4

Institutional Barriers to Medical Examinations in Barnahus

Kari Stefansen, Elisiv Bakketeig, and Susanna Johansson

Introduction

The present chapter scrutinises the role of medical examinations in the Barnahus model: a topic that has received limited attention from researchers to date. According to the quality standards for Barnahus issued by the PROMISE network,[1] medical examinations are a key component in setting up a holistic service for victimised children. The standards specify that medical examinations and treatment should be offered routinely at Barnahus and that the medical staff should be present

[1] The PROMISE Barnahus Network is a member-led stakeholder organisation that aims to harmonise and consolidate good Barnahus practice across Europe. The organisation's quality standards were issued in 2017 and are available online, in different languages: https://www.barnahus.eu/en/the-barnahus-quality-standards/.

K. Stefansen (✉) · E. Bakketeig
Norwegian Social Research (NOVA), Oslo Metropolitan University, Oslo, Norway
e-mail: karis@oslomet.no

E. Bakketeig
e-mail: elba@oslomet.no

S. Johansson et al. (eds.), *Justice and Recovery for Victimised Children*, Palgrave Studies in Victims and Victimology, https://doi.org/10.1007/978-3-031-53233-7_4

in consultation meetings and case reviews when appropriate. In line with PROMISE's core idea of the model as a flexible and adaptable structure for the provision of child-friendly justice and recovery (Johansson & Stefansen, 2020), the standards do not describe *how* its medical mandate can be achieved.

Our empirical setting is Norway, where the Barnahus model was implemented starting in 2007; today, Barnahus is a national service that is mandatory to use in police-reported cases of violence and abuse of children (as well as adults with intellectual impairments). As with many national Barnahus models, the Norwegian model is a hybrid institution that combines two "tracks," whose boundaries may shift over time and be blurred in practice: the penal track that refers to the processing of criminal cases, where the child forensic interview is the primary task to be coordinated, and the welfare track which refers to psycho-social work such as needs assessment, support, and recovery services for children and their families (Johansson, 2011; Johansson et al., 2017; Stefansen et al., 2023).

Medical examinations have been part of the Norwegian Barnahus model from the outset (Bakketeig et al., 2012; Stefansen et al., 2012), but they are primarily conducted in the small percentage of cases where the prosecutor sees them as relevant for the gathering of evidence for a criminal case; this situation primarily links medical examinations to the penal track and mandate of the model. But because medical examinations also when ordered by the prosecutor are performed according to an extensive social paediatric protocol, they can also identify healthcare needs and thus serve a purpose in the welfare track of the model.

Still, the potential of medical examinations in Barnahus to contribute to securing the welfare of victimised children more generally is presently unfulfilled in the Norwegian context. The large majority of children who are referred to Barnahus in Norway are not offered a medical examination, although scaling up the offer of medical examinations is a goal, as

S. Johansson
School of Social Work, Lund University, Lund, Sweden
e-mail: susanna.johansson@soch.lu.se

explicated in the formal guidelines for Barnahus from 2016 (Directorates of Police, Family and Health, 2016). The offer of medical examinations in cases where they are not ordered for forensic purposes has generally been understood as important primarily for two reasons: an examination can alleviate the worries of children and their families about irreparable harms, particularly in cases of sexual abuse, and an examination can identify any needs for the treatment of illnesses and conditions both related and unrelated to the violence or abuse the child has suffered (Bakketeig et al., 2012).

National authorities have recognised the limited role of medical examinations in Barnahus since the early-adoption phase of the model, but measures to increase the usage, such as the establishment of funding programmes and guidelines, have had limited effect to date. The aim of the present chapter is to examine why this situation of *institutional inertia* (Aksom, 2022; see also Firsova et al., 2022), or standstill, has materialised in an otherwise innovative and evolving organisation (Johansson & Stefansen, 2020, 2024) that has contributed to a more holistic approach to victimised children and their families (Stefansen et al., 2023), for instance through the practice of interstitial work (Andersen, 2019, 2022, 2024).

Our analysis is grounded in an institutional perspective that is sensitive to how organisations are embedded in wider institutional fields. We draw on data from two national evaluation studies; the first was conducted in the adoption phase of the model (Bakketeig et al., 2012; Stefansen et al., 2012), while the second was conducted in the post-adoption phase (Bakketeig et al., 2021). We identify three types of institutional barriers that together hamper the realisation of the potential of medical examinations, especially in the welfare track of the model: *established routines*, *regulatory issues*, and *lack of resources*. Having improved knowledge about these barriers is relevant not only to the Norwegian authorities (who have struggled to find solutions to the ongoing neglect of victimised children's healthcare needs in Barnahus), but also for countries that are in the process of adapting the Barnahus model to their specific institutional context.

As a background to the analysis, we first describe how medical examinations are organised and regulated in the Norwegian Barnahus model.

Medical Examinations in Norwegian Barnahus

In Norway, the use of Barnahus for forensic interviews is regulated by law (Criminal Procedure Act 22, May 1981, no. 25). The target group is children up to 16 years of age who may have experienced sexual or physical abuse, genital mutilation, violence in close relations, or homicide, or they may have witnessed such incidents (Directorates of Police, Family and Health, 2016). All Barnahus (11 in total in 2023) have a room for medical examinations that is equipped for the purpose and designed to be as child-friendly as possible, with pictures on the walls and other decorative elements. The examinations are conducted by doctors specialised in paediatric medicine who do their daily work at children's wards in local hospitals and are summoned to Barnahus (which are located elsewhere) when their services are needed. Medical treatment and follow-up are not offered at the Barnahus and must be done in hospitals or within the primary healthcare sector.

