and disorders, have access to timely, integrated, high quality, multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families*"

There is a joint responsibility of the Ministry for Health and DSCF to improve the mental health of all children and young people and the access to mental health care. Multi-agency service provision is at the heart of child and adolescent mental health services (CAMHS). The term comprises all those services that contribute to the mental health care of children and young people whether provided by health, education or social services or by other agencies. CAMHS services are delivered in a four-tier strategic framework (comparable with first and second line services).

At tier 1 help is provided by practioners in universal services that are not mental health specialists (school nurse, social worker). In tier 2 support is provided by mental health specialists who are part of universal services (for example in a school or youth service). Tier 3 relates to multi-disciplinary teams in mental health or psychiatry outpatient services and tier 4 includes specialised psychiatric treatment services. Especially in tier 1 and 2 the practioners will be working for the children's services and are therefore an integrated part of Access to care (according to the managed care model). Tier 3 and 4 mostly fall under the responsibility of the NHS. In this case cooperation is secured through the Children's Trust. One of the main strategies is to prevent unnecessary admissions to tier 4 services and therefore integrated working is essential.

Disabled children

Services for children with disabilities are the responsibility of the local authorities and an integrated part of Every Child Matters. At central government level, the care for children with disabilities is a joint responsibility of the Department of Health and DSCF. Disabled children are a priority both nationally and locally. The two departments published a joint policy document called 'Aiming High for Disabled Children (AHDC): Better support for families (2007). The government assists professionals, managers and children's services to deliver the programme with new financial measures, information and resources.

6.2. Germany

Mental health care for children

In Germany children with psychiatric disorders are placed in mental hospitals for children. Child and youth psychiatry in Germany is a separate sector and is not part of *Jugendhilfe*. However, according to *SGB VIII* children with mental problems are entitled to help and allows the *Jugendamt* to contact child and adolescent psychiatric or psychological services for them. The *Jugendamt* is responsible for the coordination of care of the children and thus has to remain in touch with these services. In Germany, compulsory admission to a mental hospital is generally forbidden according to the 1906 *BGB* (Civil Code Book), but may be possible under the condition that an individual endangers him- or herself and/or others. The ministry of Health is responsible for mental health for children.

Disabled children

Disabled people who need home help, home care, technological aids and/or modifications of their home in order to manage daily life, have the right to these kinds of services according to the following national social laws:

- Social Code Book XII – Social Assistance

  The so-called integration support is offered as part of the social assistance system (Social Code Book XII). This scheme is included in the chapter dealing with "assistance in special life situations". The goal of this benefit –that obeys the principle of subsidiarity- is to provide adequate assistance and financial support in those individuals in need of accessible and supported housing, help with transport and assistive technologies, etc. Ultimately, the integration support aims at securing participation in the community and education, vocational training and employment. Its target groups include – among others- children and young people with severe disabilities and their families who cannot finance special assistance privately.

This social assistance system and thus also its disability related integration support is based on the principle of community oriented assistance and care. However, this priority is not valid if its execution would result in disproportionately extra costs in comparison with institutional support. The term "disproportionately extra costs" however is not regulated and exact sums are not stated; the responsible administration takes the decision which considers the individual case in hand and the social budget of the region. In practice, according to Waldschmidt, authorities tend to be rather restrictive and make decisions that are likely to result in lower costs whereas officially disabled people have the right to opt for different types of institutional and home care.

- The *Sozialgesetzbuch Neuntes Buch, Rehabilitation und Teilhabe behinderter Menschen* (also called *SGB* IX; Social Code, Book IX – Rehabilitation and Participation of Persons with Disabilities) provides a framework for all social services and provisions for disabled people and their families. Furthermore, the special needs of children (and women) who are (at risk of becoming) disabled are taken into account.

Furthermore, the earlier mentioned *SGB* VIII outlines several services (called *Leistungen*) including help for mentally disabled children and young people as well as supplementary services. In Germany, many people believe this distinction between this *SGB* IX and *SGB* VIII (that thus both contain sections on services for disabled people is not logical and not in the interest of children. The role of the *Jugendamt* in relation to children with a disability seems to be more that of a referral agency.

