

# Nordic children Early intervention for children and families

Nordic Centre for Welfare and Social Issues

Inspiration booklet

Results of the 'Early intervention for families' project





**norden**

Nordens Välfärdscenter

Nordic children—Early intervention for children and families

Publisher:

**Nordic Centre for Welfare and Social Issues**

[www.nordicwelfare.org](http://www.nordicwelfare.org)

© November 2012

Editors: Kristin Marklund and Nino Simic

Principal authors: Kristin Marklund, project manager of 'Early intervention for families', Anna-Karin Andershed and Henrik Andershed, Örebro University.

Other authors: Mirjam Kalland, Petra Kouvonen, Terje Ogden, Helene Hjort Oldrup, Knut Sundell, Nino Simic and Eivor Söderström.

Editorial staff: Kristin Marklund, Petra Kouvonen, Nino Simic

Legally responsible publisher: Ewa Persson Göransson

Illustrations: Helena Halvarsson

Graphic design: [www.aasebie.no](http://www.aasebie.no)

Printing: Ineko

ISBN: 978-87-7919-073-3

No. of copies: 800

**Nordic Centre for Welfare and Social Issues  
Sweden**

Box 22028, 104 22 Stockholm, Sweden

Street address: Hantverkargatan 29

Phone: +46 8 545 536 00

[info@nordicwelfare.org](mailto:info@nordicwelfare.org)

**Nordic Centre for Welfare and Social Issues  
Denmark**

Slotsgade 8, DK-9330 Dronninglund, Denmark

Phone: +45 96 47 16 00

[nvcdk@nordicwelfare.org](mailto:nvcdk@nordicwelfare.org)

**Nordic Centre for Welfare and Social Issues  
Finland**

Topeliusgatan 41 a A, FIN-00250 Helsinki, Finland

Phone: + 358 (0)40-0612015

[nvcfi@nordicwelfare.org](mailto:nvcfi@nordicwelfare.org)

The report can be ordered as a printed copy or downloaded at:

[www.nordicwelfare.org](http://www.nordicwelfare.org)

under the 'Publications' tab.

In digital format, the booklet is also available in Danish, Finnish, Norwegian, Icelandic and English.



Miljömärkt trycksak, 341 142



## Introduction

You hold in your hand part 1 of the report on the 'Early intervention for families' project.

The project is part of the Nordic Council of Ministers' initiative in 2011 and 2012 in the field of 'Early preventive intervention for families at risk of social marginalisation'. As a consequence of this prioritisation, the Nordic Centre for Welfare and Social Issues was commissioned to carry out this project. The aim is to disseminate research results and knowledge about good examples, and create Nordic networks.

The project has four focus areas: current research on risk and protection factors, promising examples of early intervention in the Nordic region, simplified access to services and let the children's voices be heard!

Part 1 of the report, which you are reading now, presents the project results from the first two focus areas.

# PART 1

## EARLY INTERVENTION FOR FAMILIES AND CHILDREN IN THE NORDIC REGION .....

Early intervention—early in life .....	6
Small children are more easily influenced .....	7
Staff at preschools must react.....	8
Systematic analysis in partnership with parents.....	8
Early intervention as a continuous process.....	9
Intervention adapted to the target group.....	9
Universal, selective or indicated intervention?.....	10
Preschool—a place to identify vulnerable children .....	10
Offer intervention that works! .....	10
Train, guide and support parents .....	11
Give children the opportunity to develop.....	11
Parental support as early intervention .....	12

## PARENTAL SUPPORT IN THE NORDIC REGION

—A MODEL FOR EARLY INTERVENTION.....	13
Why manual-based parental training programmes? .....	17
Training in parental support programmes .....	17
Choosing the right programme .....	17
How can you keep up with research? .....	18
What do you do when there is no research? .....	18

## PROMISING INTERVENTIONS FOR PARENTS WITH VERY YOUNG CHILDREN .....

Support for parents in the first few years.....	20
What does the research say about intervention for children aged 0-3?.....	20
The importance of early interaction and early attachment....	22
Examples of promising intervention for new parents.....	24
School preparation programmes as early intervention.....	26
Successfully implementing new methods .....	27
More effective with national implementation.....	29
Early intervention is worthwhile.....	30
Implementation of PMTO in Iceland with limited resources...	33
Example: PMTO with Somali and Pakistani parents—interview.....	34
Concluding words .....	35