All medical examinations in Barnahus follow an extensive social paediatric protocol, which means they include a thorough clinical examination as well as a comprehensive mapping of the child's medical history, general development, family situation, daily activities, and psycho-social well-being. When the prosecutor orders a medical examination, the examination also includes the securing of evidence that can be used in a possible penal case. For this part of the examination, the doctor receives a mandate from the prosecutor and writes a forensic report on the issues specified in the mandate. (In the following, we refer to medical examinations that are ordered by the prosecutor for forensic purposes as "forensic medical examinations" and those that do not include such a purpose as "non-forensic medical examinations.") Forensic medical examinations are funded by the police on a case-by-case basis. Funding for non-forensic examinations was unresolved until 2017—ten years after the first Barnahus opened—when a corresponding funding programme was

established. These examinations were then placed under a section in the Health Personnel Act (2 July 1999, no. 64), and the responsibility for the funding of all non-forensic medical examinations was placed with the regional health authorities.[2]

The provision of medical examinations in Barnahus is regulated in two formal documents: the general Barnahus guidelines (Directorates of Police, Family, and Health, 2016) and the specific guidelines for medical examinations in Barnahus (Directorate of Health, 2019). Both documents describe the target group for medical examinations, while the latter also details competence requirements for the professionals involved, as well as procedures. Each Barnahus also has a formal agreement with its health region that specifies the responsibilities of the parties: while the Barnahus is responsible for providing equipment and facilities for medical examinations (which include functioning IT systems) and for summoning medical staff to scheduled examinations, the health sector is responsible for recruiting and qualifying doctors and nurses to conduct medical examinations in Barnahus, establishing supervision and mentoring systems, and ensuring the existence of necessary resources for conducting medical examinations and writing forensic reports.

The share of Barnahus cases that include a medical examination has been consistently low among Norwegian Barnahus, although the number has gradually increased. In 2012, 13% of all Barnahus cases included a medical examination (Stefansen et al., 2012); in 2019, after the guidelines from the Directorate of Health had been implemented, the corresponding share was 24%. The share dropped to 21% in 2020, and then to 19% in 2021—most likely because of the COVID-19 pandemic (Directorate of Health, 2022; Police Directorate, 2021).

During the whole period from 2012 to 2021, most of the medical examinations conducted in Barnahus were forensic medical examinations ordered by a prosecutor. Non-forensic medical examinations are rare and are primarily carried out in one Barnahus. In 2021, less than 1% of children referred to a Barnahus received a non-forensic medical examination. The present situation in Norway is thus that, although a

[2] "Health personnel must ensure that the health care does not cause unnecessary loss of time or expense to the patient, health institution, social security system, or others" (section 6, our translation).

system of provision and funding is in place on paper for both forensic and non-forensic medical examinations, approximately eight out of ten children referred to Barnahus are not offered a medical examination at the Barnahus following the forensic interview.

The issue of limited use of medical examinations and the dominance of forensic medical examinations in Barnahus is not exclusive to Norway. Researchers have described a similar situation in Sweden (Åström & Rejmer, 2008; Barnafrid, 2019), and Iceland is currently revising its system of provision. In Denmark, as well, very few children are offered medical examinations in Barnahus when standard procedures are followed (Spitz et al., 2022).

Theoretical Grounding

The Barnahus model has been described as a social innovation (Johansson & Stefansen, 2020), i.e. a new way of approaching an existing social problem that has the potential to drive change in its surrounding field of services as well. But from an institutional perspective, which we apply here, while organisations are malleable and can adapt to new challenges, they are also resistant to change when practices are and become routinised. Standstill in professional development is thus something that will become visible over time as an organisation becomes more settled—which the Norwegian Barnahus model is. To understand how institutional resistance to change is produced in Barnahus we draw specifically on the concept of *institutional inertia*, as it directs attention to "when and why organizations ignore, adopt, modify, maintain and abandon practices and the way intra-organizational institutional pressures shape, direct and constrain these processes" (Aksom, 2022, p. 464). The concept of institutional inertia is particularly relevant for our empirical case as it emphasises how resistance evolves over time, and not only during the adoption stage of new ideas and practices but also, more importantly, during the post-adoption stage (Aksom, 2022). According to Aksom (2022), initial change can occur, but it may lead to organisations reverting back to previous and familial routines, practices, and

structures, illustrating how intra-organisational resistance can be understood as having long-lasting impacts on existing institutional routines (Aksom, 2022; Firsova et al., 2022). Following Aksom, our analysis spans the adoption and post-adoption phase of Barnahus in Norway and is based on empirical data gathered in 2012 and 2021.

In understanding resistance to change in the Barnahus model, it is important to recognise the model's hybridity (Johansson & Stefansen, 2020; Stefansen et al., 2023). The Barnahus model brings together professionals who are simultaneously committed to the joint task of providing justice and support to victimised children and to their own professions' standards, core values, and ideals. These factors again serve different public value goals—which are embedded in different external "governance regimes" (Emerson et al., 2012). And since Barnahus is a hybrid organisation, the analysis of institutional resistance needs to encompass how different mandates (and their respective organisations and practices) become institutionalised—or non-institutionalised—to a varying extent, as well as over time (Aksom, 2022).

