

# Children placed in alternate care in Norway: A review of mental health needs and current official measures to meet them

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Children and youth placed in alternate care have often suffered detrimental care conditions before placement and the rupture of attachment bonds both before and during alternate care. In this article, we review the knowledge base on the prevalence of mental disorders, and access to mental health services, of children and youth in alternate care in Norway. Due to the increasing knowledge of this group's needs, official measures are now taken to improve service provision and cooperation between types and levels of services for children and youth in alternate care. We review the recent Norwegian official reports aiming to improve access to mental health services for children placed in alternate care and discuss their recommendations in light of empirical findings from our own research.

**Stine Lehmann<sup>1</sup>, Nanna S. Kayed<sup>2</sup>**

<sup>1</sup> Regional Centre for Child and Youth Mental Health and Child Welfare -West, Uni Research Health, Bergen, Norway

<sup>2</sup> Regional Centre for Child and Youth Mental Health and Child Welfare – Central Norway, Department of Mental Health, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology (NTNU), Norway

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Stine Lehmann, Post box 7810, 5020 Bergen, Norway.  
E-mail: stine.lehmann@uni.no

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The child protection service (CPS) in Norway has a family preserving focus. It primarily offers voluntary home-based interventions aiming at supporting and improving parental functioning (Gilbert, Parton, & Skivenes, 2011). This policy reflects an optimistic view on changing parental practices through home-based interventions. In Norway, out-of-home placements often occur rather late in childhood. Among foster children born between 1990 and 1992, more than 70% were 6 years or older at the time of their first out-of-home placement (Backe-Hansen, Madsen, Kristofersen, & Hvinden, 2014). This indicates a higher age at first out-of-home placement than in, for example, the USA (Pösö, Skivenes, & Hestbæk, 2013). Older age at first placement in Norway is in line with the often lengthy duration of in-home interventions: Families have received voluntary interventions for a mean of 3 years before placement out of home (Christiansen & Anderssen, 2010). A possible side-effect to these practices might be prolonged exposure to detrimental care conditions for the child involved. Norwegian practices and policies give preference to foster family placements, and residential youth care (RYC) placements are seen as a last resort (Backe-Hansen, Bakketeigen, Gautun, & Grønningsæter, 2011). At the end of 2015, 11,500 children were living in foster families (Statistics

Norway, 2015). In comparison, 1,841 children and adolescents had been placed in RYC in the same time period. In Norway, adoption is rare and even a long-term placement remains a foster relation (Backe-Hansen, Havik, & Grønningsæter, 2013).

## **Norwegian knowledge base on mental health of children in alternate care**

### **Foster care**

There is a growing body of knowledge concerning the mental health of children in contact with the CPS in Norway. A study on children in foster care aged 6–12 years old ( $N = 279$ ), with a mean age of 4 years at first placement, used the developmental and well-being assessment to estimate the point-prevalence of child mental disorders. Prevalence estimates showed that 50.9% of the participating children met the Diagnostic and statistical manual of mental disorders 4th edition (DSM-IV-R) (American Psychiatric Association, 2000) criteria for one or more disorders at the time of assessment. The most frequent diagnostic categories were emotional disorders (24.0%), behavioural disorders (21.5%), reactive attachment disorders (RAD) (19.4%) and attention deficit hyperactivity disorders (ADHD) (19.0%). The comorbidity rate was very high. The most common forms

of maltreatment experienced by the foster children before out-of-home placement were Serious neglect (86.3%), Parents drug/alcohol abuse (55.3%), Parents mental disorder (53.3%) and Violence exposure (36.0%). The mean number of aversive childhood experiences was 3.0 (*SD* 1.6). The risk for mental disorders increased with exposure to serious neglect, increasing numbers of types of violence and increasing numbers of prior placements (Lehmann, Havik, Havik, & Heiervang, 2013).

Social neglect and the absence of adequate caregiving during childhood are criteria for both RAD and disinhibited social engagement disorder (DSED) (American Psychiatric Association, 2013). In the sample of school-aged foster children, the construct of RAD and DSED were examined. The data supported the conceptualisation of RAD and DSED as two distinct dimensions of child psychopathology, congruent with the DSM-5 definition (Lehmann, Breivik, Heiervang, Havik, & Havik, 2016). These findings indicate that the assessment of RAD and DSED behaviour provides information beyond screening for other mental health problems and should be included in a thorough examination of mental health needs for children and youth placed out of home due to maltreatment.

