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Prevalence and Patterns of Parental Consent in Swedish Child Welfare Services: Exploring the Role of Child Demographics and Procedural Characteristics

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ABSTRACT

Parental consent is a critical prerequisite for children to receive welfare interventions following an assessment of need. Without such consent, the likelihood that children will receive necessary interventions decreases substantially. Despite its importance, research on parental consent and the factors influencing it remains limited across most welfare contexts. Understanding these patterns is essential for designing effective child welfare policies and ensuring equitable access to interventions. This study addresses this gap by examining the prevalence of documented parental consent for child welfare interventions in Sweden and by exploring differences between full, partial and absent consent in relation to the sociodemographic characteristics of the child and procedural factors. The analysis draws on survey data from 11 705 child welfare investigations involving children aged 0–17 years, of whom 52.2% were boys and 47.8% were girls, and employs multinomial regression to evaluate the relationship between predictor variables and consent outcomes. Results are presented via average marginal effects (AMEs). The findings indicate that most parents provide full consent, although partial consent and refusal also occur. Both child-related sociodemographic factors and procedural characteristics are associated with variations in consent outcomes. The implications of these findings for social work practice and future research are discussed.

1 | Introduction

Informed consent is a cornerstone of professional social work, emphasizing individuals' autonomy to decide whether to participate in interventions recommended by social workers (Pelton 2016; Regehr and Antle 1997). Consequently, consent involves trust in the potential benefits of the proposed interventions (Nilsson et al. 2023; Nilsson and Landstedt 2022; Sztompka 1999). These principles are equally relevant in child welfare services (CWS), where decision-making is dual, as it concerns both parents and children (Enroos et al. 2021; Reamer 2018). This duality is particularly evident in family-oriented systems such as Sweden (Gilbert et al. 2011), where most interventions rely on voluntariness and cooperation. Nevertheless, parental consent or refusal to an intervention generally supersedes that of the child (SFS 2025:400).

Compared to child-protection-oriented systems, such as those in the United States and the United Kingdom, where parental refusal can more readily be overridden (Berrick et al. 2023; Connolly and Katz 2019; Skivenes and Benbenishty 2022), consent thus plays a more decisive role in Sweden. Without parental consent, children's access to support may be limited despite substantial needs (Heimer and Pettersson 2023). Swedish research further shows that parental refusal is a key reason why interventions are not implemented (Loebs and Persdotter 2025), even though coercive measures are available (SFS 1990:52).

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Research in other contexts supports this claim as well (e.g., O'Mahoney et al. 2020; Pelton 2016), and Lonne et al. (2016) conclude that informed consent in child welfare is a key feature of ethical and rights-based social work practice centred on the child's best interests. Even so, O'Mahoney et al. (2020) assert that studies on consent within CWS are largely absent, and Enroos et al. (2021, 853) argue that issues of consent are so poorly studied that it is possible to speak of "conceptual neglect." Despite the importance of parental consent for implementing most CWS interventions, it is therefore unclear to what extent parents consent to recommended interventions following an assessment of need, how consent patterns are structured and whether differences exist between cases of consent and refusal.

This article addresses this knowledge gap by presenting a Swedish study on parental consent to CWS interventions, as documented in case files following an assessment of need. The study specifically aims to determine the degree of parental consent and to examine differences among cases of full, partial and no consent. To explore these issues in depth, the following research questions were formulated:

- To what extent do parents consent to recommended interventions after an assessment of need, and how do patterns differ between cases of full and partial consent?
- How are patterns of consent related to sociodemographic characteristics of the child, such as age, sex, origin, neurodevelopmental disorders (NDD) and living conditions?
- How are variations in consent patterns associated with procedural characteristics, including identified risk, application versus referral, child participation in the investigative process and prior CWS experience?

1.1 | Determinants of Parental Consent

Given that consent in child welfare is shaped by relational, institutional and contextual conditions, it is necessary to examine empirically how different factors influence parental decision-making in practice. Based on prior research, this study focuses on two overarching categories of determinants: child-related sociodemographic characteristics and procedural features of the assessment. This choice is theoretically grounded in a relational understanding of autonomy, where decision-making is embedded in social contexts while also being influenced by individual factors and interactions between the parties involved (Mackenzie and Stoljar 2000; Leviner 2014).

It is also supported by empirical findings suggesting that parental consent varies according to child and family characteristics. Previous studies have shown, for example, that parents of girls, older children and children diagnosed with NDD are more likely to consent to interventions, whereas consent is less common in two-parent households and families with migrant backgrounds (e.g., Kagan and Zychlinski 2016; Rustad et al. 2025; Loebs and Persdotter 2025). However, existing evidence remains limited and fragmented, with most studies focusing on specific interventions or service contexts rather than CWS investigations as a whole. Accordingly, this study examines whether and how these sociodemographic characteristics are related to consent outcomes (full, partial, or no consent), as they may shape both parental perceptions of need and professional assessments of risk. For example, age-related differences in consent may reflect variation in perceived need, parental authority and the legitimacy of interventions across developmental stages. Similarly, differences related to the child's origin or living conditions may capture variations in trust, norms and prior experiences with services that influence engagement with social work interventions (Nilsson and Landstedt 2022; Enroos et al. 2021).

In parallel, procedural characteristics illustrate how institutional processes and relations may shape the conditions under which consent is given. Factors such as the reason for investigation (application versus referral), type of identified risk, prior involvement with services and the child's participation reflect different entry points and trajectories within the child welfare system. From the perspective of autonomy and paternalism, these factors are central, as they signal varying degrees of voluntariness and external influence. Previous research suggests that referral-initiated cases are more likely to involve external pressure and lower levels of parental agreement than application-initiated cases (Storhaug et al. 2025), while recurrent investigations may reflect prior conflict with services (Heimer and Pettersson 2023). Likewise, parental consent appears to be more common in cases involving child behavioural problems than in those concerning adverse home environments (Heimer et al. 2018). Child participation, in turn, is not only a marker of involvement but may also influence how parents interpret both the need for and the consequences of proposed interventions (Petersén et al. 2025).