Mair et al. (2015) underline how hybridity simultaneously represents a possibility for innovation and new practices and is easily challenged. Drawing on Battilana and Dorado (2010), Johansson and Stefansen (2020, p. 6) have suggested that the Barnahus model "can be seen as a somewhat unstable hybrid organization," since the balance between the penal and welfare tracks of the model may shift over time. Researchers have proposed that the Barnahus model in both Sweden (Johansson, 2011, 2017) and Norway (Bakketeig, 2017; Stefansen et al., 2023) is skewed towards the penal track, since activities within this track tend to become prioritised over activities in the welfare track, especially when the case load increases; this scenario is often conceptualised as a process of *juridification*. In Norway, the potential of medical examinations to contribute more within the welfare track is currently hampered because of such examinations' strong link to the penal track (Stefansen et al., 2023). The institutional dynamics that have produced this situation have yet to be further explored.

Methods and Data

The analysis presented below draws on data from two evaluation studies led by the first and second authors of this chapter (Bakketeig et al., 2012, 2021; Stefansen et al., 2012). Both studies were commissioned by the Police Directorate and were designed as mixed-methods studies. In 2012, six of the then seven existing Barnahus were included in the study, while all 11 Barnahus (with sub-units) across Norway were included in 2021. For both studies, we made field visits to the Barnahus as well as conducting individual interviews with Barnahus leaders and focus group interviews with the social workers and psychologists who were employed as permanent staff. The interviews were broad, and they covered all aspects of the Barnahus model, including the organisation and purpose of medical examinations in Barnahus. We also gathered data from collaborating partners both through interviews and surveys. For the analysis in this chapter, we draw particularly on the interviews with the Barnahus leaders.

Our analysis also builds on key policy documents issued starting from the early-implementation phase through today, as well as a survey study among doctors affiliated with Barnahus in Norway. The set of documents consists of policy proposals, working group reports, and formal guidelines and legal provisions. The survey data was collected for the 2021 evaluation study. Of the 40 doctors who were affiliated with a Barnahus at the time, 36 answered the electronic questionnaire. The majority of the participating doctors were specialists in paediatric medicine and had substantial experience with conducting forensic medical examinations in Barnahus. The survey covered the doctors' professional background and competence and their work at the Barnahus, as well as systems for supervision and peer support, collaboration with other Barnahus professionals, and viewpoints on different aspects of conducting medical work in a Barnahus setting. Many questions allowed for the possibility of providing written comments, and these comments have also informed our analysis.[3]

[3] The quotes in this chapter have been lightly edited for clarity in English.

We have approached the interviews, documents, and written comments with a primary focus: What can explain the continuous marginalisation of the role of medical examinations in the welfare track of the Norwegian Barnahus model?

Institutional Barriers

Our analysis points to three interlinked institutional barriers towards fulfilling the dual mandate of medical examinations: longstanding *routines* catered to criminal cases, *regulatory issues*, and a lack of *resources* for upscaling.

Routines: From Holistic Idea to Practices Catered to the Penal Track

When the idea of establishing a Barnahus model in Norway was first launched, medical examinations were understood as vital both for securing forensic evidence for criminal cases and for ensuring children's welfare by identifying their healthcare needs. The idea of a medical examination with this dual mandate is evident in (1) the initial private member motion to Parliament in 2004 that Norway should implement the Barnahus model (Document 8:86, 2003–2004), (2) the report issued by Save the Children Norway suggesting that a Barnahus model similar to that in Iceland should be piloted (Skybak, 2004), and (3) the report from a working group appointed by the Ministry of Justice and the Police and tasked with outlining a model that could be piloted (Ministry of Justice and the Police, 2006). The working group report resulted in the establishment of a pilot project with five Barnahus in different cities. Local working group reports described how the model was to be organised, where it was to be located, and what the procedures would be for case processing. In the first of these reports, from the local working group based in Bergen (Barnehuset Region West, 2007), it was suggested that children should be medically examined if relevant to secure evidence, provide treatment, or take other follow-up measures, thus reflecting a

holistic understanding of the role of medical examinations in Barnahus. The group also underlined that the medical examination needed to be of good quality in order to secure not only the forensic value of the examination but also the well-being of the child.

When the first six Barnahus were evaluated in 2012, all were equipped with a medical examination room and had established routines for summoning doctors from local hospitals to conduct the examinations when ordered by the prosecutor. But some observers expressed concern about the rare usage of medical examinations. The Barnahus leaders voiced that prosecutors were too restrictive when considering the possibility that the examination could yield forensic evidence and therefore requested too few examinations, thus suggesting that the leaders did not see requesting medical examinations to be part of their mandate—which at the time was not formally regulated. More recent research from Norway has also pointed to physical health issues as being more or less overlooked in the welfare track, since the clinical Barnahus staff rarely ask children about physical symptoms (Myhre et al., 2019). This situation is not surprising, since the staff's follow-up mandate (according to the Barnahus guidelines) revolves around identifying and relieving psychosocial problems, which is reflected in both their understanding of their role and the practices that have developed over time (Andersen, 2019, 2022, 2024; Bakketeig et al., 2021).

In practice, the routines established during the adoption phase of the model continued through the latest evaluation in 2021. In the whole period, medical examinations have primarily been ordered by the prosecutor and conducted on a case-by-case basis. Only one Barnahus has taken a different approach by offering non-forensic medical examinations on a regular basis. As yet, no system is in place to assess whether a non-forensic medical examination should be conducted in cases where the prosecutor has not ordered a forensic medical examination, aptly illustrated in the following doctor's comment from our survey study:

> Today it's primarily the prosecutor who requests medical examinations. So it's mainly forensic medical examinations that are requested, and many children are not offered a medical examination where their health is the main purpose. I suggest the following [solution]: Health personnel should

> be included in the consultation meeting and provide recommendations on [children's] health care needs.

