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Judging parental competence: A cross-country analysis of judicial decision makers' written assessment of mothers' parenting capacities in newborn removal cases

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Abstract

This paper examines the discretionary reasoning of the judiciary in three jurisdictions, England, Germany and Norway, in cases deciding whether a newborn child is safe with her parents or intervention is necessary. Our analysis focuses on one specific dimension of decision makers' exercise of discretion, namely, if and how the strengths and weaknesses of the mother are considered. The data material consists of all decisions concerning care orders of newborns from one large city in Germany from 2015 to 2017 (n = 27) and 2016 in Norway (n = 76) and all publicly available newborn removal decisions in England for 2015–2017 (n = 14). The findings reveal a high number of risk factors in the cases and less focus on risk-reducing factors. The situation of the newborn is considered to be harmful, as most cases result in a care order. Judicial discretion differs by how much information, and what types of factors, are included in the justification for the decision. A learning point for decision makers and policymakers would be to actively undertake a balancing act between risk-increasing and risk-reducing factors.

KEYWORDS

assessment, care order, child protection, child welfare, discretion, parenting competency

1 | INTRODUCTION

In this paper, we examine how mothers' parenting capacities are assessed, understood and justified in state interventions into the family through child protection removals of newborns in three jurisdictions (England, Germany and Norway). Departing from research on parents and predictive factors relating to parental capacities that predict if significant harm is more or less likely (Ward, Brown, & Westlake, 2012), we examine which parental capacities decision makers emphasize as important for their decision to remove or not remove a baby from the birth family. Most countries and child protection systems have granted authority to the court or court-like decision-making bodies to decide intrusive and involuntary interventions into the family, including restrictions of parental rights (Berrick, Dickens, Pösö, & Skivenes, 2019; Burns, Pösö, & Skivenes, 2017). Our data material for the analysis consists of the written judgements that justify the necessity of any intervention in the form of a restriction or termination of parental rights in three systems. We have collected 117 judgements concerning care orders of newborns from three jurisdictions, comparing similar cases across systems to increase our knowledge and understanding of the reasoning and justification of a child protection intervention that concerns the best interests of a newborn baby. We are curious to reveal if decision makers and systems differ from one another, and if so, how. This study contributes

to the discussions about the thresholds for intervention into the family and the legitimate use of discretionary authority when balancing children's rights and parental rights.

The paper is structured in six parts. In the next background section, the child protection systems are presented, followed by a summary of the research on parenting capacities. Thereafter, we present our method, findings, discussion and concluding remarks.

2 | BACKGROUND

We study three high-income Western countries, England, Germany and Norway, which have organized their care order proceedings in different ways. Child protection systems are typically categorized into two types (Gilbert, 1997; Gilbert, Parton, & Skivenes, 2011): risk-oriented or service-oriented. However, systems are now increasingly incorporating elements from each other (Gilbert et al., 2011). A major difference between these two system types is found in their underlying ideologies and the ways in which they address children at risk. A risk-oriented system has a relatively high threshold for intervention and a focus on mitigating serious risks to children's health and safety (Gilbert et al., 2011). These systems have high barriers for interference with the private sphere; thus, thresholds for intervention are high. In service-oriented systems, the aims are to promote healthy childhoods and functioning family lives and to prevent serious risks and overly intrusive interventions. Thus, the state provides early intervention services to children and families who appear to be in an at-risk situation. England, Germany and Norway are service-oriented systems that aim to provide support to families and are based on a therapeutic view of rehabilitation in which it is possible for people to revise and improve their lifestyles and behaviours via support services and help. A basic principle is that the child protection system should be part of a broader child welfare system that provides services to prevent more serious harm and, as a result, prevent out-of-home placements. The aims and motivation for removals are thus different from in a risk-oriented system, as they are in principle temporary, as a means to support the family. However, England is well known to be a system that, in practice, has a clear risk-oriented approach (Thoburn, in press; Berridge, 1997; Parton & Berridge, 2011). Underfunded and understaffed, the system intervenes when there is a serious risk of harm to a child, creating a high threshold for intervention. Germany and Norway are examples of typical service-oriented systems, with Germany including traditionalist family leanings adding to the service orientation (Gilbert et al., 2011; Wolff, Biesel, & Heinitz, 2011) and Norway with a child-centric orientation adding to the service orientation (Falch-Eriksen & Skivenes, 2019; Skivenes, 2011) in which children are regarded as individuals with independent rights and interests.

With regard to statistics on child removal cases, comparable figures are hard to come by; however, numbers for the years 2016, as measured on a specific day and including voluntary placements, indicate that England has 6.2 per 1,000 children in care, Germany has 10.8 per 1,000 and Norway 10.3 per 1,000 children placed out of home (Burns et al., 2017).

In terms of children's rights across countries and living conditions for families, there are several measurements (see Table 1) that somewhat support the descriptions of the type of child protection systems in place in the three countries. In comparison, England ranks considerably lower than Germany and Norway in terms of child rights and children's living conditions, with Norway as a child-centric country ranking highest.