6.3. Norway

Mental health services for children

Since the 1990s mental health care for children and young people has been high on the governmental agenda in Norway. For example, ever since children and young people with serious behavioural problems have been a top priority of the Ministry of Children and Equality. Poor results for these children demanded government action as children with complex needs were neglected by other services, such as the Mental Health Service. There was a strong demand for interventions that were more effective in dealing with behavioural problems in children and youth. The government took several measures for this group, includes supporting research into how serious behavioural problems can be reduced and how positive behaviour can be reinforced as well developing new methods. It, among others, implemented new evidence-based methods in the work with serious behavioural problems for children of different ages, such as earlier mentioned PMTO and MST. Furthermore, According to the current national health plan for Norway for the period 2007-2010, "In the future there will be a need to develop treatment and follow-up measures for children and young people suffering from mental health difficulties. The aim is to strengthen the competence and professional environments in mental health work for children and young people in municipalities".

In Norway, The Ministry of Health and Care Services has the main responsibility for the provision of adequate and appropriate health and care services for everyone in Norway, irrespective of geographical location and financial circumstances, and the promotion of public health. This ministry is also responsible for mental health. Here, municipalities are responsible for preventive efforts and for providing nursing and care services. Furthermore, they are responsible for providing reasonable, high-quality health care and social services to everyone in need of them, regardless of their diagnosis or age. The municipalities therefore play a key role in the provision and co-ordination of services for people with mental health problems. The municipalities are entrusted with the provision of a wide variety of primary health services of which many can provide mental health care to children and adolescents. According to the Primary Health Services Act of 1982, the municipalities are to provide for care and treatment of all persons within their boundaries, including – among others- health promotion and prevention, and emergency care and immigrant health care. The services include general practice, preventive medicine and:

- health clinics for mother and child that provide health services up to pre-school age, which can include counselling. These clinics must have routines for cooperation with GPs, with other municipal services and with the specialist health service.
- school health services that serve school children and youth under 20 years of age which task it is to promote mental and physical health and good social and environmental conditions and prevent illness and injury. The school health service helps pupils with health problems that affect their school situation. It can also provide social and psychological support in the school. environment. It cooperates with pupils and parents, the school and other specialists where necessary.

- youth clinics that provide integrated individual prevention services, covering –among others – mental (and physical) health assessment.

Whereas the psychiatric health services are (thus) primarily to be built up and provided in the local environment, specialist health care services are meant to support this municipal work and to provide studies and treatment of more serious conditions. Since 2002, the central government is responsible for the provision of these specialized health services. Since then, four Regional Health Authorities (RHAs) have been set up. Each RHA is responsible for providing specialized health services to the population in their region. Regional centres in mental health care for children and young people have been established for all these health regions. The centres' tasks include counselling, development work, research, and teaching. Cooperation with child welfare services' development centres is emphasized as well as with other sectors that work with children.

Disabled children

At the national level, one of the topics the ministry of Children and Equality is responsible for is 'people with disabilities'. the brochure 'Children and young people with disabilities – what are the family's rights?' shows that many other acts outlines the responsibilities of the local governments and other organizations regarding disabled children. Some of these rights and the laws they are based on may apply to all children whereas others are concerned only with education for disabled children. Several rights and laws are relevant for them. For example, in Norway anyone who needs prolonged, combined services is entitled to an individual plan which must specify the child's requirements and how they are to be met. The purpose of such a plan is to provide a complete, coordinated and individually tailored set of services and to ensure that one person has the main responsibility for follow-up and coordination at all times. The social welfare office is responsible for the services of people or families with children with disabilities. The social welfare office grants financial support, gives advice and guidance and refers users to other relevant bodies. Furthermore, they are responsible for the provision of different services, including:

- places in institutions or accommodation with 24-hour care
- support person for persons and families in need of them owing to, among others, disability.
- practical assistance and training, including personal assistance, for those who are in special
- need of assistance owing to, among others, a disability
- economic support for people that provide exceptional care for family members