Thus, this study proceeds from the premise that procedural factors, particularly referral-based investigations, adverse home environments and prior CWS involvement, are likely to be associated with lower levels of parental consent, whereas factors indicating greater engagement (e.g., child participation or application-based entry) are likely to correspond to higher levels of consent. By combining sociodemographic and procedural factors, the study seeks to capture how different relational and institutional configurations may shape consent outcomes. Moreover, it addresses an important gap in the literature by examining parental consent across a large sample of child welfare investigations while simultaneously considering both sociodemographic and procedural determinants of full, partial and absent consent. Previous research has rarely examined these factors within a unified analytical framework (Enroos et al. 2021; O'Mahoney et al. 2020; Sandelin and Petersén 2026).

1.2 | Swedish CSWs and Consent: Context of the Study

In Sweden, CWS are organized within municipal social services and regulated by the Social Services Act (SFS 2025:400). There is no separate legislation governing voluntary child welfare, and interventions therefore require parental consent. Given strong parental rights, parents typically decide on support for children under the age of twelve (Leviner 2014). This framework is complemented by the Care of Young Persons Act, which allows coercive interventions when children are exposed to serious risks and consent is lacking (SFS 1990:52). While decisions regarding compulsory care are made by the courts, CWS are responsible

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for conducting the initial assessment and may apply for such measures, often in the form of out-of-home placements (Heimer and Pettersson 2023).

Within this context, informed consent is a legal and ethical principle in Swedish social services linked to autonomy and self-determination (Akbar 2019; Hepworth and Larsen 1993). In CWS, however, this principle is conditional, as coercive measures may be implemented (SFS 1990, 52). Consent is therefore closely intertwined with coercion, as refusal may lead to compulsory interventions (Leviner 2014; Storhaug et al. 2025). Nonetheless, informed consent and participation remain central to ethical social work practice (Korpinen and Pösö 2021; Lonne et al. 2016).

Determining what constitutes adequate information is challenging and often relies on social workers' discretionary judgements (Kaplan and Bryan 2009). Information may also be selectively communicated in ways that facilitate agreement (Burkemper 2004). Drawing on healthcare research, consent is typically defined as voluntary, informed and based on decision-making capacity (O'Mahoney et al. 2020; Reamer 1987). Empirical studies show, however, that parents may consent due to a perceived lack of alternatives (Storhaug et al. 2025) or to avoid escalation (Petersén et al. 2025), while others decline support despite this (Heimer and Pettersson 2023). Difficulties in understanding the information provided further raise questions about how "informed" consent is in practice (Enroos et al. 2021; Bergström et al. 2023). Against this backdrop, voluntary and coercive care are closely interconnected. Parental consent is given within a conditional framework in which refusal may be overridden if sufficient risks are identified (Pösö et al. 2018; Storhaug et al. 2025). The Swedish system can thus be understood as a hybrid arrangement, where the possibility of coercion shapes how consent is negotiated and enacted in practice.

2 | Methods

2.1 | Design

This study draws data from the ongoing research and development project National Follow-up of the Social Services Transition (NUSO). NUSO aims to establish a sustainable model for national follow-up of social services in Sweden and to monitor changes over time in investigations, assessments and outcomes of social services interventions. During 2024–2025, three substudies have been conducted within NUSO to monitor the baseline of CWS.

The current study is based on data from CWS in 124 municipalities concerning completed child welfare investigations conducted between 1 October 2023 and 31 March 2024. Of the total dataset of 21 858 investigations, need for support or protection from CWS was assessed in 11 705 of these investigations. In these cases, the documentation included information on whether parental consent or refusal of the recommended intervention was given, or if such information on consent was not documented. These cases formed the final analytical sample for this study. Ethical approval was obtained from the Swedish Ethical Review Board before data collection began, Dnr 2023-07959-01.

2.2 | Participants

All municipalities in Sweden were invited to take part in the study, and 124 municipalities (42.8%) decided to participate. When comparing the municipalities that chose to participate with those that did not, we found no significant differences in relation to relevant socio-demographic factors such as the proportion of children, the distribution between boys and girls or children with a foreign background. Participating and nonparticipating municipalities were also broadly similar in terms of size and geographic distribution, suggesting no systematic selection bias. The included municipalities provided data through structured forms on all children who (1) were investigated by the CWS, (2) the investigation was completed between 2023-10-01 and 2024-03-31 and (3) the child was aged 0–17 years. Informed consent was not obtained from the children or their families, as the data provided are stored in the municipalities in accordance with the formal laws on child welfare records.

2.3 | Procedure

Each responsible child welfare social worker filled in a structured form, extracting data from the child welfare investigation report, in an online-based secure platform. If the responsible child welfare social worker were not available, other staff, such as office managers, filled in the forms. The forms were based on the national information structure for child welfare investigations. All municipalities have data from the tax authority on age (achieved age at decision to investigate) and legal sex (boy or girl); all other variables are assessment data retrieved within the child welfare investigation. Data were collected between 2024-04-15 and 2024-06-30. The method used can be described as clinical data-mining (Epstein 2010).