A removal of a newborn baby is considered especially intrusive as the consequences of separation may be that the child and parents lose their attachment to each other and that the child forms an attachment to other carers. A newborn removal would often start with an emergency order, due to a risk assessment of the situation and the vulnerability of the child. In England and Germany, it is the family court that makes the decision about a care order, whereas in Norway, it is the court-like County Board. In Burns et al. (2017), details on these three decision-making bodies are outlined.

2.1 | Statutory basis for intervention

Decision makers in all three countries must adhere to the legal basis for the removal of a child from her parents. In England, the Children Act, 1989 grants power to the court to make a care order where the child is suffering, or likely to suffer, significant harm, where this is attributable to the care given to the child by the parent (s. 31). Similarly, the German Civil Code provides that the court may take measures, including the restriction or termination of parental rights, where the best interests of the child are endangered and the parents cannot, or fail to act to, avert the danger to the child (s. 1666 BGB). In Norway, the Child Protection Act of 1992 sets out the criteria for removal, specifying that a care order may be made where there are serious deficiencies in parenting, leading to neglect or maltreatment of the child (sections 4–12). The Act has specific provisions relating to the protective intervention for a newborn within the maternity clinic (§4–8) if there is a proven high probability that the child will experience a harmful situation, as defined by the care order criteria in §4–12, if sent home with the parents. In line with the Norwegian system's service orientation, the Act specifically provides that a care

TABLE 1 England, Germany and Norway: Ranking in international child-related indicators

	England	Germany	Norway
Kids Rights Index (2019)	170^	5	16
UNICEF Sustainable Development Goals (2017)	13^	2	1
UNICEF (2016) Child inequality*	=14^	=14	=2
CRIN (2016) Children's rights (access to justice)	10	66	13
GDP per capita ranking (2019)	23^	18	4
UNICEF (2013) Well-being	16^	6	2

Note: '=' indicates a joint position with another country; ^ = United Kingdom.

order may only be made where insufficiencies cannot be remedied through support measures. In Germany, interim care orders may be made for children in utero (s. 157 FamFG), and Norway has a specific provision for care orders concerning newborn babies who are still in hospital (sections 4–8(2)).

The material presented to decision makers will, in addition to the law and formal legal procedure for a care order application to the court, be dependent on the preparations and assessments that frontline child protection staff undertake. There is no guidance for the judiciary decision-makers regarding the assessment of parental capacities. However, the child protection agencies that file a care order application, which is typically given weight and is relied upon for the decision-making, have training in social work and, to a varying degree, have assessment guidelines for assessing risk and parental capacities. In England, frontline staff must use the Common Assessment Framework (CAF), which distinguishes between three categories—development of the child, parents and carers and family and environment—each with extensive sub-themes (CAF, p. 79ff.). In Germany and Norway, no such common frameworks exist. However, in Norway, an assessment manual (Kvello-manual) is used by 58% of all child protection agencies (Vis, Storvold, Skilbred, Christiansen, & Andersen, 2014), and this includes a list of both risk and protective factors (Kvello, 2015). In Germany, the use of risk assessment tools is decided at the local level. For a while and following some legal changes in 2005, checklists began to appear across the country, but this remained short-lived due to criticisms. Instead, many youth welfare offices now make use of different risk assessment tools (Pluto, Santen, & Peucker, 2016).

Thus, our expectation is that risk and parental capacities assessments are reflected in care order applications from the child protection agencies, but a systematic assessment will only be prevalent in English care order applications.

3 | RESEARCH ON PARENTING CAPACITIES

Research on parenting capacities ranges from philosophical discussions of what it means to be a 'good parent' (e.g., Macleod, 2018) to social work research on how to make decisions based on predictions of risk of harm for a child. Research on parenting capacities shares a common understanding of parents as critical agents in the healthy development of children, especially very young ones. It has been found that adversities faced by parents can impair their parenting capacity, making maltreatment more likely (Cleaver, Unell, & Aldgate, 2011). Such problems include mental health issues, substance misuse and intimate partner violence, amongst others. The Adverse Childhood Experience Studies show the long-term disadvantages of poor parenting capacities, resulting in child abuse, neglect and poor upbringing conditions, on children's well-being as children and as adults (Bentovim & Williams, 1998; Felitti et al., 1998). Exposure to childhood neglect or maltreatment may also negatively impact an individual's own parenting competency (Azar, 2002). Mothers' parenting failures tend to be judged more harshly, revealing the gendered nature of parenting (e.g., Villicana, Garcia & Biernat, 2017).