The associations between external risk factors and RAD and DSED were somewhat different depending on whether they were combined into a single diagnostic category (Lehmann et al., 2013) or treated as separate dimensional scales (Lehmann et al., 2016). Whereas more exposure to violence in the family of origin and more prior out-of-home placements were associated with having RAD according to the DSM-IV, these findings were not replicated for the dimensional measures of RAD and DSED according to the DSM-5. Instead, male gender and mental disorder in biological parents were associated with higher scores on the RAD dimension.

### Residential youth care

In the period 2010–2015, a study on mental health among adolescents aged 12–20 years old and living in RYC in Norway was carried out (Kayed & Jozefiak, 2015). Participants ( $N=400$ ) were on average 16.5 years old at the time of the study. The adolescents reported moving out of their home by order of the CPS for the first time at the mean age of 12.5 years. The Child and Adolescent Psychiatric Assessment (Angold & Costello, 2000) was used to assess psychiatric disorders according to the DSM-IV-TR (American Psychiatric Association, 2000). Some 76.2% of the adolescents fulfilled the criteria for at least one DSM-IV diagnosis within the past 3 months (Jozefiak et al., 2016). The most frequent diagnoses or diagnostic categories observed were depression and dysthymia

(37.3%), followed by any anxiety disorder (34.9%), ADHD (32.3%) and Asperger's syndrome (23.2%). The comorbidity rate was reported to be very high (Jozefiak et al., 2016).

Among the same adolescents, 71.0% reported having been exposed to maltreatment (Greger, Myhre, Lydersen, & Jozefiak, 2015). Having experienced maltreatment was associated with higher odds of Asperger's syndrome, conduct disorder, major depressive disorder, dysthymia, general anxiety disorder and having attempted suicide, and a significantly higher prevalence of comorbid disorders. In addition, Greger et al. (2015) found that poly-victimisation as measured by exposure to family violence, witnessing violence, victim of sexual abuse and household dysfunction was associated with an increased risk for mental disorders.

Regarding the subjective experience of quality of life (QoL), as measured by KINDL-R (Ravens-Sieberer & Bullinger, 2000), our results showed that adolescents in RYC report lower subjective quality of life in the areas of physical and emotional well-being, self-esteem and relationship with friends compared with young people in the general population (Jozefiak & Kayed, 2015). In addition, poor QoL was associated with experienced childhood maltreatment (Greger, Myhre, Lydersen, & Jozefiak, 2016). The adolescents' self-esteem domains – social acceptance and physical appearance – added substantially to the explained variance in QoL among adolescents living in RYC, over and beyond the levels of psychopathology (Jozefiak et al., 2017). These self-esteem domains may be targets of intervention to improve QoL, in addition to treating mental disorders.

These studies by Lehmann et al. (2013) and Jozefiak and Kayed (2015) on mental health among Norwegian children and adolescents in the CPS, reviewed above, show that both foster children and adolescents in RYC in Norway struggle with a high prevalence of mental disorders and experienced childhood maltreatment, as well as low quality of life. These findings are in line with international findings of increased rates of mental disorders in comparable samples. McMillen et al. (2005) reported an overall DSM-IV past-year prevalence rate of 33.0% among American youths ( $N=115$ ) aged 17 years, who were leaving foster care. Ford, Vostanis, Meltzer, and Goodman (2007) found an overall ICD-10 point prevalence rate of 38.6% among British foster youth ( $N=839$ ) aged 5–17 years. A recent review and meta-analysis (Bronsard et al., 2016) reviewed eight studies, including our study on Norwegian foster children (Lehmann et al., 2013), and concluded that 1 out of every 2 children or adolescents in the CPS meet criteria for a current mental disorder.

Taken together, this indicates that children and adolescents placed in alternate care, independent of different practices and policies across countries, to a

large extent have a need for specialised treatment and therapeutic help in several important life areas. The high prevalence and comorbidity of mental disorders, including attachment disorders, indicate a need for further development of diagnostic and therapeutic competence for these youth and their carers.

### **Access to mental health services for children in care**

In Norway, the CPS has the responsibility for child welfare, and emphasises provision of in-home interventions that aim to support families' provision of adequate care for their children (Gilbert et al., 2011), and work primarily after milieu-therapeutic principles. The Child and Adolescent Mental Health Services (CAMHS) is responsible for treatment of mental disorders. A review on access to mental health services for children in alternate care (Helsetilsynet, 2012) concluded that there are no national numbers on service access for these children. However, CPS accounted for only 10% of referrals to out-patient CAMHS. Results from our study of school-aged foster children, showed that 21.9% of the children were currently in contact with CAMHS (Standal-Knudsen, Helgesen, Larsen, & Lehmann, 2017). Both internalising and externalising symptoms, along with functional impairment, were associated with service use. Controlling for the other two, only functional impairment remained a significant predictor for service use. Age, gender, time in foster care and previous aversive childhood experiences were not associated with service use.