The survey also documented how the doctors became involved late in the case processing at the Barnahus, and that they only followed the case for a short period of time. The doctors were either present at the Barnahus one day a week to do scheduled examinations or were summoned to the Barnahus on a case-by-case basis. Rather than being involved in discussions about the need for medical examinations, either for forensic or welfare purposes, they were on standby. At the Barnahus, their time was primarily dedicated to the actual examination, and they most often returned to the hospital to write the forensic statement.

A recent report from the Directorate of Health (2022) points to the problems that can arise from the current routines: "The health personnel in our material feel that they are not very involved and are not very integrated in the Barnahus services, and medical examinations are presently a downgraded part of the services" (p.12, our translation). Routines for passing on medical information to professionals involved in the case from the welfare track side are also generally lacking in many Barnahus—which hampers the possibility to follow up on a child's healthcare needs, as illustrated in this doctor's description:

> There's also a missing or unclear connection to the responsibility to follow up on possible findings, because it's not always the case that what you find gives the child a right to follow-up [treatment] in the secondary health care service. To discover health care needs in otherwise healthy children is normally the responsibility for the primary health care service, and it feels unfortunate and incorrect to jump over this element for most children [who are referred to Barnahus]. The link to the child's legal guardian (in cases where a legal guardian is there for the examination) is also unclear and difficult to follow up after the examination.

But different practices may have been in place among the various Barnahus in this respect; some doctors described well-functioning routines for receiving and passing on medical information, which suggests that room for improvement does exist within the current system:

> We have good routines at the Barnahus for what's included in the case file [which the doctor receives prior to the medical examination]: the notification of concern [to the child welfare service], the mandate for the forensic medical examination, and a short summary of the forensic interview. We also provide a short briefing to the Barnahus staff and the child welfare services if they accompany the child, and to the prosecution if the examination reveals findings [relevant to the criminal case].

The weak link between the medical examination and the welfare track was however evident in the lack of routines in most Barnahus for passing on medical findings to the Barnahus staff and other professionals. Doctors generally did not participate in follow-up meetings between the professionals involved in the criminal case after the forensic interview has been conducted (the second consultation meeting) even though medical personnel who have performed the medical examination are mentioned among those who should participate in these meetings in the general Barnahus guidelines (section 5.3.5.1).

Regulatory Issues: Inconsistencies in the Scope and Integration of the Dual Medical Mandate

Our analysis also points to several regulatory issues that hamper the possibilities of offering medical examinations in Barnahus on a broader scale. One issue relates to inconsistencies about the target group for medical examinations, or the form of universality that is to be applied. The general Barnahus guidelines issued in 2016 by the Directorates of the Police, Family, and Health are unclear about whether medical examinations *should be* offered to all children who are interviewed as aggrieved parties[4] (as stated in section 2.2), or if an examination *can be* offered, as stated in section 4.2.2. The guidelines also state that the implementation of this new obligation—to offer medical examinations on a standard basis—must await a plan of action from the Ministry of Health and Care

[4] Children who witness violence against a family member are also considered victims in the Norwegian penal act (Directorates of the Police, Family, and Health, 2016) and thus are included among the aggrieved parties mentioned in the general Barnahus guidelines.

Services to increase capacity, which suggests that the intention is to scale up to a more universal offer, albeit one that is restricted to children who are referred to Barnahus as aggrieved parties.

The 2019 national guidelines for medical examinations in Barnahus issued by the Ministry of Health and Care Services are also inconsistent in terms of the target group. The guidelines first state that "all children" (p. 4) referred to Barnahus for a forensic interview should be offered a medical examination, hence indicating that children who have a prosecutorial status as witnesses, and who are not suspected of being victims of violence and abuse themselves, should also be included in the target group. But the guidelines also describe that Norway's health regions have been instructed that medical examinations in Barnahus should be offered to children who have "experienced abuse" (p. 4), thus indicating a narrower target group more in line with the general Barnahus guidelines. Similar inconsistencies also exist in the report on medical examinations in Barnahus issued by the Directorate of Health in 2022, which may be linked to different views on the scope of the medical mandate in Barnahus among the health and justice authorities. For Barnahus, the different expectations produce regulatory vagueness about the target group for medical examinations, as well as which types of procedures and routines should be developed for a more universal provision of medical examinations that caters to the dual medical mandate.

Another regulatory issue concerns the possibility for doctors (and other medical personnel) to participate in the formal multi-professional consultation meetings at Barnahus, where participants plan the forensic interview and discuss further case processing. Earlier, we described doctors' frustration that their current role was restricted to simply conducting the medical examination. In their view, their earlier involvement could ensure that the medical health perspective would be given more weight in the processing of cases, which could possibly lead to an increase in both forensic and non-forensic medical examinations.

The general guidelines for Barnahus from 2016 do not include medical personnel among those who can attend the initial consultation meeting, and our survey showed that the current practice was in accordance with this regulation. But both the recent report from the Directorate of Health (2022) and the national medical guidelines

from 2019 recommend that medical personnel should participate in the formal consultation meetings. According to the medical guidelines, full integration in the Barnahus collaboration, including consultation meetings, is necessary to assess whether a medical examination is needed. The medical personnel also need to receive necessary medical information about children and their cases in order to adapt the medical examinations to specific children and their psycho-social situations, as well as to secure forensic evidence and medical documentation. Allowing doctors to participate in the initial consultation meeting, however, would require a change in the statutory provisions on facilitated interviews (FOR-2015-09-24-1098, §7), since medical personnel are not mentioned among those who can be present. Medical personnel are also not among those explicitly mentioned in the Criminal Procedure Act (see §239d) among those who are allowed to observe the investigative interview, which also excludes them from this part of the case processing. Hence the Barnahus cannot change their routines before these regulations allow for the participation of medical personnel.