Good outcomes for children and families require successful social work assessment, involving skilled and knowledgeable decision makers and the appropriate use of assessment tools (Turney, Platt, Selwyn, & Farmer, 2012). Evaluating parenting capacity may take several forms, and we apply a framework that Ward et al. (2012) used for classifying families according to the risk of harm posed to a child, which draws on work by Jones, Hindley, and Ramchandani (2006) and identifies the factors associated with future harm (see Table 2). Although the parents' perspective has also been studied in this context (e.g., Ward et al., 2012, pp. 178–201), the focus firmly remains on the child by evaluating the risks to the child. A recent longitudinal study into the decisions made on behalf of infants suffering or likely to suffer significant harm revealed the adverse consequences of 'mistaken optimism' during assessment for the children (Brown, Ward, Blackmore, Thomas, & Hyde-Dryden, 2016, p. 20). In social work, a crucial aspect in assessing parents is their capacity to change (cf. Harnett, 2007; Platt & Riches, 2018); however, in child protection cases concerning newborn removals, the vulnerability of the child due to age and developmental stage usually precludes decision-making based on parental prospects. Instead, the decisions are based on an assessment of current risk to the child justifying a removal from her parents, leaving capacity to change considerations for a potential later decision on reunification.

The child's condition and need will also be a matter of concern, and a newborn who needs extra care will also demand a higher level of parental capacities (Harnett, 2007; Otto & Edens, 2003). In

TABLE 2 Relevant parent-related factors associated with future harm (reproduced from Ward et al., 2012)

Factors	Future significant harm more likely	Future significant harm less likely
Parent	■ Personality disorder • Antisocial • Sadistic • Aggressive ■ Lack of compliance ■ Denial of problems ■ Learning disabilities plus mental illness ■ Substance misuse ■ Paranoid psychosis ■ Abuse in childhood—not dealt with	■ Non-abusive partner ■ Willingness to engage with services ■ Recognition of problem ■ Responsibility taken ■ Mental disorder, responsive to treatment ■ Adaption to childhood abuse
Parenting and parent–child interaction	■ Disordered attachment ■ Lack of empathy for child ■ Poor parenting competency ■ Own needs before child's	■ Normal attachment ■ Empathy for child ■ Competence in some areas

addition, where very young children or babies are concerned, information on the actual parent–child relationship is limited, and any assessment will thus contain a strong predictive element. Even where there have been previous removals of siblings, depending on the facts of the case, this information may have limited applicability to the current child concerned (e.g., due to time passed and changed parental circumstances). Nevertheless, in all jurisdictions, a here-and-now assessment of parental capacities is required. In Table 2, we have summed up the core elements relevant for assessing future harm.

We depart from Ward et al.' (2012) model to study how the judiciary viewed parental strengths and weaknesses. The systems we analyse may or may not have knowledge about assessments and risk factors as laid out in this model. Thus, we set this model as the standard and as a way of measuring which factors are considered in the cases and which ones are not. For present purposes, we focused only on those factors associated with future harm that relate directly to the parent or the parent–child interaction, thus excluding other factors relating to abuse, the child herself, the wider family, the professionals involved or the social setting. These factors feature in the model developed by Ward et al. (2012) but are excluded from the present analysis, which focuses strictly on parenting-related factors. In the method section below, we present an operationalization of the model and explain how we apply it to our data material.

4 | METHOD

The data material consists of written court judgements concerning care orders relating to newborns, which are collected in relation to two research projects funded by the European Research Council and the Norwegian Research Council. In this paper, we analyse judgements from three countries: England, Germany and Norway, a total of 117 cases. We have all the judgements from one large city in Germany from 2015 to 2017 (n = 27), all judgements from 2016 in Norway (n = 76) and all publicly available newborn removal judgements (excluding placement orders) for 2015–2017 from England (n = 14). The number of cases equates the number of mothers (n = 117), and the number of newborns is 119 (including two cases of twins). We have approvals from all relevant authorities and committees to access this data material; we have used the University of Bergen's secure IT solution to store and work with the case material, and all quotes used in the paper are de-identified and sometimes altered slightly (e.g., child's gender) to ensure anonymity. A brief outline of the secure IT solution, and de-identification and anonymization of case material are available at https://www.discretion.uib.no/projects/supplementary-documentation/#1580800875158-bf47d86b-db69.

The results of our analysis will be dependent on the type of information and justifications presented in the written judgements, and based on the formal requirements, we should expect Norwegian decisions to include all the information and arguments relevant for the decision. The German decisions should include justifications, facts and legal grounds, but for the English decisions, the written form is up to the judge's discretion, and custom seems to be that facts, legal grounds and the arguments for the decision are included. As online supplementary material, a detailed outline of the formal requirements to written judgements in these countries can be found at https://www.discretion.uib.no/resources/requirements-for-judgments-in-care-order-decisions-in-8-countries/#1588242680256-00a159db-e96f. To rule out potential blind spots in our study, we have spoken to a small number of judges/decision makers in each country about the evidence and justifications they present in the written judgements, and we were told that the written justifications are usually very comprehensive, including all crucial reasons for a decision. The text material for our analysis consists of the relevant parts of the written judgements, which for Germany includes the interim and main proceedings documents concerning the care order (approximately 1–3 written pages per judgement)1; for Norway, the court's assessment and justifications (approximately 3–4 written pages per judgement); and for England, the court's assessment and justifications (very variable, either approximately 4–5 or 12–13 written pages per judgement).