# PART 2

## RISK AND PROTECTIVE FACTORS IN RELATION TO FUTURE PSYCHOSOCIAL PROBLEMS AMONG PRESCHOOL CHILDREN—WHAT WE KNOW FROM RESEARCH AND

### HOW IT CAN BE APPLIED IN PRACTICAL WORK ..... 36

Focus on acting-out and internalised problems ..... 37

What are risk factors and protective factors? ..... 38

Risk and protective factors exist at many levels ..... 39

What are the risk and protective factors  
in preschool children? ..... 40

Can US research be applied to Nordic children? ..... 40

Behavioural problems, one of the strongest risk factors ..... 42

Many risk factors means higher risks ..... 43

Similarities between boys and girls in terms of risk and  
protective factors ..... 43

Inheritance and environmental aspects of risk and  
protective factors ..... 43

Applying knowledge of risk and protective factors  
in practice ..... 44

Risk-focused prevention and treatment work ..... 44

Not an exact science ..... 45

Three principles of risk-focused prevention and  
treatment work ..... 45

Structure important when assessing risk and  
protective factors ..... 46

Importance of education ..... 47

Which professions can undertake risk-focused prevention  
and treatment work? ..... 47

Assessment, intervention and follow-up ..... 48

Concluding words on risk and protective factors ..... 49

Promotion of dialogue with parents—experience  
from Finland ..... 49

The challenge ..... 50

Parents are specialists in their own children ..... 50

Risk-focused work in practice  
—example of Sjöbo Municipality in Sweden ..... 51



## Early intervention for families and children in the Nordic region



Experts from the Nordic countries have been meeting for two years to prepare proposals for early intervention that works. Researchers and practitioners have proposed good examples from their respective countries. One of the results of this has been *Parental Support in the Nordic Region (Föräldrastöd Norden)*—a model for implementing parental support programmes. Instead of more programmes, we need fewer programmes that are effective and evaluated in the Nordic region. Many of the programmes used today are not supported by research. Some are probably effective but they lack both documentation and follow-up. There are programmes today that have good effects. Pan-Nordic research could be implemented with the focus on a few selected interventions. Successful implementation of methods is essential to successful results. National support for implementation has proved to be one way of improving success.

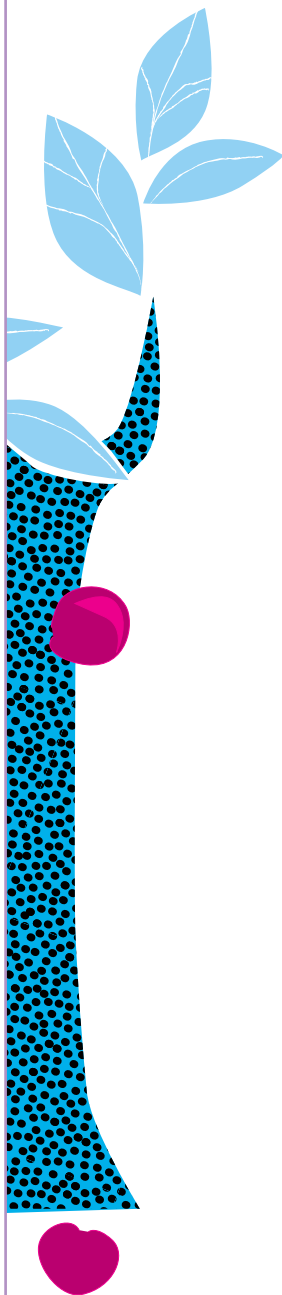
In addition to the model, examples are given of programmes that identify parents with newborn children and a school preparation programme from Denmark. An overview of research into risk and protective factors has also been carried out and is presented in the inspiration booklet. Knowledge is required to identify children and families in need of support and to prepare intervention that enhances the protective factors and reduces risk factors. Early intervention is worthwhile, not least from a socioeconomic point of view. Most parents in the Nordic region receive support from child welfare centres during pregnancy, and nearly all children attend preschool. In the Nordic countries, we therefore have a unique opportunity to identify the need for and offer support to children and families at an early stage.