2.4 | Measures

2.4.1 | Outcome—Documented Parental Consent to Recommended Intervention

Data on *parental consent to intervention* were compiled by extracting information from the casefiles detailing parental (guardian) consent. Six response options were available in the following form: (1) consent from all legal guardians, (2) consent is missing from one legal guardian, (3) consent is missing—coercive measures not applicable, (4) consent is missing—coercive measures applicable, (5) consent is present but not reliable and (6) information on guardian consent is missing in the casefile. In the analysis, the response options were coded as follows: (1) full consent—consent from all legal guardians, (2) partial consent—consent missing from one legal guardian and (3) consent missing. Consent or nonconsent was not documented in 7.62%, or 892, of the 11 705 casefiles.

2.4.2 | Predictors

The predictors in this study were selected based on previous research and theoretical perspectives on factors associated with parental consent and/or comparable aspects. The

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following predictors were included: the sex of the child, age of the child, presence of NDD (Kagan and Zychlinski 2016; Loebs and Persdotter 2025; Nilsson and Landstedt 2022), the child's living arrangements (Kassman et al. 2023; Rustad et al. 2025), origin, type of exposure, reason for investigation, type of investigation and the child's participation in the investigative process (Equality Ombudsman 2021; Kalin, Persdotter, et al. 2022; Lundström et al. 2025; Loebs and Persdotter 2025). In this study, these variables were operationalized as follows:

- Information of the *sex of the child* was extracted through the question: "What is the legal sex of the child?" With the response options: boy or girl
- The *age* predictor was constructed from the open statement: "Specify the age of the child at the start of the investigation". In the analysis, it was coded so that it included 2-year steps ranging from zero (0) years to seventeen (17) years.
- Information on NDD was obtained through the question: "Has the child been diagnosed by a doctor or psychologist?" If the answer was yes, the type of diagnosis was specified via an open-ended response. Based on this information, several abstracted dummy variables (yes/no) were created to represent broader diagnostic categories, such as cognitive disorders, psychological disorders and NDD. The abstracted dummy variable concerning NDD was used in the analysis.
- The child's living conditions were operationalized based on responses to the statement: "Specify the child's living conditions at the start of the investigation". The original response options were as follows: (1) with both parents in the same household, (2) shared parenting, (3) mostly or solely with mother, (4) mostly or solely with mother and a new partner, (5) mostly or solely with father, (6) mostly or solely with father and a new partner, (7) own accommodation, (8) other living arrangements and (9) living conditions not specified. For analysis, the item was recoded into four categories: (1) with both parents in the same household, (2) shared parenting, (3) mostly or solely with mother and possible new partner and (4) mostly or solely with father and possible new partner. Categories 7–9 were omitted due to limited data.
- The *child's origin* was measured through statements of whether the child and/or parents were born in Sweden or abroad. In the analysis, this was coded in alignment with the definition of "foreign background" provided by the Statistics Sweden, namely, that person with a foreign background can be either foreign-born or native-born with two foreign-born parents.
- *Type of exposure* was operationalized through an overall assessment of identified risks uncovered during the investigation and included the following categories: (1) no risks identified, (2) adverse home environment, (3) risk-related personal behaviour of the child and (4) both adverse home environment and risk-related personal behaviour of the child.
- *Reason for investigation* was measured through answers on the statement: "Indicate the type of actualization that formed the basis of the investigation" with the following response options: (1) application, (2) referral, and (3) information through other means. Multiple answers to the statement were possible.
- *Type of investigation* was established through information on whether the investigation was a first-time or recurrent investigation
- The *child's participation* was operationalized through the question: "Has the child been involved in investigation interviews, individually or together with a parent/other caregiver?" The response options were yes, no and not indicated in the documentation.

2.4.3 | Statistical Analysis

Chi-square statistics were used in bivariate descriptive analyses, while associations between predictors and the outcome were assessed via multinomial logistic regression (see, e.g., Field 2018), using the *nnet* package in R. Both unadjusted and multivariate models were estimated. Only predictors that were significant in descriptive analyses and/or unadjusted models were included in the multivariate models. All regression results are presented as average marginal effects (AMEs). AMEs indicate the percentage point difference in outcome probability associated with a one-unit change in the predictor (see, e.g., Mize et al. 2019; Mood 2010; Williams and Jørgensen 2023 for further arguments on why AMEs are often preferred over odds ratios or relative risks).

Before fitting the final models, we explored the mechanism of missing data via Little's Test for Missing Completely At Random (Little and Rubin 2002) and by creating binary missingness indicators for the predictor variables and fitting logistic regression models using all other observed variables as predictors. This approach allowed us to assess whether the probability of missingness was associated with known covariates. These analyses, along with our detailed knowledge of the data collection procedures, suggest that missingness is consistent with a Missing At Random (MAR) mechanism. Accordingly, no systematic differences were identified between observations with missing outcome or predictor data and those included in the analytic sample. No issues with multicollinearity between predictors (VIF < 2) were detected.

To assess potential clustering at the municipality level, an intercept-only multilevel model was estimated (see, e.g., Hox et al. 2018) using the lme4 package in R (Bates et al. 2015). The intraclass correlation coefficient (ICC) was very low (≈ 0.035), indicating that only a small proportion of the variance in the outcome was attributable to differences between municipalities. In addition, sensitivity analyses, including municipality as a fixed effect, were conducted, yielding no substantial differences. This suggests that municipality-level clustering is unlikely to meaningfully influence the results and that the substantive conclusions are therefore robust to potential multilevel dependence (cf. Hox et al. 2018; Snijders and Bosker 2012).

Given that data were classified as MAR and the proportion of missing data in the predictors ranged from 0.5% to 15% (see Table 1), missing values were handled using multiple imputation by chained equations (MICE), as implemented in the *mice* package (van Buuren and Groothuis-Oudshoorn 2011). A total of 30 imputed datasets were generated to ensure stable estimation. The outcome variable was included as an auxiliary variable to improve the imputation of predictors and preserve associations

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TABLE 1 | Description of the sample, complete cases and missing, in absolute and relative numbers, $n = 11\,705$.