In our analysis, we focus on mothers and their parenting capacities, due to their relative importance with regard to newborns and the widespread absence of fathers. We operationalized each factor of the Ward et al. (2012) framework and made mutually exclusive codes as outlined in Table 3. We also report on learning disabilities and mental illness (marked in grey), although these are only used in combination, not as separate categories in Ward's framework. The analysis of the cases was undertaken in four steps. First, we mapped the characteristics of the cases, including information about the parents and any risk factors mentioned in the judgements. Second, we identified any discussions of the parents and their parenting capacity. Third, a selection of cases from each country was coded in accordance with the operationalized coding scheme by the researchers. Fourth, all cases were coded by research assistants using NVivo 12 and thereafter reliability tested by another research assistant. Where discrepancies were detected, these were resolved in discussion between researchers and coders. Applying the framework by Ward et al. (2012) to classify families according to the level of risk posed to a child, our findings show that both the factual explanations and justifications provided by the courts fit into the framework, and we were not left with unaccounted for reasoning during coding; thus, the appropriateness of the chosen framework for the purposes of our study was confirmed. We test for significant differences between percent cross-tables, using the programme Zigne Signifikans, applying a one-tailed, single randomized sample test at both a 5% and 1% significance level when testing for differences between these three samples. We report significance as '**'$p < .05$ and '***'$p < .01$, with the awareness that the $p < .05$ is on the margin of what is relevant to report as statistically significant.

For the sake of simplicity, we use the term 'country,' although it is a non-representative sample from England, and for Germany, our material is from one large city. Furthermore, we do not report findings that are marginal; that is, when a code is represented in only 10–15% of the cases, we do not comment on it in the findings and discussion sections. We present the findings in the order of frequency in which they appear in the judgements. We have given each case a code, starting with the letter for the type of case, newborn, followed by an

TABLE 3 Operationalization of risk-increasing and risk-reducing factors based on Ward et al. (2012)

Name	Description
Child vulnerabilities	Child-related factors, affecting the specific needs of the child, making her particularly vulnerable (e.g., premature birth, disability, withdrawal symptoms and acute or chronic illness).
Risk-increasing factors: Parent. Future significant harm more likely	
Substance misuse	Medicine, drugs or alcohol misuse, during pregnancy or after birth. Does not have to result in addiction; i.e., misuse can consist of repeated use of illicit drugs or excessive use of legal substances.
Learning disability	General or specific learning disabilities; lower cognitive functioning or cognitive impairment.
Mental illness	General or specific mental illness or mental health problems. May have been confirmed by a formal medical diagnosis or can be inferred from observations/reports by experts (e.g., psychologist).
Learning disabilities & mental illness	Combination of the codes 'learning disability' with 'mental illness.'
Personality disorder	Any form of personality disorder, e.g., antisocial/sadistic/aggressive personality disorders. May be the result of long-term substance misuse.
Paranoid psychosis	Acute mental illness, mostly paranoid psychosis or paranoid schizophrenia. May include other psychiatric illness. If there is doubt concerning the diagnosis but it has not been definitely refuted, it will be included (i.e., mother may have paranoid psychosis, but the diagnosis is under assessment).
Denial of problems	Failure to recognize problems, such as mental illness, addiction or violence, includes failure to recognize own limitations in ability to provide care.
Lack of compliance	Failure to comply with recommended treatment or therapy, either by failing to enrol or dropping out. Includes refusal to move into a parent–child unit or to accept in-home services, where this has been recommended. Narrowly defined, i.e., parents do not accept services offered to them. Does not include cases where parents accept services and try to comply but are not able to implement what they learn. It is possible to have both lack of compliance and willingness to accept services in the same case, as parents may object to one kind of treatment but accept another type.
Abuse in childhood	Parent has own history of abuse, neglect, maltreatment in childhood. May have a history with child welfare services. This is not recognized as a problem/or something that needs treatmentBroad category: all kinds of childhood issues such as bullying, learning difficulty and CWS involvement because of parents' diagnosis (i.e., not abuse by their parents/family). Also includes early drug use unless it is otherwise specified that parents were neglected/abused in the home. Narrow category: abusive situation/neglect at home.
Risk-increasing factors: Interaction. Future significant harm more likely	
Disordered attachment	Unstable attachment to the child. Interest in the child may be limited, contact sessions may be missed, or a diagnosed attachment disorder may be present.
Lack of empathy for child	Inability to recognize the child's emotional needs.
Poor parenting competency	General deficiencies in parenting, including a failure to recognize the child's physical needs for stimulation. Often correlated with other risk factors. May require intensive assistance in basic parenting tasks.
Own needs before child's	The parent's own needs prevail, either due to selfishness or own childhood trauma, meaning that the parent's own needs will outweigh the child's needs. May overlap with lack of empathy—coded twice if so.
Risk-reducing factors: Parent. Future significant harm less likely	
Adaptation to childhood abuse	Parent's history of childhood abuse, neglect or maltreatment is recognized as a problem and has been addressed (through adaptive behaviour, therapeutic interventions, etc.).
Mental disorder responsive to treatment	Mental disorder is responsive to treatment.
Non-abusive partner	Presence of a supportive, non-abusive partner.
Recognition of problem	Parental awareness of problems, whether health-related or other problems.
Responsibility taken	Parent actively tries to change/improve.
Willingness to engage with services	Willingness to follow recommendations by professionals, both in health-related or child welfare-related contexts.
Risk-reducing factors: Interaction. Future significant harm less likely	
Normal attachment	Parent–child bond is present and adequate.
Empathy for child	Parent is responsive to the child's needs, especially emotionally.
Competence in some areas	Parenting competency is only partially limited.

abbreviation for country and a number, plus two digits to indicate the year, for example, *NENG01-16*.