The study on adolescents living in RYC showed that, while the point-prevalence of mental disorders was 76.2%, only 25.1% reported having received help from CAMHS in the same timeframe (Kayed & Jozefiak, 2015). This indicates a large disparity between health-care needs and access. Kayed and Jozefiak (2015) examined the adolescents living in RYC's own experience of the use of general practitioner (GP), CAMHS and specialised treatment for addiction and substance abuse (TSB). Results showed that there was little coordination between the services. The GP was seldom involved in referring the adolescents to CAMHS or TSB, and when they received help from TSB very few received help from CAMHS at the same time. These young people have complex needs that cannot be solved by one service alone but require extensive cooperation and coordination within and between the municipal and specialised services.

### **Official measures to improve service provision for children placed in alternate care**

Partly as a result of the findings from the two Norwegian studies on foster children and adolescents in RYC, providing substantial knowledge on the needs

of children and youth in alternate care in Norway, several Governmental reports have recently been issued aiming to strengthen the service provision and corporation between the health and the child protection sectors.

In the priority instructions for CAMHS, revised in 2015, we find the following instruction especially targeting children living in harmful care conditions:

A vulnerable family situation, influencing the patient's mental health negatively, will strengthen the main criteria for graveness..... The specialized mental health services should be especially attentive towards vulnerable groups in high risk of mental disorders... Children with mental health problems due to circumstances in the child's primary context may be in great need of, and profit from, health care from the specialized mental health services. (Directorate for Health, 2015)

These instructions especially target the informal policy in some CAMHS, where children in transition between their biological family and the care of the CPS are often rejected from CAMHS.

This highlighting of the responsibility of CAMHS to offer mental health services for children in vulnerable or unstable family situations is followed up by an official report (Directorate for Health/Directorate for Children, Youth and Family Affairs, 2015). Here, we find that the focus also encompasses the responsibility of the CPS to elaborate their practices when referring children and their families to CAMHS. The report emphasises the responsibility of the primary care level to conduct a preliminary screening and also to try out primary interventions before referring to specialist services.

Further, the report states, in quite detailed manner, standards for the content of any referral from primary care to specialist services: 'The referral should comprise a description of the child's condition and circumstances, development, family and network, previous interventions, and the referrers' evaluation of the service needed' (Directorate for Health/Directorate for Children, Youth and Family Affairs, 2015, p. 21). A survey of this report's impact on the practitioners' ability to cooperate showed that among those who had applied the recommendations in the report, cooperation was facilitated. However, a substantial proportion of the participants in the survey were not familiar with the existence of the recommendations (Lauritzen, Vis, & Fossum, 2017). This implies that while the report seems to target the challenges of day-to-day cooperation between services, more work has to be done on the implementation of the recommendations in the services concerned.

In 2017, the official report ‘Summary and recommendations from work on healthcare for children placed in alternate care by the CPS’ (Directorate for Health/Directorate for Children, Youth and Family Affairs, 2017) was issued. The report aims at improving access to mental health services for children placed in alternate care and enhance the collaboration between CAMHS and CPS. Here, several specific recommendations are given for the future organisation of services and legislative changes, of which we highlight some.

First, it is recommended that the cooperation for early identification and assessment of healthcare needs when children are moved out of home be strengthened. The recommendation calls for further development of methods and models to secure early identification and thorough assessment of service needs in cooperation between CPS and CAMHS. This can prevent further escalation of mental health problems and the need for more comprehensive treatment (Membride, 2016). An ongoing research project led by the University of Oslo, ‘Children at Risk Evaluation (CARE) models’ (<http://www.med.uio.no/klinmed/english/research/projects/children-at-risk-evaluation-care/index.html>), was initiated in 2016 to focus evaluation of health, development and need for care in high-risk children.

Second, the report also recommends establishing primary care teams with competency on children and youth with complex needs, encompassing children in the CPS. The primary care team should, according to the report, have a coordinating function between municipal levels of services and ambulatory teams in CAMHS responsible for youth in RYC. By defining recourses in CAMHS responsible for youth in RYC, the designated therapists will be more likely to have knowledge of the CPS system, the RYC institutions and the specific challenges many of these residents have in their day-to-day lives. This could facilitate access to, and stability of, mental health services. Also, by making these services ambulatory, the attendance in therapy is made easier for the residents, as CAMHS may be located far away from the RYC institution. These structures may also facilitate supervision of the institutional staff.