	Valid, *n* (%)	Missing, *n* (%)
Child's sex		
Boy	5936 (52.2)	329 (2.81)
Girl	5440 (47.8)	
Child's age		
0–2 years	880 (7.6)	
3–5 years	1520 (13.1)	
6–8 years	2039 (17.5)	61 (0.51)
9–11 years	2195 (18.9)	
12–14 years	2769 (23.8)	
15–17 years	2241 (19.3)	
Child diagnosed with NDD		
Yes	2013 (17.2)	0 (0)
No	9692 (82.8)	
Child's living conditions		
Both parents; same household	4179 (37.5)	568 (4.85)
Shared parenting	1777 (16)	
Mostly with mom[a]	4213 (37.9)	
Mostly with dad[a]	968 (8.7)	
Child's origin		
Swedish	6780 (68.2)	1764 (15.07)
Foreign	3161 (31.8)	
Child's participation		
Not involved	2279 (19.8)	
Involved	9210 (80.2)	216 (1.85)
Type of exposure		
None	524 (4.5)	64 (0.55)
Adverse home environment	6937 (59.6)	
Risk-related personal behaviour of the child	1648 (14.2)	
Both home environment and personal behaviour	2532 (21.8)	
Reason for investigation		
Application	2020 (17.4)	83 (0.71)
Referral	9602 (82.6)	
Type of investigation		
First-time investigation	4697 (43.5)	895 (7.65)
Recurrent investigation	6113 (56.5)	

[a]And new partner of applicable.

between outcomes and covariates. Imputed outcome values were not used in the final models, as including model-generated outcome values may introduce bias in regression estimates (Enders 2010; van Buuren 2018). Parameter estimates and standard errors, as well as AMEs, were pooled across imputations according to Rubin's rules (Rubin 1987). Observations with missing outcome data were excluded from the final models using listwise deletion. All analyses were conducted in R, version 4.5.3.

3 | Results

3.1 | Description of the Sample

A description of the sample, including missing values for the predictors, is presented in Table 1. As shown, there is a slight overrepresentation of boys and an underrepresentation of younger children. The majority of children live in households either with both parents or with their mother, and approximately two-thirds have a Swedish background. Child participation in the investigative process is common, and the most frequently reported type of exposure is an adverse home environment. Referrals represent the most frequent reason for initiating investigations, and a slight majority of cases are classified as recurrent investigations.

3.2 | Distribution and Patterns of Consent

Information on parental consent was not documented in 897 (7.62%) of the 11 705 case files, meaning that such information was available in 10 813 cases. As illustrated in Figure 1, most parents in the cases who included information on consent provided full consent to the proposed interventions (63.8%). Nearly one-fourth did not consent, while partial consent—where only one parent agreed—was less common. Although not visible in the aggregated categories presented in Figure 1, compulsory care was deemed necessary in 2.9% of cases without documented parental consent, including 0.7% of cases in which consent was assessed as unreliable.

As shown in Table 2, the bivariate analyses indicate that parents of girls are more likely to provide consent than parents of boys. Additionally, the likelihood of obtaining consent from both parents increases with the child's age, whereas younger children are more often associated with a lack of parental consent. Parents of children with NDD are also more likely to consent. It is also more common for consent not to be given when the child resides with both parents in the same household, while consent from only one parent is more frequently observed when the parents live separately.

Moreover, it is considerably more common that parents of children with foreign backgrounds withhold consent compared to parents of children of Swedish origin. Consent is also more likely to be granted if the child has participated in the investigative process. Conversely, consent is less likely when the identified risks pertain to an adverse home environment, when the investigation is initiated through a referral or when it is a recurrent investigation.

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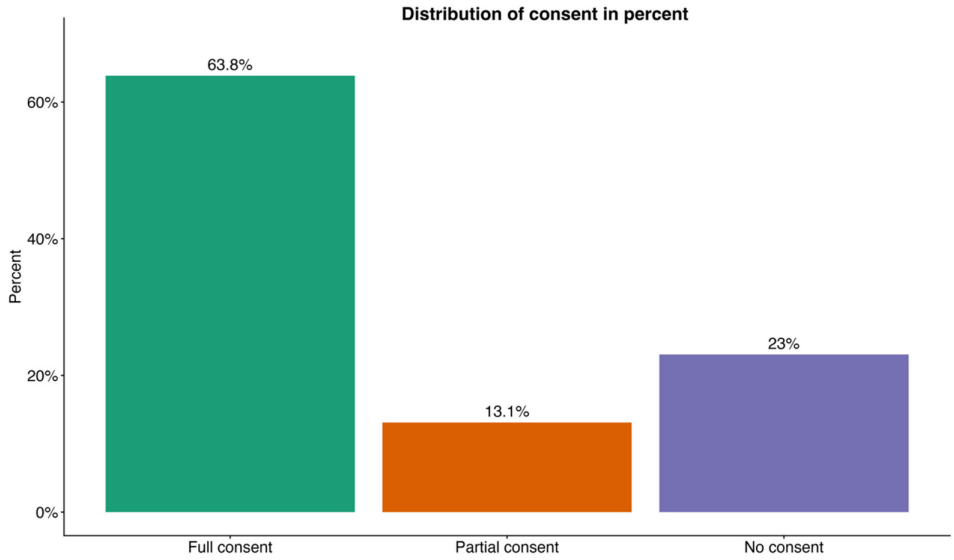

FIGURE 1 | Distribution of consent in the sample in relative numbers, $n = 10\,813$.