Only persons who are unable to care for themselves or who are completely dependent on practical or personal help to manage their daily tasks, are entitled to these services. In general, the organisation of these services varies one from municipality to the next. Thus the local authorities may organise their services at their own discretion provided that they comply with statutory obligations. However, the user's preferences will be given due emphasis. Nowadays, many municipalities have split into a purchasing agency/office and providing units that makes the decision about extent of support, most often based on an assessment made by a social worker or nurse. In most cases the person him/herself,

and/or family members will be involved in the assessment. However, the decision is up to the municipality. This decision can be appealed to the County Governor. In general, the county governor is the appeal body for services provided under the Social Services Act. The right to services is not unlimited; an assessment will thus often be both about needs and a decision about the services to be provided. According to, Tøssebro, the needs assessments are thus likely to be influenced by economic considerations.

In Norway neither care for children with disabilities nor mental health care for children is thus regulated via the earlier mentioned child welfare act. The only exception is that this act stipulates that the County Committee for Social Affairs may decide that the child shall receive treatment or training with the assistance of the child welfare service if the parents fail to ensure that a child that is disabled or in special need of help receives the treatment and training required. In such cases a care order can also be made. After the placement of this care order, the child shall be placed in a training or treatment institution when this is necessary because the child is disabled.

6.4. Sweden

In Sweden, all people have a fundamental right to medical care, treatment, rehabilitation and medical assistance. For people with severe functional impairment this also means the right to such a level of additional support to enable them to live as normally and independently as possible.

Mental health services for children

In Sweden, mental health care is part of health and medical care. The responsibility for providing good health care and social services to people suffering from mental illness and mental impairments is divided between the central government and the county and municipal councils.

- The role of the central government is to establish principles and guidelines for care and to set the political agenda for health and medical care. Regarding mental health the government is primarily responsible for ensuring that legislation fosters development towards adequate and safe care and for issues such as knowledge dissemination. The government has a number of tools at its disposal to meet these responsibilities, such as proposing new legislation, issuing ordinances to clarify existing legislation and assigning government agencies to undertake specific tasks. At the national level, the ministry of Health and Social affairs is responsible for (mental) health care.
- At the national level there are a number of governmental agencies within the area of health care, including the earlier mentioned *Socialstyrelsen* which is the central government's expert and supervisory authority. Its tasks include providing authorities with guidelines on care and treatment.

- In Sweden the responsibility for providing health care is decentralized to the county councils and, in some cases, the municipalities. Under the Health and Medical Care Act, every county council must work toward promoting good health in the entire population and provide residents with good-quality health services and medical care. As mentioned earlier, psychiatric treatment is part of health and medical care. As the county councils have small services areas, they are grouped into six health care regions. One of the purposes of the regions is to facilitate cooperation in highly specialized care. Health and medical care can be divided into primary and specialized care:
    - primary care: Primary care is the basis of health and medical care and is intended to meet the needs of most patients for medical treatment, care, preventive measures and rehabilitation. Various occupational categories are represented in primary care services, including – among others- doctors, (children's) nurses, and social workers. The responsibility for persons with slight or moderately serious mental disturbances often lies with primary care.

Specialized care is offered by county as well as regional hospitals.. Patients who cannot be treated within the primary care system due to a lack of resources and/or diagnostic and/or treatment skills are referred to specialist psychiatric care. .

- In Sweden, the municipalities are responsible for support and service to people whose medical treatment has been completed and who have been discharged from hospital care. Municipalities are also responsible for housing, employment and support of people with psychiatric disabilities. In addition, they have compulsory care powers under the earlier mentioned LVU.

Mental health care for children and young people is high on the Swedish agenda. For example, the Swedish government has implemented several measures in order to prevent mental poor health among them, including improving the access to child and adolescent psychiatry and supporting the development of a virtual clinic for young people on the Internet. Furthermore, in the current Government's policy aimed at strengthening psychiatric care children and young people are a special priority. The Government has also reached an agreement with the Swedish Association of Local Authorities and Regions on the joint development of models for the reception of children and young people in 'front-line' health and social care services, namely local primary health care centres, youth clinics, school health care and ante-natal and child health care centres.