Third, the report proposes to strengthen services from GPs by establishing child protection physicians. The concrete recommendation encompasses children and youth placed in institutions. In Norway, The Regular General Practitioner Scheme ensures that all citizens who are registered in the National Population Register are entitled to a regular GP. For youth in institutional care, contact with the GP can be difficult due to placement instability. By establishing a child protection physician who is associated with the institution rather than the individual, better healthcare

for youth in institutions is ensured. This proposal is in line with already established legislation and practices in England, where all looked after children are assigned to designated doctors for a comprehensive health assessment within 20 days of care (Simkiss & Jainer, 2017).

Fourth, the report proposes to increase use of digital tools in treatment. Youths in RYC report that they have moved, by order of the CPS, on average 3.3 times (Kayed & Jozefiak, 2015). A consequence of moving residence could be disruption of ongoing therapy and change of therapist. This could negatively influence the young person’s motivation for therapy, future therapeutic alliances and the belief in a positive outcome of therapy. Internet-aided consultations for youth living in RYC is thus proposed as a means of hindering abrupt treatment due to placement shifts. Digital tools in treatment has shown positive effects, especially for anxiety (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Haug, Nordgreen, Öst, & Havik, 2012). At the same time, digital tools should not fully replace direct consultations between child and therapist. Piloting should therefore be carried out to evaluate the effects of these measures for young people in alternate care.

Fifth, the report proposes to continue the development and strengthening of specialised institutions run by the CPS, in cooperation with CAMHS. The aim is to clarify issues of responsibility for inpatient treatment in CAMHS by mandate of the child protection legislation. It is suggested to impose on the regional health authorities a responsibility to designate institutions for simultaneous care and treatment. Given the high prevalence of mental disorders among adolescents in RYC (Jozefiak et al., 2016), and the complexity and severity of the disorders, there will be youths who are in need of highly specialised services that extend beyond what can be offered in a traditional RYC setting. It is estimated that this group could amount to 6–10 children on a national basis (Directorate for Health/Directorate for Children, Youth and Family Affairs, 2017). According to the report, the proposed agreements and legislations will emphasise the dual responsibility of the CPS and CAMHS, but recommend that CAMHS is given the legal responsibility in the Act of Specialized Health Services (Bassett, Lampe, & Lloyd, 2001). Two such pilot institutions are currently under establishment in Norway, but the government has chosen to place the legal responsibility with the CPS. The report also recommends commitment to partnership agreements between CPS and CAMHS on all levels, with national regulations of the content of these agreements. The official Norwegian report on the new child welfare act (Norwegian official reports, 2016, p. 16) also addresses the need for better cooperation between CPS and CAMHS. In line

with the recommendations from the directorates, this report opens for legally stated demands on the content of partnership agreements between CPS and CAMHS.

In sum, a number of measures are now being taken to ensure better and more available healthcare services, as well as more coordinated services, for youth in institutional care. The aim is to reduce the prevalence of mental disorders and increase their quality of life.

However, even though the report 'Summary and recommendations from work on healthcare for children placed in alternate care by the CPS' refers to the established knowledge base on mental health issues for all children in alternate care by the CPS, the concrete recommendations for further development of the field focus almost exclusively on youth in institutional residences. While this report summarises a substantial and much needed effort to move forward in the coordination of services needed to promote healthy development for youth in RYC, a differential approach to all children and adolescents placed in alternate care by the CPS as a group is still lacking. All in all, very few children placed in alternate care are in need of specialised in-patient treatment. Given that 9/10 of the children placed in out-of-home care in Norway live in foster families, these reports are strikingly unbalanced in their focus on improving the services offered to the minority of youth in need of RYC. A majority of maltreated children with mental disorders are, as children and youth in general, in need of both a caring and developmentally supportive family setting *and* out-patient treatment interventions tailored to their needs on an out-patient basis.

### **Recommendation for clinical practice; tools for early identification and foster parent guidance**

For the majority of children placed out of home, foster parents are key agents in providing correctional emotional experiences aiding the child in reaching his/her developmental potential. To enable foster parents in this task and to prevent further relational damage to the children by breakdowns of foster care, foster parents should be included as central allies carrying out the CPS' responsibility to care for children in alternate care. They should be offered mandatory, individually tailored guidance based on the individual child's needs and functioning, from the beginning of the placement. A review of common factors of effective guidance to foster parents highlights the importance of strengthening attachment bonds to the child, reducing behavioural and emotional problems in the child and focusing on the child's resources, as important components of guidance to foster parents (Leve et al., 2012).