The Barnahus model is also regulated by a complex set of other legal provisions, which can pave the way for misunderstandings. The report from the Directorate of Health (2022) shows that some Barnahus employees feel that the Norwegian legislation is vague about who has the authority to refer a child to non-forensic medical examinations. According to the same report, however, this question is partly resolved through the National Insurance Act (28. February 1997 no 19) and the statutory provision about out-patient health services in the specialist health service (FOR-2007-12-19-1761), which regulates who has the authority to claim reimbursement and claim equity of patients within specialist health services. Beyond this provision, however, no legal regulations stipulate who can refer people to medical help—which, according to the Directorate of Health, implies that anyone employed at a Barnahus can refer a child to a medical examination. The lack of knowledge in Barnahus about who holds the legal authority to refer a child to a non-forensic medical examination has likely contributed to the rarity of such examinations, which is an understanding also shared by the health authorities. The report from the Directorate of Health (2022, p. 19) thus underlines the necessity for developing routines within the Barnahus

to ensure that children are offered a medical examination based on a thorough assessment. But for Barnahus to take on this responsibility, it would need to be included in the general Barnahus guidelines, which is currently not the case.

Another area where the regulations are insufficiently clear among Barnahus employees relates to who has the legal authority to consent to non-forensic medical examinations on behalf of children in cases where one or both parents are suspects in the criminal case. Starting at age 16, children can consent on their own behalf; for younger children, their parents hold the right to consent on their behalf due to their parental rights. In this situation, however, the parents and the child may have conflicting interests. When this is the case, a legal guardian may be appointed according to the Guardianship Act (26. March 2010 no 9, section 16) and issued the authority to consent on behalf of the child. A widespread understanding in Barnahus is that the legal guardian lacks the authority to consent to a non-forensic medical examination on behalf of a child. The Directorate of Health report (2022), however, points out that this interpretation is incorrect, at least in terms of medical examinations conducted on the same day as the forensic interview at the Barnahus, since both the Guardianship Act and its preparatory work indicate that this authority lies within the mandate of the legal guardian. The non-forensic medical examination is also explicitly mentioned in the standard text on mandates for legal guardians, appointed by the county governor in Oslo and Viken Counties, thus mirroring the same view. If the medical examination is to be done sometime after the forensic interview has been performed, then the situation might be different, since the reasons prohibiting the parents from consenting on behalf of the child might no longer be present. Under these circumstances, the parents' consent would be required if they are holders of parental rights and if the child is younger than 16. Even though the question of consent according to the health authorities is at least partly resolved in the present regulations, the current practice in Barnahus reflects a need for more information on how the regulations should be interpreted, as well as guidance on the routines that must be in place for obtaining a valid consent to non-forensic medical examinations. This situation again

would require clarification of the target group for such examinations: whether they should be offered to all children interviewed in Barnahus or only to those interviewed as aggrieved parties.

Resources: Little Capacity for Upscaling

The rarity of cases that include a medical examination has been a continuous source of concern ever since the Barnahus model was implemented, and an explicit goal from national authorities is to upscale this part of the Barnahus operation. But what, exactly, medical examinations in Barnahus should entail is not part of the discussion. As mentioned earlier, medical examinations today are performed according to an extensive social paediatric protocol, regardless of the purpose of the examination (forensic or not). Most Barnahus observers take for granted that upscaling means a more universal offer of social paediatric medical examinations, which require specialist training and is time consuming. This view is explicated in the national medical guidelines from 2019 and is supported by Barnahus leaders and doctors alike.

For doctors, setting the protocol aside would mean going against agreed-upon medical standards for the assessment of vulnerable children's healthcare needs, as illustrated in this quote from our survey study: "It's important to sustain the quality of what we deliver and not increase the number of cases at the expense of quality." To date, no one has fully acknowledged the resource requirements for upscaling to a universal offer of medical examinations, based on the social paediatric protocol. Upscaling would require investments on the Barnahus side, and thus for the justice sector where Barnahus is affiliated. Investments would include additional examination rooms and medical equipment, which are minor costs compared to the costs involved for the health sector. Even though not all children summoned to Barnahus will need a medical examination, the goal of having a more universal provision of medical assessment in Barnahus is hardly within reach in any foreseeable future: Only one in five cases presently include a medical examination, and qualified doctors are already a scarce resource in Norway's health regions (Bakketeig et al., 2021; Directorate of Health, 2022). Such is the situation, despite the fact

that Norway's health regions in 2016–2017 were instructed to develop sufficient competence and capacity in order to be able to offer children interviewed at Barnahus medical examinations (Directorate of Health, 2022, p. 13).

In our survey, we asked the Barnahus doctors about how realistic they thought the plan to upscale to more universal provision in their respective health regions was. Close to half the doctors indicated the capacity to do more forensic medical examinations in their health region. Their answers most probably reflect their experience that prosecutors are generally restrictive when considering the need for forensic medical examinations, and that upscaling would not mean a considerable increase in such examinations—at least not in the short term. The possibility of upscaling to offer medical examinations in *all* Barnahus cases was another matter. Six out of ten doctors answered with a definitive "no" to this question, while only a quarter answered with a definitive "yes." The positive answers should be interpreted with caution, however, given the rarity of cases that include a medical examination today.