Disabled children

The national, regional and local government share the responsibility of ensuring good health and social and financial security for people with disabilities:

- The central government is in charge of legislation, general planning and distribution and insurance. Several ministries are involved for the government's cross-sectoral disability policy, The Ministry of Health and Social Affairs has the task of coordinating this disability policy.
- Different boards, including the National Board of Health and Welfare and a number of other government bodies are responsible for issues relating to the disabled. They are responsible for safeguarding the rights and interests of disabled people by co-coordinating, supporting and promoting such issues in their dealings with other authorities. This responsibility applies to social services as well as health care, but is currently focused on two main areas: developing a system to describe the living conditions of disabled people, and improving the co-ordination of rehabilitation work.
- The county councils are responsible for health and medical care, which includes assistive technology, (re)habilitation, interpreting services (for the hearing- impaired) and dental care for certain disabled individuals.
- As mentioned earlier, the municipalities are responsible for social services. They also have to provide the individual citizen with basic security in the form of public support and services. With respect to health and medical services, they are responsible for people with disabilities living in special accommodation. Municipalities also have a responsibility to plan to meet the current and future needs of the community, including planning for the future housing needs of the community including people with special needs due to disability.

  Sweden does not have a law specifically establishing the rights of all people with disabilities. Instead, certain laws contain clauses that apply specifically to disabled people, such as:
- the Education Act provides for the educational needs of people with a disability
- the Health and Medical Services Act covers the health services to be provided to people with a disability. Responsibility under this act includes assistive devices for daily living, for care and treatment and also personal assistive devices for education and school. Social insurance offices and employment agencies are responsible for work assistive devices for people with a reduced working capacity. The provisions and routines relating to the allocation of assistive devices are applied very differently across Sweden. However, there is no right as such to claim any specific assistive aid.
- Three laws that will be discussed in more detail later as they may also apply to people with certain mental health problems: the Assistance Benefit Act (LASS) and the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) and the Social Services Act.

People with disabilities

Several laws outline the responsibilities of the (county councils) and municipalities regarding people with disabilities (and mental health problems):

- *Through The Assistance Benefit Act* (LASS) law assistance is provided for people with very high care needs (more than 20 hours per week).
- The *Lagen om stöd och service till vissa funktionshindrade* (*LSS*; the Swedish abbreviation for the Act concerning Support and Service for Persons with Certain Functional Impairments) is a law that sets out rights for persons with considerable and permanent functional impairments., including people who are autistic, or who have a condition resembling autism. This law entitles them to the special support services that they may need over and above what they can obtain under other legislation. Individuals must meet the criteria specified by the Act to be entitled to measures pursuant to this Act; they must need assistance in activities of daily living and their needs may not be met in any other way. Furthermore, measures pursuant to this Act are only provided when the individual requests them. Ten types of measures for special support and service under this law:
  1. Counselling and other personal support;
  2. Personal assistance;
  3. Companion service for clients not eligible for personal assistance;
  4. Personal contact;
  5. Relief service in the home;
  6. Short stay away from home;
  7. Short period of supervision for schoolchildren over the age of 12 (before and after the school day and during school holidays);
  8. Residential care in family homes or homes with special services for children and young persons who cannot live at home full-time;
  9. Residential living arrangements with special services for adults, or other specially-adapted residential arrangements;
  10. Daily activities for people with an intellectual disability who cannot work or study.

The county councils are responsible for the first measure, the municipalities are responsible for the other nine. People who are not covered by LSS can seek assistance from their municipal authority under the earlier mentioned *Social Services Act*.

6.5. Conclusions

- Mental health care is high on the governmental agenda's in England, Norway and Sweden.