For staff at RYC institutions and caseworkers in municipal CPS, it is necessary to increase the competency on mental health problems and incorporate this

knowledge into the daily routines to ensure that the mental health and relational problems are uncovered and that individually tailored therapeutic interventions are implemented.

A first step in identifying children in need of further assessment and treatment is to ensure that caseworkers in primary care have the competency to utilise standardised and validated screening tools for early detection of mental health problems. They also need valid information on the suitability and limitations of frequently used screening instruments when applied to young people in high-risk. The strengths and difficulties questionnaire (SDQ) (Goodman, 1997) has shown high sensitivity and acceptable specificity as a screening tool for foster children (Lehmann, Heiervang, Havik, & Havik, 2014). Also, the structural validity of the parent version of the SDQ in Norwegian foster children has been supported (Lehmann, Bøe, & Breivik, 2017). Based on our findings, we recommend the implementation and use of SDQ as a first choice when screening foster children for mental health service needs. Still, as symptoms of RAD and DSED seem salient in the description of these children's relational functioning (Kay & Green, 2013; Lehmann et al., 2016; Oosterman & Schuengel, 2007; Zeanah et al., 2004), caution should be taken against using the SDQ as the sole screening tool of mental health and relational functioning. Further research is needed to gain more knowledge about how to best combine screening instruments to adequately capture dimensions of psychopathology that are especially relevant for this high-risk group of children. Although the early identification and assessment of healthcare needs is of major importance for these children and adolescents, more emphasis should also be given to systematic identification of maltreatment, as this is associated with mental disorders (Gover, 2004; Greger et al., 2015; Kaplan et al., 1998; Lehmann et al., 2013; McLaughlin et al., 2012; Mills et al., 2013), poor QoL (Greger et al., 2016) and poor physical health in a long-term perspective (Rich-Edwards et al., 2010; Springer, Sheridan, Kuo, & Carnes, 2007; Thurston et al., 2014). There are several standardised instruments available for assessing maltreatment history and trauma-related symptoms, for example the Childhood Trauma Questionnaire (Bernstein & Fink, 1998; Bernstein et al., 2003), validated in Nordic samples. In addition, identifying human strengths, resilience and well-being should also be the objective for both the CPS and the CAMHS (Jozefiak & Kayed, 2015). The young persons' subjective experience of QoL is an important outcome measure to supplement the mental health focus. Both KINDL-R (Ravens-Sieberer & Bullinger, 2000), KIDSCREEN (Ravens-Sieberer et al., 2014) and Inventory of Life Quality in Children and Adolescents (Jozefiak, Mattejat, & Remschmidt, 2012) are instruments that could be used for this purpose.

## Ongoing and future research

In 2016, a 4-year study started up with funding from the Norwegian research Council. 'The children at risk revelation models (CARE)' is a large-scale study comprising three work packages. One study aims to evaluate models for mental health assessment and interagency cooperation for children in foster care. A second study is a 5-year follow-up of a cohort of children born by mothers in Opiate Maintenance Treatment (Sarfi, 2012). The third study is a 5-year follow-up of the cohort of children placed in foster care, after the first assessment in 2011 (Lehmann, 2015). In this latter study, the focus will be on factors that promote adaptive development and quality of life in young people in foster care. We will also examine the use and experiences of health and welfare services from the perspective of the foster youth themselves and that of their foster families. Results from the CARE project will provide unique evidence of mental health need and development for high-risk children.