We should note that the doctors differed somewhat in their view about the universal provision of full medical examinations in Barnahus. Some doctors were open to alternatives, for instance, the use of a screening model, or the idea that medical professionals should be more involved in deciding which children should be examined:

> Medical examinations should be mandatory to offer to all children who come to Barnahus. Alternatively, health personnel should play a larger role in decisions on who should be given the offer of a medical assessment.

Some doctors also stated that medical examinations were unnecessary in certain types of cases and that, given the limited resources, more serious cases should be prioritised. The Directorate of Health report (2022) also brought up the issue of differentiation, or finding the right level of universality. According to the report, medical examinations in Barnahus could be unwarranted in cases where the health of the child has been assessed elsewhere, the child does not belong to the target group, or the incident happened a long time ago.

The doctors' survey answers also indicated the existence of unresolved resource issues in the present situation, which provides important context to their answers about upscaling: 22% indicated that they sometimes had too little time for a medical examination, and only 19% stated that they always had enough time to write the forensic report. For most (61%), whether they had enough time varied, while 17% usually experienced problems finding the time. The following quote from one doctor is illustrative of these findings:

> We have the capacity to do more forensic medical examinations, but it's a challenge to write the reports from them. [If we were to upscale], the hospital would need to allocate enough time for report writing, court appearances, consultation meetings, and so on.

In addition, the doctors' answers indicated major differences between hospitals in terms of their quality control and psycho-social support systems, which also points to a lack of priority for medical work in Barnahus in Norway's health regions. Only four out of ten doctors answered that their hospital units regularly conducted case reviews—which is a well-established method for quality assessment and knowledge transfer. Some doctors described how quality control routines were lacking altogether in their hospitals:

> We don't have any systematic quality control of forensic medical examinations. No time is allocated to training, reviewing reports, or supervising [inexperienced doctors'] writing or preparation before [they] must give testimony in court. We really need to establish a system for these things. Managers who don't have experience with this field of expertise don't understand this need, and as long as there aren't any official recommendations, they won't follow through.

As illustrated, the issue of funding of non-forensic medical examinations is much more complex than simply funding doctors' time so they can conduct medical examinations and write reports. The issue also involves recruiting and qualifying doctors and resources for supervision and quality control as well as ensuring their participation in collaborative work throughout case processing.

Concluding Remarks

Drawing on the concept of *institutional inertia* (Aksom, 2022), in the present chapter, we have examined how resistance or standstill can occur within a system designed to work innovatively and to provide momentum to broader societal changes in response to child victimisation (Devaney et al., 2024, chapter 9). Despite clear aims and efforts to the contrary, in the Norwegian Barnahus model, medical examinations have become closely intertwined with the penal track, while their role in the welfare track has been sidelined. The reasons for this development are complex. While the professionals and agencies involved generally understand that medical examinations in Barnahus have a dual mandate and serve important roles in both the penal and welfare tracks of the model, the established system of institutional routines, regulations, and funding programmes seems to have facilitated more of a bifurcation in how the system "thinks" about medical examinations in Barnahus.

Our analysis shows some of the challenges involved when a hybrid practice is to be implemented in an "unstable" hybrid organisational model (Johansson & Stefansen, 2020) that (in the case of Barnahus) has become increasingly skewed towards the penal mandate (Stefansen et al., 2023). When the Barnahus model was first implemented in Norway in 2007, these challenges were only partly understood, and many of the routines for case processing through the Barnahus were established according to the logic of criminal cases, with the forensic interview as the primary task to be coordinated. The room for integrating the medical staff—and making use of their expert competence in the whole process of the case—has been hampered from the outset. Progress has been held up by legal and administrative regulations that exclude medical staff from key collaborative arenas in the preparatory stage of case processing (such as the formal consultation meeting) and by weak or absent routines for information sharing and collaboration with the professionals responsible for children's recovery and welfare during the follow-up phase. Their possibility of offering medical assessments to a broader group of children is also restricted due to the perceived lack of clarity in which circumstances Barnahus staff must refer children to non-forensic medical examinations and their perception of their role in

terms of follow-up. Non-forensic medical examinations are thus a largely non-institutionalised practice, even though they are clearly included in the idea behind the Barnahus model as a holistic service.

All in all, the present guidelines do not sufficiently explicate the Barnahus mandate to coordinate and facilitate medical examinations within the welfare track. The Barnahus staff also see their role as primarily linked to ensuring the psycho-social welfare of children and their families. In addition to securing the necessary legal basis for medical examinations, including having sufficient legal clarity, the incorporation of the medical mandate across the penal and welfare tracks thus entails changes both in organisational routines and professional "gaze" and practices, both of which are more difficult to achieve when a practice has become more set. In the Norwegian context, the medical examinations have become more institutionalised within the penal track than the welfare track. The barriers can be understood as a clash between external governance regimes (Emerson et al., 2012) and existing institutionalised intra-organisational norms (Aksom, 2022) related to the respective collaborating agencies and professionals. Medical staff often struggle with long-lasting intra-organisational routines, established within their ordinary healthcare organisations, while non-institutionalised routines for practices that fulfil the dual medical mandate within the hybrid Barnahus organisation present their own challenges. As Aksom (2022) acknowledges, this scenario tends to push organisations back towards previously routinised practices and structures, thus making successful changes difficult to achieve.

Another contributor to institutional inertia is the resource situation in the healthcare sector and the fact that qualified doctors are a scarce resource. Even if Barnahus do succeed in establishing new routines for needs assessments and referrals to non-forensic medical examinations, the goal of upscaling to the universal provision of full-scale social paediatric medical examinations at the Barnahus is not within reach in any foreseeable future. To date, policy documents have not sufficiently addressed this issue. Such documents include the Barnahus guidelines and the latest report from the Directorate of Health (2022), which assumes that medical examinations in Barnahus should be done according to the social paediatric protocol and do not discuss alternative systems of provision.