4.1 | Limitations

Our approach includes several limitations. First, we only base our study on the written judgements. We have not observed the court proceedings and the parties' presentation of the cases, nor have we interviewed the judicial decision makers.2 This also means that information referred to in the judgements, such as reports by experts on the parents and their parenting, has not been available to us. Our insight into the facts of the cases can therefore be limited. Second, jurisdictional differences may affect comparability of the three countries studied. Examples are variation between professional guidelines available to guide decision-making processes by both social workers and the courts, evidence available to judges and the legal requirements as to the level of detail of the reasons and justifications to be given in the written judgements. Third, the written judgements are produced for the purpose of the court proceedings and are written after the decision has been made; as such, we need to be aware that judgements adhere to each legal sphere's logic of appropriateness. The requirements for written judgements vary, and thus, differences between countries may be due to differences in how judgements are written. Fourth, the sample from England is non-representative, as we analyse only the publicly available judgements. Despite

TABLE 4 Results for mother-related risk-increasing and risk-reducing factors

Name	England (*n* = 14)			Germany (*n* = 27)			Norway (*n* = 76)			Total (*n* = 117)	
Mean/median no. of risk factors	**3.6/4**		**Sig diff Eng — Ger**	**3.3. /3**		**Sig diff Ger — Nor**	**5.6/6**		**Sig diff Eng — Nor**		
Child vulnerabilities (*n* = children)	**2**	**14.3%**	**-**	**8**	**29.6%**	**-**	**25**	**32.9%**	**	**35**	**29.9%**
Risk-increasing factors: Mother (*n* = cases)											
Substance misuse	4	28.6%	-	11	40.7%	-	18	23.7%	-	**33**	**28.2%**
Learning disability	*2*	*14.3%*	-	*3*	*11.1%*	***	*28*	*36.8%*	**	***33***	***28.2%***
Mental illness	*5*	*35.7%*	-	*14*	*51.9%*	-	*49*	*64.5%*	**	***68***	***58.1%***
Learning disabilities & mental illness	0	0.0%	-	1	3.7%	**	12	15.8%	***	**13**	**11.1%**
Personality disorder	2	14.3%	-	5	18.5%	-	13	17.1%	-	**20**	**17.1%**
Paranoid psychosis	2	14.3%	-	4	14.8%	-	4	5.3%	-	**10**	**8.5%**
Denial of problems	7	50.0%	-	8	29.6%	**	40	52.6%	-	**55**	**47.0%**
Lack of compliance	5	35.7%	-	11	40.7%	-	43	56.6%	-	**59**	**50.4%**
Abuse in childhood	5	35.7%	***	1	3.7%	***	56	73.7%	***	**62**	**53.0%**
Risk-increasing factors: Interaction (*n* = cases)											
Disordered attachment	4	28.6%	-	6	22.2%	-	10	13.2%	-	**20**	**17.1%**
Lack of empathy for child	6	42.9%	-	8	29.6%	***	57	75.0%	**	**71**	**60.7%**
Poor parenting competency	3	21.4%	***	16	59.3%	-	50	65.8%	***	**69**	**59.0%**
Own needs before child's	4	28.6%	***	0	0.0%	***	22	28.9%	-	**26**	**22.2%**
Risk-reducing factors: Mother (*n* = cases)											
Adaptation to childhood abuse	1	7.1%	-	0	0.0%	-	0	0.0%	-	**1**	**0.9%**
Mental disorder responsive to treatment	1	7.1%	-	1	3.7%	-	8	10.5%	-	**10**	**8.5%**
Non-abusive partner	2	14.3%	-	0	0.0%	**	4	5.3%	-	**6**	**5.1%**
Recognition of problem	3	21.4%	-	3	11.1%	**	21	27.6%	-	**27**	**23.1%**
Responsibility taken	1	7.1%	-	4	14.8%	-	6	7.9%	-	**11**	**9.4%**
Willingness to engage with services	3	21.4%	**	13	48.1%	**	52	68.4%	***	**68**	**58.1%**
Risk-reducing factors: Interaction (*n* = cases)											
Normal attachment	7	50.0%	***	1	3.7%	-	1	1.3%	***	**9**	**7.7%**
Empathy for child	0	0.0%	-	1	3.7%	***	15	19.7%	***	**16**	**13.7%**
Competence in some areas	7	50.0%	***	1	3.7%	***	21	27.6%	-	**29**	**24.8%**

**p < .05.
***p < .01.

these limitations, the judgements are a suitable source for reconstructing the judicial decision-making process by studying the courts' reasoning in these cases.