While, as this review shows, we do have a solid knowledge base in Norway concerning the mental health needs of children in alternate care (Kayed & Jozefiak, 2015; Lehmann, 2015), studies on the effects of prevention and treatment of mental health problems for children in alternate care are lacking in an European context (Luke, Sinclair, Woolgar, & Sebba, 2014). We do have some indications that evidence-based treatment approaches may not have the same effect on children with complex symptom patterns or high comorbidity (Weisz, Eckshtain, Ugueto, Hawley, & Jensen-Doss, 2013). We need more knowledge of what works for whom. There is a need to develop, implement and evaluate interventions that especially target the needs of maltreated children in alternate care. Further, longitudinal studies are needed that focus on stability and change in mental health from childhood to adolescence, for this group of children, as well as from adolescence into adulthood. Also, as therapeutic care institutions are now proposed to be established on a national basis (Directorate for Health/Directorate for Children, Youth and Family Affairs, 2017), research is warranted that documents the effects for the individual or for specific groups of residents.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). DSM-IV-TR. Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.
- Andersson, G., Cuijpers, P., Carlbring, P., Riper, H., & Hedman, E. (2014). Guided Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: A systematic review and meta-analysis. *World Psychiatry*, 13(3), 288–295.
- Angold, A. & Costello, E. J. (2000). The child and adolescent psychiatric assessment (CAPA). *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(1), 39–48.
- Backe-Hansen, E., Bakketeigen, E., Gautun, H., & Grønningseter, A. B. (2011). *Institusjonsplassering—Siste utvei. Betydningen av barnevernsreformen fra 2004 for institusjonstilbudet* [Institutional placements—Last resort? The impact of the child welfare reform from 2004 on the institutional service]. Oslo: Norsk institutt for forskning om oppvekst, velferd og aldring.
- Backe-Hansen, E., Havik, T., & Grønningseter, A. B. (2013). *Fosterhjem for barns behov—Rapport fra et fireårig forskningsprogram* (Vol. 16) [Foster care for childrens needs—Report from a 4-year research program]. Oslo: Norsk institutt for forskning om oppvekst, velferd og aldring.
- Backe-Hansen, E., Madsen, C., Kristofersen, L., & Hvinden, B. (2014). *Barnevern i Norge 1990–2010. En longitudinell studie* (Vol. 9) [Child welfare in Norway, a longitudinal study]. Oslo: Norsk Institutt for forskning om oppvekst, velferd og aldring.
- Bassett, H., Lampe, J., & Lloyd, C. (2001). Living with under-fives: A programme for parents with a mental illness. *The British Journal of Occupational Therapy*, 64(1), 23–28.
- Bernstein, D. P. & Fink, L. (1998). *Childhood trauma questionnaire: A retrospective self-report: Manual*. San Diego, CA: Harcourt Brace & Company.
- Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse & Neglect*, 27(2), 169–190. Retrieved from [https://doi.org/10.1016/S0145-2134\(02\)00541-0](https://doi.org/10.1016/S0145-2134(02)00541-0)
- Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system: A systematic review and meta-analysis. *Medicine*, 95(7), e2622.
- Christiansen, O. & Anderssen, N. (2010). From concerned to convinced: Reaching decisions about out-of-home care in Norwegian child welfare services. *Child & Family Social Work*, 15(1), 31–40. Retrieved from <https://doi.org/10.1111/j.1365-2206.2009.00635.x>
- Directorate for Health. (2015). *Prioriteringsveileder—Psykisk helsevern for barn og unge* [Priority instructions—Child and adolescent mental health services]. Oslo.
- Directorate for Health/Directorate for Child, Youth and Family Affairs. (2015). Samarbeid mellom barneverntjenester og psykiske helsetjenester til barnets beste [Cooperation between child welfare services and mental health services in the best interest of the child]. (ISBN-nr.: 978-82-8286-256-1), Oslo.
- Directorate for Health/Directorate for Children, Youth and Family Affairs. (2017). *Oppsummering og anbefalinger fra arbeidet med helsehjelp til barn i barnevernet* [Summary and recommendations from the work on health services for children in care]. Oslo.
- Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *British Journal of Psychiatry*, 190(4), 319–325. Retrieved from <https://doi.org/10.1192/bjp.bp.106.025023>
- Gilbert, N., Parton, N., & Skivenes, M. (Eds.). (2011). *Child protection systems: International trends and orientations*. New York: Oxford University Press.

- Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581–586.
- Gover, A. R. (2004). Childhood sexual abuse, gender, and depression among incarcerated youth. *International Journal of Offender Therapy & Comparative Criminology*, 48, 683–696. doi:10.1177/0306624x04264459
- Greger, H. K., Myhre, A. K., Lydersen, S., & Jozefiak, T. (2015). Previous maltreatment and present mental health in a high-risk adolescent population. *Child Abuse & Neglect*, 45, 122–134. Retrieved from <https://doi.org/10.1016/j.chiabu.2015.05.003>
- Greger, H. K., Myhre, A. K., Lydersen, S., & Jozefiak, T. (2016). Child maltreatment and quality of life: A study of adolescents in residential care. *Health and Quality of Life Outcomes*, 14(1), 74. doi:10.1186/s12955-016-0479-6
- Haug, T., Nordgreen, T., Öst, L. G., & Havik, O. E. (2012). Self-help treatment of anxiety disorders: A meta-analysis and meta-regression of effects and potential moderators. *Clinical Psychology Review*, 32(5), 425–445.
- Helsetilsynet. (2012). *Mytar og anekdotar eller realitetar? Barn med tiltak frå barnevernet og tenester frå psykisk helsevern for barn og unge. Ei kunnskapsoppsummering [Myths or realities? Children with services from the child services and child and adolescent mental health services. A summary of knowledge]*. Retrieved from [www.helsetilsynet.no](http://www.helsetilsynet.no)
- Jozefiak, T. & Kayed, N. S. (2015). Self- and proxy reports of quality of life among adolescents living in residential youth care compared to adolescents in the general population and mental health services. *Health and Quality of Life Outcomes*, 13(1), 1–12. doi:10.1186/s12955-015-0280-y
- Jozefiak, T., Kayed, N. S., Ranoyen, I., Greger, H. K., Wallander, J. L., & Wichstrom, L. (2017). Quality of life among adolescents living in residential youth care: Do domain-specific self-esteem and psychopathology contribute? *Quality of Life Research*, doi:10.1007/s11136-017-1603-8
- Jozefiak, T., Kayed, N. S., Rimehaug, T., Wormdal, A. K., Brubakk, A. M., & Wichstrom, L. (2016). Prevalence and comorbidity of mental disorders among adolescents living in residential youth care. *European Child & Adolescent Psychiatry*, 25(1), 33–47. doi:10.1007/s00787-015-0700-x
- Jozefiak, T., Mattejat, F., & Remschmidt, H. (2012). *Inventory of life quality in children and adolescents manual, Norwegian version*. Stockholm, Sweden: Hogrefe.
- Kaplan, S. J., Pelcovitz, D., Salzinger, S., Weiner, M., Mandel, F. S., & Lesser, M. L. (1998). Adolescent physical abuse: Risk for adolescent psychiatric disorders. *American Journal of Psychiatry*, 155, 954–959. doi:10.1176/ajp.155.7.954.
- Kay, C. & Green, J. (2013). Reactive attachment disorder following early maltreatment: Systematic evidence beyond the institution. *Journal of Abnormal Child Psychology*, 41(4), 571–581.
- Kayed, N. S. & Jozefiak, T. (2015). *Ungdommer i barneverninstusjoners erfaringer med bruk av fastlegeordning, psykisk helsevern for barn og unge og tverrfaglig spesialisert rusbehandling [Adolescents in residential youth care's experiences with the use of general practitioner, mental health services and specialized treatment for substance abuse]*. Retrieved from [https://www.ntnu.no/documents/10293/1263899358/Ungdommer+i+barneverninstusjoners+erfaringer+med+bruk+av+behandling\\_Kayed+og+Jozefiak%5B1%5D.pdf/0c0f948b-888b-420c-a4f8-922a0bf74bbb](https://www.ntnu.no/documents/10293/1263899358/Ungdommer+i+barneverninstusjoners+erfaringer+med+bruk+av+behandling_Kayed+og+Jozefiak%5B1%5D.pdf/0c0f948b-888b-420c-a4f8-922a0bf74bbb)
- Lauritzen, C., Vis, S. A. M., & Fossum, S. (2017). Samhandling mellom barnevern og psykisk helsevern for barn og unge—Utfordringer og muligheter [Intersectoral collaboration between child welfare services and mental healthcare for children and adolescents in Norway—Mapping current challenges]. *Scandinavian Psychologist*, 4, e14. Retrieved from <https://doi.org/10.15714/scandpsychol.4.e14>
- Lehmann, S. (2015). *Mental disorders in foster children: A study of prevalence, comorbidity and risk factors Dissertation for the degree of philosophiae doctor (PhD)*. Bergen, Norway: University of Bergen.
- Lehmann, S., Breivik, K., Heiervang, E. R., Havik, T., & Havik, O. E. (2016). Reactive attachment disorder and disinhibited social engagement disorder in school-aged foster children—A confirmatory approach to dimensional measures. *Journal of Abnormal Child Psychology*, 44(3), 445–457.
- Lehmann, S., Bøe, T., & Breivik, K. (2017). The internal structure of foster-parent completed SDQ for school-aged children. *PLoS ONE*, 12(6), e0176625.
- Lehmann, S., Havik, O. E., Havik, T., & Heiervang, E. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child and Adolescent Psychiatry and Mental Health*, 7(39), Retrieved from <http://dx.doi.org/10.1186/1753-2000-7-39>
- Lehmann, S., Heiervang, E. R., Havik, T., & Havik, O. E. (2014). Screening foster children for mental disorders: Properties of the strengths and difficulties questionnaire. *PLoS ONE*, 9(7), e102134. doi:10.1371/journal.pone.0102134
- Leve, L. D., Harold, G. T., Chamberlain, P., Landsverk, J. A., Fisher, P. A., & Vostanis, P. (2012). Practitioner review: Children in foster care—vulnerabilities and evidence-based interventions that promote resilience processes. *Journal of Child Psychology and Psychiatry*, 53(12), 1197–1211.
- Luke, N., Sinclair, I., Woolgar, M., & Sebba, J. (2014). *What works in preventing and treating poor mental health in looked after children*. London: NSPCC.
- McLaughlin, K. A., Greif Green, J., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2012). Childhood adversities and first onset of psychiatric disorders in a national sample of us adolescents. *Archives of General Psychiatry*, 69(11), 1151–1160. doi:10.1001/archgenpsychiatry.2011.2277
- McMillen, J. C., Zima, B. T., Scott, L. D. Jr., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(1), 88–95. Retrieved from <https://doi.org/10.1097/01.chi.0000145806.24274.d2>
- Membride, H. (2016). Mental health: early intervention and prevention in children and young people. *British Journal of Nursing*, 25(10), 552–557.
- Mills, R., Scott, J., Alati, R., O'callaghan, M., Najman, J. M., & Strathearn, L. (2013). Child maltreatment and adolescent mental health problems in a large birth cohort. *Child Abuse & Neglect*, 37(5), 292–302. Retrieved from <https://doi.org/10.1016/j.chiabu.2012.11.008>
- Norwegian official reports. (2016). *Ny barnevernlov Sikring av barnets rett til omsorg og beskyttelse [New Child welfare act, securing children's right to care and protection]*. Oslo.
- Oosterman, M. & Schuengel, C. (2007). Autonomic reactivity of children to separation and reunion with foster parents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(9), 1196–1203. Retrieved from <https://doi.org/10.1097/chi.0b013e3180ca839f>
- Pösö, T., Skivenes, M., & Hestbæk, A.-D. (2013). Child protection systems within the Danish, Finnish and Norwegian welfare states—Time for a child centric approach? *European Journal of Social Work*, 17(4), 475–490. doi:10.1080/13691457.2013.829802
- Ravens-Sieberer, U. & Bullinger, M. (2000). KINDL-R. *Questionnaire for measuring health-related quality of life*