Universal provision can be achieved through other organisational setups, however. In a trial project in Denmark, all children suspected of having experienced violence and abuse in close relationships, and who were referred to the Barnahus via the Copenhagen police for an investigative interview, were offered a forensic medical screening (Spitz et al., 2022). One of the aims of that project was to strengthen the child's rights by documenting traces of physical harm to the child caused by being exposed to violence, and, on a qualified basis, optimising further follow-up of the child within the legal, medical, and social systems. Based on parental consent, the examination consisted of a comprehensive forensic examination combined with an examination of the child's general health and well-being, consistent with what we have referred to as Barnahus's "dual medical mandate." Within three days, the forensic examinator issued a preliminary conclusion that was shared with the prosecutor; based on this conclusion, the prosecutors decided if they would ask for a full forensic medical statement, which could be used as a legal document. Among the children who were examined for the trial project, almost half showed traces of abuse and/or illness. The report concluded that the project had contributed to a stronger evidential basis in criminal cases, as well as securing more children's medical follow-up after the investigative interview. The strength in this trial project seems to lie in its universalism, since all children who are interviewed at Barnahus are offered an examination and are examined if their legal guardian consents. This routine removes the assessment of whether an examination is necessary and gives the prosecutor a better foundation for deciding if any medical evidence is relevant to the penal case.

One question that could be raised from our analysis is whether children who are referred to Barnahus for a forensic interview should have a legal right to a medical examination. Making medical examinations a legal right would strengthen Barnahus's obligation to offer such examinations, and to establish necessary routines for the follow-up of any healthcare needs that are identified in collaboration with medical personnel. How such a right could be regulated within the Norwegian legislation would first need to be assessed. Another necessary precondition for such a system to function is that sufficient resources must exist in the healthcare sector to educate and allocate medical personnel to

conduct medical examinations in Barnahus on a much larger scale than is the case today.

Legal changes take a long time. In the short term, progress is possible by implementing new guidelines that explicate the responsibilities of the Barnahus staff for referrals to medical examinations, and the possibilities of acquiring consent from a child's legal guardian in cases where the parents and the child have conflicting interests. More can be done within the present regulatory system to involve doctors in multi-professional consultation meetings at Barnahus and to develop routines that ensure that any medical health needs that are identified are attended to after the forensic interview has been completed.

For countries that are piloting or implementing the Barnahus model, some general advice from our analysis is that the role of Barnahus staff in medical matters must be explicated in Barnahus guidelines as part of the coordinating responsibility. The quality standards from PROMISE can be a starting point for how to carve out the medical mandate of national Barnahus models. Such standards are general in nature, however, and must be complemented by context-specific analyses of both the formal and practical obstacles to fulfilling the dual aim of medical examinations.

References

Aksom, H. (2022). Institutional inertia and practice variation. *Journal of Organizational Change Management*, *35*(3). https://doi.org/10.1108/JOCM-07-2021-0205

Andersen, L. C. (2019). Mellomromsarbeid—Om barnehusrådgiveres arbeidspraksiser. In K. Skjørten, E. Bakketeig, M. Bjørnholt, & S. Mossige (Eds.), *Vold i nære relasjoner* (pp. 178–194). Universitetsforlaget.

Andersen, L. C. (2022). Phronetically guided use of knowledge: Interstitial work at Barnahus and how it can inform the knowledge debate in social work. *British Journal of Social Work*, *52*(2), 1038–1054.

Andersen, L. C. (2024). Enabling and preserving situational social work in Barnahus: A vulnerable jurisdiction in the crossfire between juridification and psychologisation. In S. Johansson, K. Stefansen, E. Bakketeig, & A.

Kaldal (Eds.), *Justice and recovery for victimised children: Institutional tensions in Nordic and European Barnahus models*. Palgrave Macmillan.

Åström, K., & Reimer, A. (2008). *"Det blir nog bättre för barnen": Sluttrapport i utvärderingen av nationall forsöksverksamhet med barnahus 2006–2007.* Lund University, Sociology of Law, report no. 7/2008.

Bakketeig, E. (2017). Exploring juridification in the Norwegian Barnahus model. In S. Johansson, K. Stefansen, E. Bakketeig, E., & A. Kaldal (Eds.), *Collaborating against child abuse: Exploring the Nordic Barnahus model*. Palgrave Macmillan.

Bakketeig, E., Stefansen, K., Andersen, L. C., & Gundersen, T. (2021). *Evaluering av Statens barnehus 2021.* NOVA, report no. 12/21.

Bakketeig, E., Berg, M., Myklebust, T., & Stefansen, K. (2012). *Barnehusevalueringen 2012, delrapport 1: Barnehusmodellens implikasjoner for politiets arbeid med fokus på dommeravhør og rettsmedisinsk undersøkelse.* Politihøgskolen, report no. 6/2012.

Barnafrid. (2019). Slutrapport—Utvärdering av Barnahus 2019. Linköpings universitet.

Barnehuset Region West. (2007). Rapport fra planleggingsgruppen, 1 June 2007 (unpublished report).

Battilana, J., & Dorado, S. (2010). Building sustainable hybrid organizations: The case of commercial microfinance organizations. *Academy of Management Journal*, *53*(6), 1419–1440.

Criminal Procedure Act 22, May 1981, no. 25: Lov om rettergangsmåten i straffesaker (Straffeprosessloven).