5 | FINDINGS

The 117 mothers were between 15 and 45 years old: Five mothers were under the age of 18 years, 15 between 19 and 21 years and 69 were 22 years or older. In 28 cases, the mother's age could not be ascertained from the judgement. Paternity was not known in 26 cases (22%). Nineteen mothers (16%) had a previous child taken into care, and 42 mothers (36%) had a history with child protection services of their own. Child vulnerabilities were described in 35 cases (30%), including 14 premature births (12%) and nine with withdrawal symptoms (8%), whereas 66 cases (56%) provided no information about the baby's condition. One hundred one cases resulted in the removal of the child from her family (86%), indicating that the courts saw significant risk of future harm to the child.3 The vast majority of cases referred to more than one risk factor, with a mean/median of 3.6/4 (England), 3.3/3 (Germany) and 5.6/6 (Norway).4 Furthermore, risk-increasing factors clearly dominated in the judgements. The results of risk-increasing and risk-reducing factors are displayed in Table 4 below, and as shown, all risk factors were present in our sample.5

5.1 | Risk-increasing factors

With 60.7% of all cases in our study, **lack of empathy for the child** was the most discussed factor, present in 75% of cases in Norway, 43% in England and 30% in Germany. ('… the supervisors of the contact sessions observe that after only 50 minutes a certain restlessness of the mother arises and she is unable to empathize with her son.'—*NGER24-18*).

Next, 59.0% of all cases referred to the mother's **poor parenting competency**. In Norway and Germany, this was even higher (66% and 59%, respectively) but lower in England (21%). ('The Board agrees that the mother has already shown serious deficiencies in the care of [child].'—*NNOR66-16*).

Mental illness appeared as the third most frequent risk factor overall (58.1%), with some country variation: 65% of Norwegian cases, 52% of German cases and 36% of English cases mentioned the mother's mental illness.

Fifty-three percent of cases refer to the mother herself having experienced some form of **abuse in childhood**. This risk factor was most prevalent in Norway (74%), followed by England (36%) and was rare in Germany (4%). ('It is a tragic matter of fact that both parents suffered abuse in their childhoods and were known to the Local Authority as children.'—*NENG10-15*).

Lack of compliance with the professionals was registered in 50.4% of all cases, specifically in 36% of English cases, 41% of German cases and 57% of Norwegian cases. ('The mother, to the conviction of the court, is not able to avert the existing danger for the child's well-being, because she has discontinued the withdrawal treatment in [hospital].'—*NGER18-17*). Further examples included missed appointments, discontinuation of detoxification programme participation and the refusal to move into a mother–child unit (e.g., *NENG01-16*: 'Although her attendance for the social work assessment began well, her engagement significantly decreased and she only attended four out of eleven of the sessions.'; (*NGER21-16*): '… in-patient placement in a fully supervised mother-child facility is required in order to ensure the child's well-being. The child's mother is not willing to do this').

Forty-seven percent of cases describe the mother's **denial of problems**, which is evident in 50% of English cases, 30% of German cases and 53% of Norwegian cases. ('[Mother] has aligned herself to father and committed herself to an enduring relationship with him and refuses to accept that he is a risk to [child].'—*NENG12-15*).

Over a quarter of cases (28.2%) refer to the mother's **substance abuse** problem. In Germany, 41% of cases mention some form of substance abuse and 29% in England and 24% in Norway.

Learning disabilities were also registered in 28.2% of cases, with 37% of Norwegian, 14% of English and 11% of German mothers being described as learning disabled.

The remaining risk factors appeared less frequently, in less than a quarter of the cases. **Putting her own needs before the child's** was a risk factor in 22.2% of cases but in none of the German cases. A **personality disorder** was mentioned in 17.1% of cases and was similar for the three countries. 17.1% of cases referred to **disordered attachment**.

5.2 | Risk-reducing factors

Risk-reducing factors were much less discussed, with only three factors standing out. Overall, the Norwegian cases more frequently referred to risk-reducing factors than those from the other two countries. The most present factor (58.1%) was the **mother's willingness to engage with services**, referred to in 68.4% (Norway), 48.1% (Germany) and 21.1% (England) of cases. ('[Mother] is receptive for assistive services from the child protection service. The County Board perceive [mother's] attitude to be positive.'—*NNOR24-16*).

Her **competence in some areas** was mentioned in 24.8% of all cases, with huge variation between the three countries: 50.0%, 27.6% and 3.7%, respectively, in England, Norway and Germany. ('On the positive side, the parents, in particular [mother], are better at stimulating [child] and at dealing with the basics. They have shown this in contact. They can change nappies and feed [child] and play with him and read with him.'—*NENG03-15*).

Twenty-three percent of cases referred to the mother's **recognition of a problem**, which was considered in 27.6% of Norwegian, 21.4% of English and 11.1% of German cases. ('[Mother] gave up her parental right to care for [child] in March this year, when she became aware of the hospital's concerns. [Mother] is upholding this decision, and recognises that she is not able to care for the daughter.'—*NNOR19-16*).

The mother's **empathy for her child** was discussed in 13.7% of cases, mostly from Norway (19.7%) and in none from England.