### **EARLY INTERVENTION—EARLY IN LIFE**

Children at risk of developing functional problems do not have time to wait. It is necessary for someone to identify the problems they have and what they are struggling with. For these children, early help means good help, and this may mean that it is possible to prevent the problems increasing and becoming more difficult to manage. The difficulties are usually associated with sleep, meals, hygiene or play. There may be learning and development difficulties in the background or biological immaturity that may be temporary. Examples include children with delayed language development, children with reduced functional ability and children who come from difficult family circumstances. All may need special training, follow-up and adaptation, socially, educationally or physically. In some areas, there may be progressive problems, i.e. new problems are added to the old ones as the children get older. Children with language problems may, for example, have problems learning to read when they start school, which may, in turn, lead to increased difficulties throughout their school career.

### **SMALL CHILDREN ARE MORE EASILY INFLUENCED**

To be able to intervene early for children in the risk zone, problems must be identified early. However, it is essential to identify and map the functional problem and then follow it up with intervention. The longer it takes before a child receives help, the more difficult it is to provide the right help. Although many very young children show clear signs that they have difficulties, many do not get help in time. Early help is good help and small children are, in many ways, more easily influenced and more receptive to help than older children.



## STAFF AT PRESCHOOLS MUST REACT

One obstacle to early intervention may be that those who work with very young children adopt a 'wait and see' attitude. As it is normal for there to be differences between children, they expect some children to grow out of their problems. This is also true for some children, for example those who mature later than their peers, or those who develop late for other reasons. When those who work with children, for example employees in preschools, are cautious about identifying children in the risk zone, the reason is often because they do not want children to be 'pigeonholed' and 'stigmatised'. Staff know that early diagnosis can sometimes have unintentional negative effects and therefore want to protect children from this. Diagnosis can also be unreliable, which means that some children are not diagnosed at all and receive no special treatment.

Another problem of early identification is also that different informants make different assessments of children's functional levels and problems. There is often a surprising lack of concordance between parents' view of their child at home and the experience of staff at preschool. This makes it difficult to establish a child's development status. However, whatever the reason for assuming a wait and see attitude to early analysis and identification, it is unfortunate for the children who need early intervention.

Therefore, it is important for everyone who works with children and families to be aware that there are children with special needs. At the same time, the analysis work must take into account the many elements of uncertainty that are associated with children's risk status, and caution should be shown when using diagnosis or other criteria to categorise children. A good aid may be to carry out a study in relation to risks and protective factors and an analysis to identify a child's strengths and weaknesses. The procedure for early identification of vulnerable children should be standardised and research-based rather than being based on subjective opinions. If the approach takes the child's development level into account, the analysis can be followed up with early intervention to correct, prevent or stimulate the child's development.

## SYSTEMATIC ANALYSIS IN PARTNERSHIP WITH PARENTS

Early identification should be based on observations and assessments of children in their daily environment and take a broad approach to their physical, cognitive, social and emotional functional level and difficulties. The work should be accurate so that the most time and expertise is devoted



to children who need it most. Therefore, it is necessary for the analysis and follow-up to be systematic.

This can be implemented as a three-stage process in which the first stage consists of informal assessments of all children carried out by expert staff in a medical centre or preschool. The assessment criteria may be formulated as checklists and should be based on relevant research. Children who differ from their peers in important areas or who need to be studied for other reasons should be followed up in greater depth. Stage two can therefore consist of analysis and assessment of interaction, behaviour and skills with the aid of standardised analysis tools or observation routines. A more detailed study should be made of children who exceed critical thresholds. Stage three can therefore consist of tests and individual observation in structured and unstructured activities in which a more in-depth analysis of the child's behaviour and development is made. Throughout the process, it is important for the parents to be informed and for them to participate if the child needs further investigation.

### EARLY INTERVENTION AS A CONTINUOUS PROCESS

However, it is important to note that early intervention does not function as a 'vaccine' that has unlimited effect. For some children, it may be important to maintain intervention measures over time if they are to work. As children get older, they may be exposed to risks in the form of new burdens and stress. Early intervention must therefore not be regarded as one-off intervention. It is a continuous process in which children are followed closely for periods of time and in situations in which they may be vulnerable, for example when they move from preschool to school.

### INTERVENTION ADAPTED TO THE TARGET GROUP

Children may also be divided into risk or intervention groups. Most children belong to the low-risk children group, with good intellectual, motor, behavioural, social and emotional function. *A small group of children are in the risk zone and may develop functional difficulties as they are exposed to risks of an individual and environmental nature.* The last and smallest group are children who have already developed problems related to mental health, motor skills, behaviour and cognitive function. These children may need extensive, long-term help and stimulation and are presumably the group that benefit most from early intervention. It should be clear which children are in the target group when early intervention begins.