Devaney, J., Mitchell, M., Alaggia, R., & Gray, C. (2024). Papering over the cracks or rebuilding the system: Opportunities and challenges for the Barnahus model in the United Kingdom. In S. Johansson, K. Stefansen, E. Bakketeig, & A. Kaldal (Eds.), *Justice and recovery for victimised children: Institutional tensions in Nordic and European Barnahus models*. Palgrave Macmillan.

Directorate of Health. (2019). Nasjonale faglige råd om medisinske undersøkelser i barnehus. https://www.helsedirektoratet.no/nyheter/nasjonale-faglige-rad-ved-medisinske-undersokelser-i-statens-barnehus

Directorate of Health. (2022). Medisinske undersøkelser ved Statens barnehus—Utfordringer og anbefalinger. https://www.helsedirektoratet.no/rapporter/medisinske-undersokelser-ved-statens-barnehus--utfordringer-og-anbefalinger

Directorates of the Police, Family, and Health. (2016). Felles retningslinjer for Statens barnehus.

Document 8:86. (2003–2004). Privat forslag fra stortingsrepresentantene May Hansen og Inga Marte Thorkildsen. https://www.stortinget.no/Global/pdf/Representantforslag/2003-2004/dok8-200304-086.pdf

Emerson, K., Nabatchi, T., & Balogh, S. (2012). An integrative framework for collaborative governance. *Journal of Public Administration Research and Theory*, 22(*1*), 1–29.

Firsova, S., Bilorus, T., Olikh, L., & Salimon, O. (2022). The landscape of post-institutional practice variation theories: From travelling ideas to institutional inertia. *International Journal of Organizational Analysis.* https://doi.org/10.1108/IJOA-12-2021-3061

FOR-2015–09–24–1098, §7: Forskrift om avhør av barn og andre særlig sårbare fornærmede og vitner (tilrettelagte avhør).

FOR-2007–12–19–1761. Forskrift om godtgjørelse for å yte poliklinisk helsehjelp i spesialisthelsetjenesten (poliklinikkforskriften).

Guardianship Act. (26. March 2010 no 9, section 16). Lov om vergemål (vergemålsloven).

Health Personnel Act. (2 July 1999, no. 64). Lov om helsepersonell m.v. (helsepersonelloven).

Johansson, S. (2011). Juridifiering som institutionell förändring: Om mötet mellan straffrätt och socialrätt vid interorganisatorisk samverkan. *Retfærd: Nordisk juridisk tidsskrift*, 34:4(*135*), 38–59.

Johansson, S. (2017). Power dynamics in Barnahus collaboration. In *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model*. In S. Johansson, K. Stefansen, E. Bakketeig, E., & A. Kaldal (Eds.), *Collaborating against child abuse: Exploring the Nordic Barnahus model*. Palgrave Macmillan.

Johansson, S., & Stefansen, K. (2020). Policy-making for the diffusion of social innovations: The case of the Barnahus model in the Nordic region and the broader European context. *Innovation: The European Journal of Social Science Research, 33*(*1*), 4–20. https://doi.org/10.1080/13511610.2019.1598255

Johansson, S., & Stefansen, K. (2024). Included on paper, excluded in practice—Or vice versa? Formal and actual target groups of Barnahus across jurisdictions. In S. Johansson, K. Stefansen, E. Bakketeig, & A. Kaldal (Eds.), *Justice and recovery for victimised children: Institutional tensions in Nordic and European Barnahus models*. Palgrave Macmillan.

Johansson, S., Stefansen, K., Bakketeig, E., & Kaldal, A. (Eds.). (2017). *Collaborating against child abuse: Exploring the Nordic Barnahus model*. Palgrave Macmillan.

Mair, J., Mayer, J., & Lutz, E. (2015). Navigating institutional plurality: Organizational governance in hybrid organizations. *Organization Studies, 36*(6), 713–739.

Ministry of Justice and the Police. (2006). Barnas hus: Rapport om etablering av et pilotprosjekt med ny avhørsmodell for barn som har vært utsatt for overgrep m.m. Justis- og politidepartmentet.

Myhre, M. C., Syringen, F., & Augusti, E. M. (2019). Helse hos barn som kommer til Statens Barnehus. In K. Skjørten, E. Bakketeig, M. Bjørnholt, & S. Mossige (Eds.), *Vold i nære relasjoner: Forståelser, konsekvenser og tiltak* (pp. 270–286). Universitetsforlaget.

National Insurance Act. (28. February 1997 no 19). Lov om folketrygd (folketrygdloven).

Police Directorate. (2021). Statens Barnehus, Årsrapport 2021.

Skybak, T. (2004). *Barnas hus: Et helhetlig og barnevennlig tilbud til barn som har vært utsatt for seksuelt misbruk*. Redd Barna.

Spitz, P., Banner, J., & Belling, B. (Eds.) (2022). *Systematisk retsmedicinsk screening av børn ved mistanke om vold: Børnehus Hovedstaden.* Børnehus Hovedstaden.

Stefansen, K., Bakketeig, E., & Johansson, S. (2023). From dissenting to conforming hybridity—Experiences from a justice sector–affiliated Barnahus model. In A. St. Amand et al. (Eds.), *Contemporary and innovative practices in child & youth advocacy centre models* (pp. 77–97). Presses de l'Université du Québec.

Stefansen, K., Gundersen, T., & Bakketeig, E. (2012). *Barnehusevalueringen 2012, delrapport 2: En undersøkelse blant barn og pårørende, samarbeidspartnere, ledere og ansatte.* NOVA, report no. 9/2012.