- In Norway and Sweden, there is a distinction between primary health care that seems to be offered at the local and more specialist services that are offered at the regional level. Different types of local primary mental health services can reach adolescents.

- In all the countries of the quick scan municipalities also play a role in the provision of certain services for people with mental health problems.

- In Germany, Norway and Sweden more than one law regulates the provision of services to disabled people.

- In Sweden the *LSS* sets out rights for persons with considerable and permanent functional impairments., including people who are autistic, or who have a condition resembling autism.

- England has the most integrated system for disabled children and mental health being part of or closely linked to the children's services.

7. Possible lessons from foreign policies and systems

7.1. Introduction

The Netherlands and the countries from the country sheets have many similarities. All countries have deliberately formulated a policy to protect all children from ‘missing out’, which is often based on the ideology of the Convention of the Rights of the Child. It is also safe to say that the child support systems and structures in the described countries are constantly developing and changing. All over, this type of care –youth care in the Netherlands – is discussed on a public as well as a governmental/political level. There seems to be a universal trend of parents (prematurely) looking for *expert* intervention rather then trusting their own judgement and skills or having a social network to support them. Newspapers and magazines often feature headlines like “Help, parenting is too hard” (De Standaard) and “Parents no longer trust their own judgement” (Der Spiegel). In the countries from this report, more people seem to be turning to specialized care and the number of outplaced children is expected to grow even more. Norway is the only exception here, although they do face a fast growing number of families applying for family care. In the end, it is hard to compare the available data from the various countries as their definitions of youth care differ considerably.

7.2. Medicalization

In the Netherlands, the trend of more children receiving (unnecessary) specialized care, is referred to as a form of medicalization. We have adopted this term in our descriptions of the systems of the four countries. However, the experts in these countries seriously objected to the use of the word; due to cultural or translational differences. For example, the German expert commented that there is no relation whatsoever with the medical system; children in the youth care system aren not there for medical reasons. He would rather say describe the ‘it is better to intervene than to do nothing’ phenomenon as a reaction to a number of serious incidents involving children who were already monitored by youth care. The same is true in England where it is referred to as the *baby Peter* effect. This fatal incident with a child that was monitored by youth care led to a large-scale investigation into the system (four years after a similar investigation took place in reaction to a similar incident). Thus, this trend of earlier and more radical interventions seems to be a widespread international phenomenon. Another trend that can be observed in the countries in this research is a growing complexity of society, more knowledge of and identification of (imminent) problems and better care. Also, there seems to be more diagnosis of special indications, like ADHD. The main differences with the Netherlands are associated with the structure of the care system for children and youth.

7.3. The structure of youth care

A remarkable difference between the described counties and the Netherlands is the position of youth care in politics and society. In the Netherlands, as we observed earlier, there is a clear line between the so-called overall preventive youth policy on the one hand, and youth care on the other. Subsequently, the main debate in the Netherlands is about connecting these two policy fields. Terms like the 'preliminary' field or preventive youth policy (prevention of escalation) are used. In the described countries, youth care is a component of the overall youth policy. It is, for example, referred to as *Jugendhilfe* in Germany or *Child Welfare* in Norway. It gets even more complicated if we consider 'indicated' youth care, as in most countries the care system is 'gradually' scaled up without having a clearly defined moment of indication. This is probably (partly) due to the fact that in the Netherlands one government section is responsible for the general services while another department governs youth care. Another remarkable outcome of the research is that some countries are particularly sensitive about the proper terms to use for children in youth care. This is most noticeable in England, where imagery and politically correct language are deemed highly important. Children who are monitored by a child protection agency are not *children in care*, but *looked-after children*.