- in children and adolescents. Retrieved from <http://www.kindl.org>
- Ravens-Sieberer, U., Herdman, M., Devine, J., Otto, C., Bullinger, M., Rose, M., & Klasen, F. (2014). The European KIDSCREEN approach to measure quality of life and well-being in children: development, current application, and future advances. *Quality of Life Research, 23*(3), 791–803.
- Rich-Edwards, J. W., Spiegelman, D., Lividoti Hibert, E. N., Jun, H. J., Todd, T. J., Kawachi, I., & Wright, R. J. (2010). Abuse in childhood and adolescence as a predictor of type 2 diabetes in adult women. *American Journal of Preventative Medicine, 39*(6), 529–536. doi:10.1016/j.amepre.2010.09.007
- Sarfi, M. (2012). *Vulnerable but adaptable. A longitudinal study of a national cohort of children born to women in opioid maintenance (OMT) treatment*. Oslo: University of Oslo.
- Simkiss, D. & Jainer, R. (2017). *Legislation and practice in England, Designated doctors for looked after children*. Paper presented at the MOCHA Equity Workshop, Stockholm, Sweden.
- Springer, K. W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse & Neglect, 31*(5), 517–530. doi:10.1016/j.chiabu.2007.01.003
- Standal-Knudsen, A., Helgesen, T., Larsen, M., & Lehmann, S. (2017). *Hvem får hjelp og hvorfor? Fosterbarns kontakt med psykiske helsetjenester for barn og unge, og faktorer som er assosiert med kontakt* [Who receives services and why? Foster childrens contact with mental health services, and factors associated with contact]. Accepted for publication in *Norges Barnevern*.
- Statistics Norway, S. (2015). *Barnevern* [Child welfare]. Retrieved from: <https://www.ssb.no/sosiale-forhold-og-kriminalitet/statistikker/barnevern>
- Thurston, R. C., Chang, Y., Derby, C. A., Bromberger, J. T., Harlow, S. D., Janssen, I., & Matthews, K. A. (2014). Abuse and subclinical cardiovascular disease among mid-life women: The study of women's health across the nation. *Stroke, 45*(8), 2246–2251. doi:10.1161/strokeaha.114.005928
- Weisz, J. R., Kuppens, S., Eckshtain, D., Ugueto, A. M., Hawley, K. M., & Jensen-Doss, A. (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. *JAMA Psychiatry, 70*(7), 750–761.
- Zeanah, C. H., Scheeringa, M., Boris, N. W., Hellers, S. S., Smyke, A. T., & Trapani, J. (2004). Reactive attachment disorder in maltreated toddlers. *Child Abuse Neglect, 28*, 877–888. doi:10.1016/j.chiabu.2004.01.010