## UNIVERSAL, SELECTIVE OR INDICATED INTERVENTION?

Universal intervention is generally preventive and is targeted at all children. Selective intervention is targeted at children who are assessed as being in the risk zone. Indicated intervention is targeted at children who are particularly vulnerable or have already developed functional problems. Risk factors in a child's development have a tendency to form a coherent pattern that affects sensitive children when they are exposed to negative social and psychological influences. It is not always possible to anticipate the problems to which the pattern will lead, and the same risk factors may lead to different forms of problem development. As a consequence, early intervention should have a broad focus that prevents problems and develops resources and expertise.

## PRESCHOOL—A PLACE TO IDENTIFY VULNERABLE CHILDREN

Compared with children of school age, fewer Nordic preschool children receive special educational help or psychiatric treatment or are reported to the social service authorities. This may be a sign that preschools are used too little as a place for identifying vulnerable children and that intervention only takes place when they start school. There are studies that show that preschool has less influence on children than parents and the home, for which reason it is important for parents to participate in early intervention. It is often an advantage for early intervention to have a 'low threshold' so that the parents themselves can make contact and ask for an assessment of their child's problems and for this opportunity to be available where the child is, i.e. at preschool or in a medical centre. Preschools have a unique opportunity to take preventive action, identify needs and implement intervention for children who need extra care and help in the development and learning of skills. By limiting the use of diagnosis and categorisation of children according to the type and degree of the functional problems, it is also possible to prevent early intervention having stigmatising effects on children and their environments.

## OFFER INTERVENTION THAT WORKS!

There is increased understanding that early intervention should consist of intervention or measures that have been shown by research to work for defined problems and in specific situations. In other words, it is important to make

use of the best knowledge of what works and let research guide practice. There are models, programmes, measures and methods that have produced good results via controlled evaluation.

Intervention should be clearly described via guidelines or manuals and implemented in accordance with theoretical and practical preconditions. The evaluation should cover the benefit to children and their families of the intervention, as well as the implementation of the intervention. *If a measure does not produce positive results, it may be because the intervention was not as effective as expected or its implementation was deficient.*

### TRAIN, GUIDE AND SUPPORT PARENTS

Early intervention for children who have not started school often aims to improve the children's physical health or promote their cognitive, social and emotional development. However, intervention may also be started earlier with follow-up of mothers during pregnancy and childbirth. An overview of international knowledge shows that most preventive intervention targeted at children of preschool age aims to stimulate children's cognitive development or otherwise enhance their ability to cope with school. Some intervention has also been shown to have a long-term positive impact on children's function. Training, guidance and support for parents are also a common denominator of successful projects and measures and they often focus on promoting expertise, initiative and independence among both parents and children.

### GIVE CHILDREN THE OPPORTUNITY TO DEVELOP

Not all children can achieve as much in terms of functional capacity, and inherited conditions may limit learning ability and development potential. In spite of this, it is important to make full use of environment-related intervention, regardless of children's conditions, to stimulate and support children in their learning and development.

The aim of early intervention is to reduce the risk of children developing behavioural problems, mental or physical health problems or problems with school. The intervention may involve identifying and stimulating children's resources and talents, and also promoting their ability to handle stress, setbacks and crises. It may involve creating a childhood environment in which children have a feeling of belonging and in which they learn important skills so that they can make a contribution and be appreciated for their contribution.



## PARENTAL SUPPORT AS EARLY INTERVENTION

One result of the Nordic project is a proposal for Nordic implementation of parental support. The idea is to focus on just a few parental support programmes and implement them in all municipalities. This would mean that pan-Nordic research could be carried out and it would result in greater cost efficiency, in particular in respect of training and implementation costs. The introduction of national implementation support seems to be an efficient model. The implementation of TIBIR in Norway is a good example in the Nordic region. Parental support in the Nordic region is a proposal for a simplified model of TIBIR. It is important to adapt parental support programmes so that they are attractive to parents who are at risk of marginalisation. Later in the booklet, we show how parental support has been successfully implemented with Pakistani and Somali parents.

## TIBIR—EARLY INTERVENTION FOR CHILDREN AT RISK

The TIBIR programme was developed in Norway on the basis of experience from previous implementation work. The objective of TIBIR was to prevent and remedy behavioural problems in children aged 3-12 at an early stage and contribute to developing children's positive and prosocial behaviour. The programme therefore enhances intervention that is targeted at families with children who have already developed behavioural problems or who are at risk of doing so. The programme consists of six intervention modules that form an overall intervention strategy for families with children. TIBIR training is given to municipal staff who work in welfare services for children and families.