7.4. Government responsibility

In all four countries in the research the national government has a central role and task within the system of youth care, in terms of policy as well as legislation. In all countries, one ministry is directly accountable for the system. In Germany, this is the longstanding Federal Minister for Family Affairs, Senior Citizens, Women and Youth, although most responsibilities are appointed to the separate states (länder). In England, the introduction of *Every Child Matters* eventually led to the design of a new ministry combining education, family and youth policy: the *Department for Children, Schools and Families*. Another notable fact is that none of the four country systems include a fully active third government layer in the field of youth care. Germany is the only country where – as could be expected in a federal system – responsibilities are both found at a federal level and at a county (länder) level, while the actual execution occurs on a local level. In Norway, the *county* layer was removed from the system structure five years ago. The same will happen in Sweden in 2010, in order to establish more equal and effective monitoring of the executing *social services*. The changes in Norway were introduced because the system was unable to guarantee the same level and quality of youth care in all regions. Now, the central government is monitoring and where necessary supporting the municipalities.

In the investigated countries, the local levels carry a great deal of responsibility. The central government mostly controls and directs the local governments through legislation. The regulations describe the duties and responsibilities of the local governments, like, for example, the Social Support Act (WMO) in the Netherlands. Although, all countries have different ways of formulating and dealing with these responsibilities, all four have one (government) service with final responsibility for the policy and often the (co-ordination of the) implementation as well: the *Jugendamt* (Germany), the *Children's Services* (England), or *Child Welfare Service/Committee* (Norway/Sweden).

Distinctly different from the situation in the Netherlands is the fact that in all four countries the (national and local) government is much more involved and directive with regard to the scope of services and facilities. The government strongly influences the field. Among other things, this translates to the legislation (see section on the right to care). In the Scandinavian region, government intervention is particularly far-reaching as they have a major offer of –obligatory- parenting support programmes for all parents. In England, government intervention is part of the public debate. The population regularly protests against the 'nanny state'.

7.5. Policy, action and access to care

All four countries have policies that emphasize the importance of collaboration between the services. Sometimes this has always been a logical trait of the system – like with the *Jugendamt* in Germany – and for other systems it will be an explicit target of a newly implemented policy. This is mostly true for the *Every Child Matters* programme in England, wherein collaboration between various services is explicitly made mandatory by law.

In addition, all countries distinguish both a so-called 'voluntary route' and a 'forced route' to/by the youth care system. The legal route is the child protection policy; a clear similarity between the four countries and the Netherlands. However, the described countries all put a great deal of effort into the voluntary care-offer for children and parents. In England, this is represented by the *managed care* model of the windshield wiper, meaning that parents and children should first and foremost be treated by the general services and that 'light' support should be available at all times or at least as fast as possible through a system of early *assessment*. In Norway and Sweden this is already the case, partly because the system includes a (mandatory) offer of parenting support as a universal service. This offer covers the entire scope of childhood and adolescence and 'grows' along with the parents and children.

It is remarkable that all four countries have one local (government) organization that is responsible for both the 'voluntary' and the 'forced' route to/by the youth care system. They are legally separate procedures but executed by the same organization. It would be interesting to find out what parents think of these organizations, especially regarding the fact that they are responsible for both the 'voluntary' and the 'mandatory' care procedures. We have not found any information on this in the available literature.

While working on this quick scan a second question arose with regard to the organization of mental health care and care for disabled youth in the described countries, in particular if they are integrated in the youth care system. We ran short of time to seriously address this question, also because we are talking about extremely complex care systems. What has become clear is that (part of) the responsibility is allocated to a local level and that there are collaborations between other government layers and/or care providers.

The local services, like the *Jugendamt,* are at least responsible for appropriate referrals. In addition, various local parties in Norway and Sweden are providing *primary mental health care (*primary mental health care). England seems to have the most integrated system (and mandatory collaboration). The care for disabled children is part of the *Every Child Matters* programme and collaborations with mental health care services are formulated in the *Children's Trust*.

7.6. Right to Care

In all countries in this study there seems to be an obligation to provide care and relevant services, rather than a right to care of the users. The German *Jugendhilfe Gesetz* is the exception; here we identify a right to care and support for every child and youth in order to further his or her development into fully capable and participating adults.

Another remarkable outcome is that relevant youth care or general youth policy regulations of all four countries are much more elaborate in their descriptions of obligations and responsibilities with regard to parent and child services of the (local) government and organizations, than the Dutch legislation proves to be.