In unadjusted multinomial models, the patterns presented in Table 2 above are generally repeated, meaning that all included predictors are significantly associated with different patterns of consent (consent–both parents, consent–one parent and no consent). Consequently, all predictors are included in the multivariate model (see Table 3).

As shown in Table 3, parental consent to recommended interventions varies significantly depending on demographic and procedural characteristics. In cases where full consent is provided, several factors are positively associated with parental consent. Parents are more likely to consent when the child has a NDD (AME: 5.5), lives in a shared parenting arrangement (AME: 4.6), when the child has participated in the investigative process (AME: 7.9), exhibits risk-related own behaviour (AME: 15) or when dual exposure is present (AME: 6.3). Conversely, full parental consent is less likely in cases involving children with a foreign background (AME: −9), when they are exposed to an adverse home environment (AME: −4.3 pp) for children who are referred to CWS (AME: −17.4) and for children subject to recurrent investigations (AME: −6.7).

In cases where only one parent provides consent, the most salient predictor is the child's living arrangement. It is more likely that only one parent consents when the child lives primarily with one parent compared to when the parents live together. In contrast, single-parent consent is less likely when the child is diagnosed with a NDD, as well as in all cases involving child risk exposure. The lowest likelihood of single-parent consent is observed in cases where risk is concentrated in the child's own risk-related behaviour (AME: −10.7).

When examining patterns of parental refusal of intervention, refusal is more prevalent in referral-based investigations compared to those initiated by application (AME: 13.4). Refusal is also more likely when the child is exposed to an adverse home environment (AME: 9.1) and when the child has a foreign background (AME: 8.7). Conversely, refusal is less likely when the child is a girl (AME: −2.1), when the parents are separated (AME range: −4.0 to −11.7) and when risk exposure is concentrated in the child's own risk-related behaviour (AME: −4.3).

Overall, when adjusting for both demographic and case-related factors, child age does not significantly influence parental consent outcomes. However, all other predictors included in the model are statistically significant. Notably, the most influential factor appears to be how the CWS are notified, that is, if the investigation is initiated via application or referral. Given the robustness of this pattern across the full sample, stratified analyses were conducted, dividing the data into application- and referral-initiated groups. To ensure comparability, the same set of predictors was included in each stratified model, as illustrated in Figure 2.

As shown in Figure 2, the stratified analysis generally supports the findings from the full-sample analysis. However, some key similarities and differences between case types also emerge. Because the estimates are derived from separate models, these observations remain valid despite overlapping confidence intervals (CIs), although such overlap should be acknowledged in the interpretation (cf. Cumming and Finch 2005; Schenker and Gentleman 2001).

3.2.1 | Full Consent

In referral-initiated cases, parents are more likely to give full consent when the child is diagnosed with a NDD (AME: 6.1) or is a girl (AME: 4.8). Shared parenting increases the likelihood of full parental consent in referral cases (AME: 5.6), while child participation in the investigation is associated with full consent in both application and referral cases (AMEs: 5.8 and 8.5, respectively). Across investigation types, full consent is more likely when the exposure concerns the child's own risk-related behaviour (AMEs: 12.4 and 14.3 for application and referral cases, respectively) and when exposure is dual—combining an adverse home environment and risk-related behaviour (AMEs: 8.3 for application cases and 4.6 for referral cases).

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TABLE 2 | Parental consent to intervention divided by the child's gender, age, living conditions, background and participation as well as type of exposure, reason for investigation and type of investigation.

	Consent, both parents, *n* (%)	Consent, one parent, *n* (%)	No consent *n* (%)	Total *n* (%)	*p*
Child's sex					
Boy	3424 (62.7)	746 (13.7)	1294 (23.7)	5465 (100)	0.033
Girl					
	3284 65.1)	639 (12.7)	1121 (22.2)	5044 (100)	
Child's age					
0–2 years	451 (56.4)	105 (13.1)	244 (30.5)	800 (100)	
3–5 years	790 (56.2)	212 (15.1)	404 (28.7)	1406 (100)	
6–8 years	1147 (60.8)	262 (13.9)	476 (25.3)	1885 (100)	< 0.001
9–11 years	1321 (64)	274 (13.3)	469 (22.7)	2064 (100)	
12–14 years	1784 (69.1)	315 (12.2)	483 (18.7)	2582 (100)	
15–17 years	1374 (68)	242 (12)	406 (20.1)	2022 (100)	
Child diagnosed with NDD					
Yes	1435 (74.3)	190 (9.8)	307 (15.9)	1932 (100)	< 0.001
No	5469 (61.6)	1227 (13.8)	2185 (24.6)	8881 (100)	
Child's living conditions					
Both parents; same household	2416 (61.7)	352 (9)	1149 (29.3)	3917 (100)	
Shared parenting	1151 (67.5)	282 (16.5)	271 (15.9)	1704 (100)	< 0.001
Mostly with mom[a]	2543 (65)	615 (15.7)	755 (19.3)	3913 (100)	
Mostly with dad[a]	567 (63.9)	132 (14.5)	213 (23.4)	912 (100)	
Child's origin					
Swedish	4363 (67.7)	835 (13)	1243 (19.3)	6441 (100)	< 0.001
Foreign	1598 (56.6)	347 (12.3)	880 (31.2)	2825 (100)	
Child's participation					
Not involved	1083 (56.9)	268 (14.1)	554 (29.1)	1905 (100)	< 0.001
Involved	5720 (65.3)	1131 (12.9)	1908 (21.8)	8759 (100)	
Type of exposure					
None	214 (67.1)	55 (17.2)	50 (15.7)	319 (100)	
Adverse home environment	3708 (57.5)	958 (14.8)	1786 (27.7)	6452 (100)	< 0.001
Risk-related personal behaviour	1230 (78.9)	128 (8.2)	200 (12.8)	1558 (100)	
Both home environment and personal behaviour	1712 (70.5)	268 (11)	450 (18.5)	2430 (100)	
Reason for investigation					
Application	1472 (80.3)	174 (9.5)	188 (10.3)	1834 (100)	< 0.001
Referral	5388 (60.5)	1233 (13.9)	2279 (25.6)	8900 (100)	
Type of investigation					
First-time investigation	2875 (66.5)	503 (11.6)	948 (21.9)	4326 (100)	< 0.001
Recurrent investigation	3529 (61.5)	811 (14.1)	1395 (24.3)	5735 (100)	

[a]And new partner of applicable.