Read more at:  
[www.atferdssenteret.no](http://www.atferdssenteret.no)



## Parental support in the Nordic region —a model for early intervention

*Parental support in the Nordic region* involves support for families on three levels. The basic idea is that it must be easy to get support as a parent and that the support must be provided at an early stage. When the problems are severe, it must be easy to get help to obtain more extensive support. The intervention offered should have been evaluated and have demonstrated good results in the research.

The implementation of *Parental support in the Nordic region* means that the range of intervention is limited and the intervention offered can be evaluated. Research takes time and constant replacement of intervention may mean that knowledge of what works is only presented after the intervention is no longer being used. There are benefits of thinking long-term and not replacing intervention before you know what works.

*Parental support in the Nordic region* is a full-service package of early support for families with children in a municipality. Implementing *Parental support in the Nordic region* does not automatically mean increased costs for the municipality's preventive work. It may involve reprioritising the intervention that already exists. During an introductory period, costs may be incurred on training and guiding staff who will be group leaders. It is important for there to be a long-term plan for implementation of the model. Parental support should be evaluated and, if necessary, adapted to the needs of different target groups.

The basis of the model is a shared knowledge base for staff who work with children. All professionals who work with children, for example in a preschool or family centre, should have knowledge of risk and protective factors. To spread this knowledge to all staff who work with children, educational initiatives can be carried out continuously. Read more about risk and protective factors on page 36.

Three modules of parental support are offered to parents in all municipalities:

### **1. Universal support for all parents**

The tradition in the Nordic welfare model is for most services to be universal, i.e. they are offered to everyone and are not means-tested. This also applies to parental support, and maternity and child health care and preschools are offered to all families with small children. These universal services are a

unique arena for preventive work and make high-quality parental support possible. There are also a number of parental support programmes today as well. The programmes cannot replace other welfare services but they can be an important supplement in the development of the support offered to families. In this project, we propose that the municipalities supplement their welfare services with one of the proposed programmes.

As a universal initiative, it is proposed that parents in all municipalities be offered *consultations* as short-term intervention. This may involve a problem that has arisen with the child and may consist of a few discussions. Consultations are with staff who are trained in a parental support programme that is based on research, for example PMTO, the Parent Management Training Oregon model, The Incredible Years (De otroliga åren) or KOMET.





Read more at:  
[www.allabarnicentrum.se](http://www.allabarnicentrum.se)

The module may also involve universal *parental training* based on the same principles as the programme mentioned above. Parental training is provided for all interested parents and involves a few information evenings. In Sweden, for example, there is ABC, Alla Barn i Centrum (Focus on all children).

## **2. Parental support—groups**

*Module 2 involves Support for parents in groups.* The target group is parents who experience problems with their children or parenting skills. For example, this may involve children who are often in conflict with other children, siblings and parents. Parents who seek support for help with strategies that improve their parenting skills. The parents seek out the help themselves or have been recommended the programme by child health-care professionals, preschools, social services or other parents.

The interventions in this group involve guiding parents in groups with other parents. The groups of parents usually meet once a week for 2-2.5 hours on 10-12 occasions. The groups are led by 1-2 leaders who are trained in the parental support programme. The teaching method is 'mini-lectures', group discussions, roleplay and exercises between meetings. The programmes proposed are PMTO (group intervention), The Incredible Years (De otroliga åren) (Basic) and KOMET.

## **3. Parental support—individually**

*Module 3 involves Individual support for parents who have children with significant behavioural problems.* For an extended period of time, the relationship between parents and child has been characterised by constant conflict which has also been manifested between the child and schoolmates or between the child and staff at preschool/school. The family may have undergone parental support in a group but it has not been adequate intervention. The aim of the programme is for the parents and child to establish a positive relationship so that the child's positive development is promoted. Parents are trained in parenting skills and in how to encourage their child when he or she is learning new skills. Parents also receive training in regaining parental control and developing positive interaction with their child. The programme includes practical exercises and homework. The parents and therapist set up objectives and sub-objectives during the treatment and these are followed up. The parental support takes 1-1.5 hours per session and the number of sessions is tailored to the family's needs. The individual support proposed is PMTO, The Incredible Years (De otroliga åren) (Advanced) or Enhanced KOMET.