6 | DISCUSSION

Our analysis shows the challenges and struggles mothers in our sample face and have to overcome, as well as the seriousness of the situation for the newborns, in our three countries of study. One third of the babies are considered vulnerable. A majority of the mothers is registered with mental health problems, one third with substance abuse problems and one third with learning disabilities. It is evident that the decision makers consider these serious cases involving high risks for the newborns, as they decide in a majority of the cases that a care order is necessary and that nothing else will do. Our initial observation is that the descriptions of the risk-increasing and risk-reducing factors concerning parents and parent–child interactions constitute a comprehensive set of factors and elements decision makers consider in their decisions on newborn removals. There are, however, differences across countries. One being that the Norwegian cases are far more informative, providing a lot of facts and background on the family. Three immediate findings stand out: First, risk-increasing factors are much more evident in the cases than risk-reducing factors. Second, there are cross-country differences as to which factors are most often mentioned and which ones are rarely mentioned. Third, there is a lack of balancing act of risk-increasing versus risk-reducing factors in their justifications for decisions.

6.1 | The courts' assessment of parenting capacity

Five risk-increasing factors are mentioned in about half of the judgements of which the two most frequently mentioned concern interaction: lack of empathy for child (61%) and poor parenting capacity (59%). These are followed by mother's abuse in childhood (53%); lack of compliance (50%); and denial of problems (47%).

A mother's lack of empathy for her child characterizes an inability to recognize the child's emotional needs. This risk factor is mentioned in all three countries, but in Norway, it is present in three quarters of cases, whereas in England, it is mentioned in 43% and in Germany in less than one-third of cases. This may indicate that Norwegian decision makers have a stronger child-centric focus than their peers in England and Germany, in the sense that the child's perspective is recognized and that the importance of attachment and emotional needs of a baby are more explicitly considered in the decision-making process. Over half of the cases refer to poor parenting competency (parenting insufficiencies or lack of parenting ability) as part of the assessment. The courts tend to arrive at this conclusion either based on intrinsic features of the parent, on behavioural evidence or on a combination. For instance, where the mother is found to misuse substances or has a mental health condition, this is used as an explanation of the mother's inability to reliably care for the child. Alternatively, where a mother has failed to show sufficient interest in the child or to prioritize her needs over her own, the court will conclude that this constitutes poor parenting competency. In some of the cases in the first category, the courts would emphasize the mother's need to address her own challenges before being able to look after a child.

A mother's history of abuse, neglect or maltreatment in her own childhood may affect her ability to parent, where this has not been recognized as a problem and has not been addressed by her. This risk factor is mentioned in 53% of cases, with Norway leading (74%), followed by England (36%). In Germany, this risk factor was largely absent (4%, n = 1). Although there are clear country differences, our findings align with the research evidencing the difficulties of breaking the cycle: Parents in the child protection system have themselves been mistreated as children and have not had a safe and good upbringing and childhood. It then follows that they themselves are not well equipped to parent and care for a child, and this tragic fact shows the shortcomings of the welfare state and the child protection systems.

Lack of compliance was more evenly distributed between the countries, ranging from 57% (Norway) to 36% (England) and 41% (Germany). The high prevalence of this risk factor indicates that many mothers were offered services to help them address their challenges but that mothers often fail to comply with a course of action recommended by social services. Examples include treatment or rehabilitation programmes, a move into a parent–child unit, or the provision of in-home services. Some mothers initially agreed but later dropped out, whereas others refused from the outset.

A mother's denial of problems indicates her persistent failure to recognize problems, such as mental illness, substance misuse, or violence, or her limitations in her ability to provide care for the child. This risk factor was mentioned in about half of the cases in Norway (53%) and England (50%) and approx. a third of German cases (30%).

6.2 | Cross-country differences

A notable difference between the three countries is the level of consideration of risk factors: In Norway, this was far more comprehensive than in England and Germany, as the overall higher percentages for the different parent-related risk factors indicate. Particularly, parental compliance and willingness to engage with services feature more strongly in Norwegian cases. The country differences may be due to the type of welfare state model and child protection system in the three countries, because the Norwegian family-service-oriented system typically provides many support measures to parents before more intrusive means of child protection are chosen. Furthermore, there is a comprehensive public service network for an individual in need of support, so when a mother with comprehensive needs is pregnant and gives birth, a lot of information about her is already within the system (Juhasz, 2020). Thus, the County Board as decision maker in these cases is able to assess the engagement with support services and the mother's needs and behaviour when deciding on a child's removal. In contrast, England and Germany typically provide fewer family support services, possibly meaning that questions of information and compliance will more often relate to medical or therapeutic services (as our case material demonstrated).