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TABLE 3 | Multinomial regression analysis of parental consent.

	Full consent (both parents)	Partial consent (one parent)	No consent
Predictors	Adjusted AME (95% CI)	Adjusted AME (95% CI)	Adjusted AME (95% CI)
Child's sex			
Boy (ref)	—	—	—
Girl	0.038 (0.011–0.065)	−0.017 (−0.069–0.034)	−0.021 (−0.025 to −0.017)***
Child's age	−0.003 (−0.020–0.014)	0.003 (−0.029–0.035)	0.000 (−0.001–0.001)
Child diagnosed with NDD			
No (ref)	—	—	—
Yes	0.055 (0.043–0.066)***	−0.028 (−0.048 to −0.008)**	−0.026 (−0.054–0.001)
Child's living conditions			
With both parents together (ref)	—	—	—
Shared parenting	0.046 (0.000–0.092)*	0.071 (−0.007–0.148)	−0.117 (−0.135 to −0.099)***
Mostly with mom (and partner if applicable)	0.014 (−0.030–0.058)	0.069 (0.027–0.112)***	−0.083 (−0.139 to −0.027)**
Mostly with dad (and partner if applicable)	−0.012 (−0.039–0.016)	0.052 (0.029–0.074)***	−0.040 (−0.073 – −0.007)*
Child's origin			
Swedish (ref)	—	—	—
Foreign	−0.090 (−0.112 to −0.068)***	0.003 (−0.026–0.031)	0.087 (0.050–0.125)***
Child participated in the investigative process			
No (ref)	—	—	—
Yes	0.079 (0.070–0.088)***	−0.018 (−0.047–0.012)	−0.061 (−0.128–0.006)
Type of exposure			
None (ref)	—	—	—
Adverse home environment	−0.043 (−0.075 to −0.011)**	−0.048 (−0.084 to −0.011)**	0.091 (0.058–0.123)***
Risk-related own behaviour	0.150 (0.105–0.195)***	−0.107 (−0.130 to −0.084)***	−0.043 (−0.072 to −0.015)**
Both home environment and own behaviour	0.063 (0.028–0.098)***	−0.083 (−0.124 to −0.043)***	0.020 (−0.006–0.046)
Reason for investigation			
Application (ref)	—	—	—
Referral	−0.174 (−0.192 to −0.157)***	0.041 (−0.013–0.094)	0.134 (0.102–0.166)***
Type of investigation			
First-time investigation (ref)	—	—	—
Recurrent investigation	−0.067 (−0.076 to −0.058)***	0.018 (−0.009–0.044)	0.049 (−0.009–0.107)

Note: Pooled adjusted marginal effects (AME) for consent decisions based on sociodemographic and case-related factors. Predictor values were imputed using multiple imputation by chained equations (MICE).
*$p = < 0.05$.
**$p = < 0.01$.
***$p = < 0.001$.

Children with a foreign background are consistently associated with a lower likelihood of full parental consent in both application (AME − 13.9) and referral cases (AME − 8.0). Recurrent investigations are also linked to reduced full consent, with AMEs ranging from −4.8 to −6.8 percentage points. In referral cases, an adverse home environment is likewise

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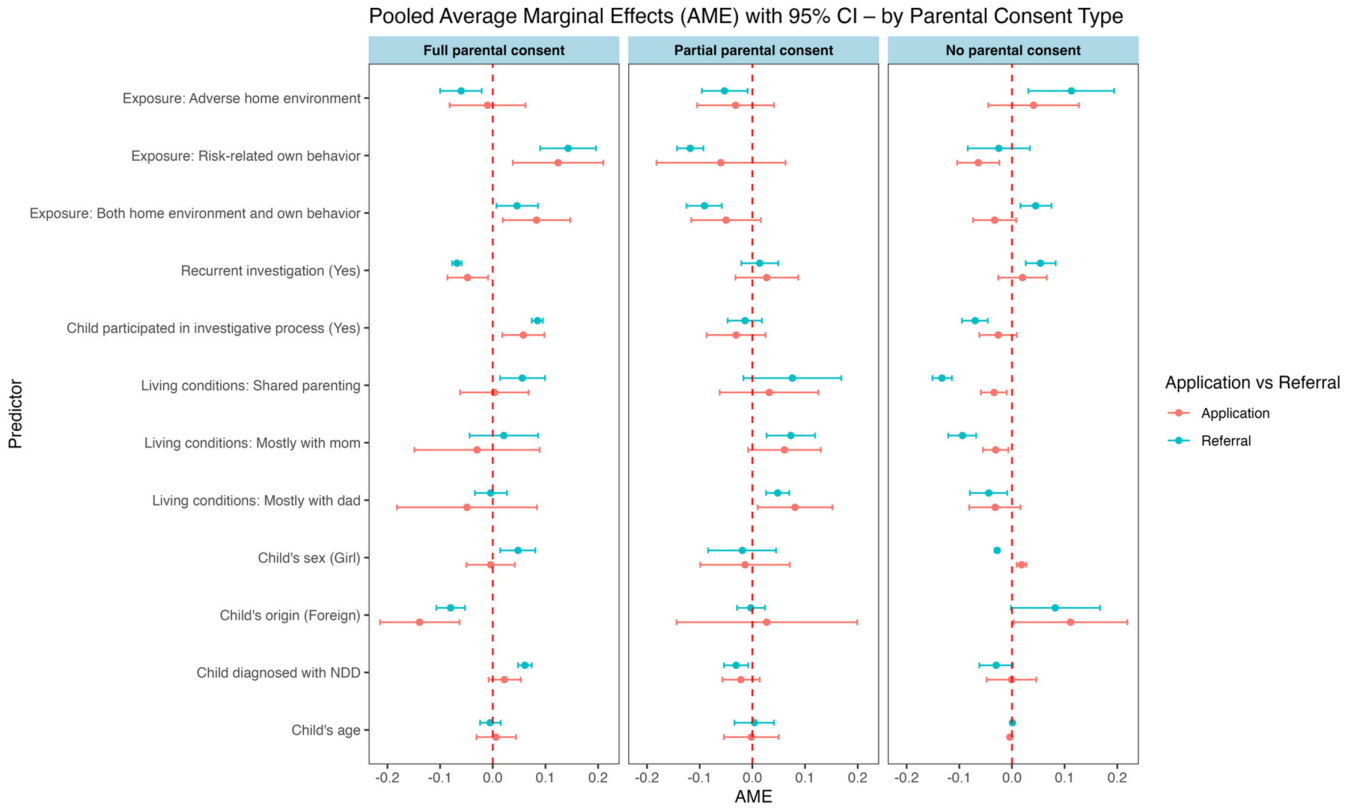