In many countries the care offer is legally defined as well as a listing of the required facilities and services. Available literature does not show whether this is felt to be a burden in the field. The *local authorities* in England report that the mandatory framework offers enough room to integrate and execute local priorities. In addition, the local governments are legally responsible for more services than the total of youth care services in the Netherlands. Admittedly, there are considerable differences in size of municipalities in the described countries; more than half of the municipalities in Norway consist of less than 5000 people, while municipalities in England mostly add up to over 300.000.

We haven't heard or read much about the problem of waiting lists in youth care. That does not mean that there are no waiting lists (England reports a *waiting time* of several weeks for cases involving forced care that need to appear in court), but it hardly seems to be a subject that is dominating the political and public debate, as it is in the Netherlands. A possible explanation could be the fact that different services are bundled into one system. For example, England explained that this way children's services are able to use other services to temporarily support children, as these services are theirs to manage as well. Norway has been investigating ways to solve the waiting lists in youth mental health care.

7.7. Unique approach

For this research we have described one unique approach per country, starting from the debate in the Netherlands. This has been a personal choice of the writers, who feel that the described approaches all deserve to be studied in more detail.

England

For England, we chose to describe the *Local Safeguarding Children's Boards*. This legally mandatory structure organizes the collaborations that are to guarantee the safety of children. In England *safeguarding* is more than child protection alone, although it is a major focal point. It also includes safe roads to travel to school and supporting young victims to get back on their feet and move around in daily traffic. The LSCB is a good practice with regard to collaborations aimed at the safety of children, but also because it represents a much broader view on the concept of child protection.

Germany

For Germany, the chosen model was the *Jugendamt*, as this (government) service is locally responsible for the general youth policy – including youth work - as well as youth care. The *Jugendamt* is a longstanding system, fully integrated in society and a well-known service at the local level. The interesting part in this structure is that part of the *Jugendamt's* task is to provide the statutory care services (for the more serious cases). With regard to general youth work services, the local authorities are free to choose any care provider.

Norway

Five years ago, Norway centralized its youth care system and took out the *county* layer. The central government mobilized 26 *Regional Response and Consultation Teams* with psychologists, orthopedagogues and other professionals to support municipalities with the decision making around complicated *cases* (for example with regard to diagnostics). We were unable to find a great deal of information on the concrete functioning of the teams, but it does seem to be a possible effective link between small municipalities and the national government.

Sweden

Voluntary contact person/ contact families

This low-threshold, voluntary offer has a long history in Sweden and appears to be an effective intervention to provide short-term support to families. Part of the success lies in the fact that this type of support can prevent the need for more far reaching interventions. The contact person is often a friend or acquaintance of the family. Each family is entitled to apply for a contact person. A local 'social service' handles the allocation. This particular type of support is a great example of low-threshold support for families, which is likely to diminish the risk of an escalation of problems.

7.8. Finally

Care for children and youth who run a risk of missing the boat is complex. So much is clear from the descriptions of the systems from the four countries in this quick scan. It is hardly possible to fully understand and explain the cultural and historical contexts of the youth care systems in these countries in this short period of time. However, we did observe a number of universal trends. Society has become more complex, family structures have changed; there is more focus on the interest of the child, which entails more and earlier interventions. The care offer has changed as well; it is more accessible to all children. Parenting problems are identified at an earlier stage, by parents as much as by professionals from the immediate context of the child. Deviant behaviour is more likely to be labelled a problem.

A few other remarkable similarities between the described countries and the Netherlands can be observed. There is a great deal of public and political debate on the care for children and an urgent call for more immediate care. A child missing out on a warm and safe childhood is socially unacceptable in Western countries. It is easy to become inspired by the countries surrounding us. At the same time, it is not easy, if not utterly complex, to copy 'good practices' or transfer desirable elements, as every country has its own particular context. However, there are more than a few good lessons from abroad that we can use to improve the care for children in the Netherlands. With this quick scan we hope to contribute to the achievement of this goal.

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November 2009

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