6.3 | Balancing risk-increasing and risk-reducing factors

We notice that the courts in all three countries spend significantly more time on assessing the risk-increasing factors in their assessment of parenting capacity. We found no systematic way of balancing positive and negative factors for the purposes of assessing the parent, which is demonstrated by the fact that in 25% of cases, no discussion of risk-reducing factors takes place at all. Surely, this may be due to a lack of risk-reducing factors, as many of them relate directly to the mothers' handling of risk-increasing factors or are a negation of a risk-increasing factor, such as 'lack of empathy for child' versus the risk-reducing factor 'empathy for child.' However, this indicates that the courts do not generally approach their risk assessment by balancing risk-increasing with the corresponding risk-reducing factors. For example, in cases where the mother had experienced abuse in her own childhood, this did not lead decision makers to consider whether any adaptation to such abuse had taken place, which might diminish the risk to her own child. Similarly, in cases of mental disorder, the responsiveness to treatment was not systematically considered. It may of course be that the severity of the mothers' problems made such considerations superfluous; however, when it comes to providing full justifications for such a serious decision, we would have anticipated at least some consideration of potentially risk-reducing factors. Furthermore, little evidence of risk-reducing factors was maybe to be expected, given the severity and multiplicity of risk factors present. Few cases in our sample referred to only one risk factor, which suggests that wherever the risk is deemed so significant that the child's removal from her parent(s) is the only action to take, the courts are not inclined to discuss risk-mitigating factors in great detail.

7 | CONCLUDING REMARKS

Our study shows that in general, decision makers in newborn removal cases take a somewhat child-centric perspective when assessing the risk of future harm to the child. We found that parenting competence was described by way of assessing the various risk factors impacting on a mother's ability to look after her child, with a clear emphasis on risk-increasing factors. Although we noticed explicit acknowledgements of parents' love for their child—'The parents […] clearly love their son and contact has been very beneficial to [him] and to them. I have no reason to doubt whatsoever what the guardian has said about the parents' warm relationship with their son.'—*NENG07-17*—the decision makers' focus remained firmly on the child's prospects and well-being.

We have only analysed one particular aspect that is relevant in deciding whether or not a newborn child should be removed from her parents, namely, the capacities of her mother to take care of her. We readily acknowledge that any justifiable decision-making process in these cases will have to stretch farther to take into account other aspects. Our scope here was narrower, examining and comparing discretionary decision-making with regard to assessing parental competence to take care of a child. Our findings reveal that the decision makers focus on the risk posed by the mothers, rather than an evaluation of general parenting quality. It is of course a peculiarity of newborn removal cases that the factual evidence available to the court with regard to parent–child interaction and relationship is extremely limited; the very young age necessitates a predictive rather than an evidential assessment of parenting capacities. However, that is not a hindrance to considering risk-reducing factors. On the contrary, it should open the space for decision makers to consider various factors. For decision makers, it seems that once a sufficiently serious risk is established, no further discussion of other risk factors will be undertaken. An example is the case of a mother's substance misuse, where even a great willingness to undergo therapy would not suffice to reduce the risk to the child, due to the long-term nature of the intervention.

From a decision-making point, it is important that all relevant information is available, and in some systems, the knowledge about a parent may be comprehensive depending on the specific content of the care order application from the child protection agency. Possibly, the gap in the judicial balancing act is due to the information provided by social workers. An important consideration in child protection cases is the interplay between parenting deficiencies and risk mitigation strategies and the role of social support measures—this insight might be a critical learning point for both the judiciary and social workers. Although we found no systematic consideration of this interplay, the decision makers did sometimes refer to risk-reducing factors. However, given the severity of problems our analysis reveals, it is perhaps unsurprising that no full balancing exercise is undertaken. The requirement to act immediately to avert risk to the child will thus outweigh any risk-reducing factors in the short term in these most serious cases.

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ETHICAL STATEMENT

The project has been independently reviewed and approved by the University of Bergen's Ombudsperson for research. Processing of personal data in relation to the projects is in accordance with the Norwegian Personal Data Act (2000, 2018) and Regulation (EU) 2016/679 (General Data Protection Regulation). Information is handled as confidential material in accordance with regulations set by the Norwegian Authorities and with the obligations set by the Norwegian and European Research Councils. All procedures for storage, anonymization, and deletion of data follow national and EU regulations, and all data handling use SAFE storage systems, which is the University of Bergen's data solution for secure storage of sensitive data material.

DATA AVAILABILITY STATEMENT

Data cannot be released due to confidentiality agreements.

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ENDNOTES

[1] For Germany, we have used youth welfare agency reports to establish some basic factual information not contained in the court documents.

[2] Although we have not interviewed the individual decision makers in the cases in our data material, we did speak to judges in all three countries to confirm the validity of using written judgements as a source of judicial reasoning (please see our method section on pp. 6–7 for details).

[3] Due to the low number of cases not resulting in a care order (n = 16), no comparison was done with those cases where a care order was granted. The proportion of cases with granted care orders ranged from 66.7% (Germany) to 85.7% (England) and 94.5% (Norway).

[4] Ten cases mentioned only one risk factor, namely, substance abuse (n = 4), poor parenting competency (n = 3), disordered attachment (n = 1), lack of empathy for the child (n = 1) and denial of problems (n = 1). One case contains no parental risk factors; rather, unexplained injuries to an older sibling were used to justify the removal of both children (*NENG09-16*); this risk factor falls outside our framework for parental risk.

[5] All translations are the authors' own.

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