FIGURE 2 | Stratified multinomial regression analysis on parental consent outcomes. Avarage marginal effects (AME) for consent decisions based on sociodemographic and case-related factors. Predictor values were imputed using multiple imputation by chained equations (MICE).

associated with a lower likelihood of full parental consent (AME: −6.0).

3.2.2 | Partial Consent

In referral cases, the likelihood that only one parent provides consent is lower when the child has an NDD diagnosis (AME: −3.1) and varies across types of exposure (AMEs ranging from −5.3 to −−11.8). Conversely, partial consent is more likely in referral cases when the child primarily resides with the mother (AME: 7.3). When the child resides with the father, partial consent is more likely in both referral and application cases (AMEs: 4.8 and 8.1, respectively).

3.2.3 | No Consent

In referral cases, parental refusal of consent is more likely when exposure is concentrated in the home environment (AME: 11.3) or when this is combined with the child's own risk-related behaviour (AME: 4.5). Recurrent investigations are also associated with a higher likelihood of no consent in referral cases (AME: 5.4).

In application cases, parental refusal of intervention is more likely when the child is a girl or of foreign descent (AMEs: 1.8 and 11.1, respectively). In contrast, parents of girls are less likely to withhold consent in referral cases (AME: −2.8). Separated parents are generally less likely to withhold consent across both case types (AMEs ranging from −3.1 to −13.3). Finally, child participation in the investigative process is associated with a reduced likelihood of parental refusal in referral cases (AME: −7.0).

4 | Discussion

This study contributes to the limited research on parental consent in CWS. The findings show that consent is not simply an individual choice but is shaped by the context in which decisions are made. Consistent with previous research (Enroos et al. 2021; O'Mahoney et al. 2020), the results demonstrate clear differences depending on both child-related and procedural factors.

Our findings both echo and advance prior research on consent patterns. For example, full parental consent is documented in most cases where support is assessed as needed (63.8%), a considerably higher rate than reported in studies focusing on violence-related cases (Loebs and Persdotter 2025) and in studies with smaller samples (Heimer and Pettersson 2023). This difference may reflect the broader scope of the present study, which includes investigations across all CWS areas and both referral- and application-initiated cases. It may also be attributable to the substantially larger dataset, which exceeds those used in previous Nordic studies (e.g., Heimer and Pettersson 2023; Loebs and Persdotter 2025; Lundström et al. 2025; Rustad et al. 2025). A larger sample reduces the influence of individual outliers (Falk et al. 2011) and increases the stability of the estimates. Nevertheless, intervention was

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refused in 23% of cases, and partial consent was observed in about 13%, underscoring a discrepancy between assessments of need and parental consent.

The most salient procedural predictor of full parental consent identified in this study is how the investigation was initiated, while the strongest child-related predictor is the child's own risk-related behaviour, which significantly increases the likelihood of consent regardless of whether the case originated through an application or referral. This finding partially corroborates Lundström et al. (2025), although the AMEs reported here suggest a stronger influence than previously found. Parental consent is also more likely when the child participates in the investigation. However, this association should not be interpreted causally, as child participation may be easier to achieve when parents are already willing to cooperate. Qualitative research further suggests that these effects are context-dependent (Petersén et al. 2025). In addition, parents of children with NDD and separated but co-parenting parents are more likely to consent, particularly in referral cases (cf. Rustad et al. 2025). Across both case types, consent is more likely when the child exhibits risk-related behaviour, especially when combined with an adverse home environment. Conversely, recurrent investigations and a foreign background reduce the likelihood of consent, corroborating the findings of Loebs and Persdotter (2025).

Partial consent is most common among parents living apart, except in shared parenting arrangements. Extending the findings of Rustad et al. (2025), our results indicate that separated parents are not only more likely to provide full consent to interventions; in some cases, one parent consents while the other does not. One plausible explanation is that one parent agrees with the assessment of need while the other does not (Enroos et al. 2021; Sandelin and Petersén 2026). An equally plausible explanation is that one parent perceives the recommended intervention as appropriate, whereas the other considers it unwanted or unnecessary. Previous studies in other contexts have elaborated on such reasons for parental refusal (see, e.g., Korpinen and Pösö 2021; Lynch 2017), and it is reasonable to assume that Swedish parents may think similarly.

The full-sample analysis indicates that all types of exposure reduce the likelihood of partial consent. However, stratified analyses show that this pattern is confined to referral cases. Although previous studies have linked exposure types to parental consent patterns in terms of *consent* versus *refusal* (e.g., Heimer and Pettersson 2023; Lundström et al. 2025), our findings underscore that this dichotomy is too simplistic to capture the relationship between exposure type and consent. This is particularly important given that children may still receive CWS interventions even if one parent refuses (SFS 1949:381). Similarly, although adolescents over the age of 15 have greater procedural autonomy in the Swedish system (SFS 1990:52), no systematic association between age and parental consent is observed in the present data.

Finally, the full-sample analysis shows that parents of children with foreign backgrounds exhibit a higher likelihood of refusal, consistent with Loebs and Persdotter (2025) and Semanchin Jones (2015). That this trend is particularly apparent in application cases is noteworthy. Two interrelated mechanisms may explain this: (1) recommended interventions may diverge from parental preferences, and (2) applications may reflect indirect coercion rather than genuine voluntarism (cf. Kalin, Ahlgren, and Persdotter 2022; Petersén et al. 2025). As Pösö et al. (2018) note, consent and refusal form a spectrum; a "voluntary" application may be an involuntary act driven by external pressures. For instance, parents might feel pressured by other professionals—such as teachers or healthcare staff—to apply for help to avoid being referred to the CWS (Storhaug et al. 2025). These pressures may be especially common within this parent group (Nilsson et al. 2025). In referral cases, an increased likelihood of refusal is also observed in cases involving adverse home environments, multiple adversities or recurrent investigations, while parents of girls and separated parents are less likely to refuse interventions. For application cases, it is most noteworthy that parental refusal is less likely when the child exhibits risk-related behaviour.

The study contributes to emerging research that moves beyond a dichotomous understanding of consent and refusal. By examining full, partial and absent consent, the findings show that parental decision-making is more nuanced than previously assumed. The findings should also be interpreted considering the Swedish child welfare context, where voluntary participation and parental consent are central principles of service provision. Compared with more intervention-oriented systems, this makes parental agreement particularly important for children's access to support (Connolly and Katz 2019). As expected, the reason for investigation is central to consent patterns (cf. Heimer and Pettersson 2023; Rustad et al. 2025), but the relationship is not straightforward. Applying for support does not necessarily imply consent, particularly in cases involving foreign children and girls, where application cases are associated with a higher likelihood of refusal. The overlap in consent and refusal patterns across referral and application cases further suggests that the relationship between consent and reason for investigation is complex and cannot be reduced to a simple distinction between application and referral pathways.

5 | Limitations

Although this study has several strengths, certain limitations warrant consideration. First, measurement error, though rarely discussed, remains a concern in all survey-based research (Innes et al. 2021), and this study is no exception. Sensitivity analyses, however, indicate low levels of measurement error where assessment was possible, most notably less than 2.5% in the outcome variable. This is substantially lower than estimates reported in prior research, which suggest measurement error and misclassification rates of 20%–30% for single-item measures (Atsusaka and Kim 2025; Backström et al. 2025). Thus, the magnitude of measurement error observed in this study is comparatively low.

Furthermore, sensitivity analyses (not shown in tables but available upon request) demonstrate stable estimates across training and testing datasets, after accounting for measurement error and when applying alternative imputation strategies. Given its performance on similar data (Memon et al. 2023), imputation based on the k-nearest neighbours (KNN) algorithm was

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employed alongside MICE. Estimates derived from the KNN-imputed data were largely consistent with those obtained using MICE. Nevertheless, the presence of measurement error should be considered when interpreting the findings.

Another limitation is that the cross-sectional design offers only limited insight into the causal relationships between child-related factors, procedural characteristics and parental consent patterns. Future studies using longitudinal or quasi-experimental designs could better establish these relationships. Research should also examine how professional assessments of non-reliable consent function in practice, particularly as indicators of constrained voluntariness at the boundary between voluntary services and compulsory care. Finally, given the importance of context and differences in child welfare legislation and organization across welfare systems (Connolly and Katz 2019), these findings should be generalized beyond Nordic and similar European countries with caution. Comparative research across diverse welfare settings would therefore provide further insights into parental consent for CWS interventions.

6 | Conclusion and Implications

Based on consent as documented in casefiles, the findings show that six in 10 parents fully consent to CWS interventions following a needs assessment. Approximately one-fourth of cases involve refusal of intervention, while partial consent occurs in just over one-tenth of cases. Furthermore, the socio-demographic characteristics of the child, the type of assessed risk and other procedural factors are associated with parental consent patterns. Given that parental consent acts as a gatekeeper for children's access to CWS interventions (Pösö 2022; Swedish Agency for Health and Care Services Analysis 2018), these findings highlight areas where additional efforts may be needed to secure consent. Such efforts could be particularly important when the child is referred to CWS, has a foreign background, prior experiences with CWS or lives in a harmful home environment. For practitioners, this may involve strengthening communication about the purpose of interventions, addressing parental concerns and misconceptions from both parents early in the investigative process and building trust with families who may have had previous negative experiences with services (cf. Nilsson and Landstedt 2022; Nilsson et al. 2025; Sandelin and Petersén 2026). Addressing these issues early in the investigative process could increase the likelihood of parental consent and ensure that children receive necessary services, supporting positive developmental outcomes.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data are not available due to privacy and ethical restrictions.

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