Read more:

[www.kometprogrammet.se](http://www.kometprogrammet.se)

## KOMET

KOMET was developed in public service activities at the Prevention Centre in Stockholm. This is an evidence-based parental training programme that is based on international research on the interaction between parents and children and on social learning theory. KOMET offers training for staff who have the opportunity to arrange parent groups for parents with children aged 3-11. KOMET parental support is targeted at parents who find that they are often in conflict and arguing with their child and find it difficult to manage the situation well.

KOMET is also available as Enhanced KOMET with individual support for parents (children aged 3-11) and KOMET for parents of teenagers in groups (children aged 12-18).

## PMTO, PARENT MANAGEMENT TRAINING—OREGON

PMTO is an evidence-based programme that provides individual support for parents with children aged 4-12 with severe behavioural problems. The programme enhances social skills and cooperation. The objective is to prevent and reduce behavioural problems in children. The programme is based on research and development work carried out at the Oregon Social Learning Center in the USA. Norway has been the only country in the world to implement a national PMTO initiative. The programme has been developed for Norwegian conditions by the Norwegian Center for Child Behavioral Development (Atferdssenteret).

On the basis of the same principles as in PMTO, group intervention has been developed for parents who have children with behavioural problems or children at risk of developing a behavioural problem (aged 4-12); TIBIR—parental group intervention.

Read more:

[www.atferdssenteret.no](http://www.atferdssenteret.no)

## DE OTROLIGA ÅREN (THE INCREDIBLE YEARS)

The Incredible Years is evidence-based parental training. The initiative was developed by the US psychologist and researcher Carolyn Webster-Stratton. The target group is parents of children aged 3-12 who have emotional problems or behavioural difficulties. The parental training, in which parents learn how to promote positive development in their children, is divided into two parts. The first part is based on play, praise and rewards, and the aim is to enhance the relationship between children and parents. The second part develops strategies for the parents so that their children's behavioural problems can be reduced. The Incredible Years is available as group intervention at *Basic* and *Advanced* levels.

Read more:

[www.ungsinn.uit.no](http://www.ungsinn.uit.no)



If a municipality chooses to apply this intervention, the same person can work at different levels but on the basis of the same theory. For example, group leaders for parental support groups can be the same people who provide universal training for parents at a family centre.

### WHY MANUAL-BASED PARENTAL TRAINING PROGRAMMES?

To prevent behavioural problems in children, there are a number of manual-based parental training programmes available today. Extensive international research and studies from the Nordic countries have shown good results from parental support programmes, including those concerning behavioural problems in children. A common starting point for these programmes is that it is possible, via education and training, to change parents' behaviour in relation to their children. The objective of parental support is to break a negative interaction pattern between parents and children.

For parents who have children with behavioural problems, it has been shown that *support discussions alone are not sufficient*. If you add strategies for upbringing, training, roleplay and feedback (on training tasks), the potential for parents to develop their parenting skills increases.

### TRAINING IN PARENTAL SUPPORT PROGRAMMES

Training of leaders for parental support programmes often starts at the same time as the group leader holds a parental support group. Top-up training is compulsory and all material that is used at the sessions is collected in manuals. The manual may, for example, consist of theory, exercises and film clips showing examples of situations groups can work with. A municipality can train group leaders who, in turn, train other group leaders. The training is relatively short but requires guidance and further training. For example, all training for KOMET group leaders takes place over 8 days, divided into two halves.

### CHOOSING THE RIGHT PROGRAMME

A great deal of the advice and support intervention offered today lacks evaluation and, in many cases, any documentation. Intervention that is *not* effective may mean that problems increase and the parents may find that there is no point in seeking support again. When a family seeks support, it is important for the help to come fast and to be effective.

A municipality can choose a parental support programme that is already implemented on a large scale. However, it is important to choose programmes that are effective and have good research results. In Sweden, for example, many municipalities have chosen to implement KOMET. In Norway and Iceland, the focus has been on PMTO. In Denmark, the Incredible Years has been implemented in some municipalities. In Finland, parental support is seen as part of an excellent range of universal welfare services, including free maternity and child healthcare. The use of programme-based parental support is limited. The TIBIR implementation model in Norway may inspire countries that have no national strategy for implementation of programme-based parental support.

### HOW CAN YOU KEEP UP WITH RESEARCH?

It may be difficult for a municipality or for professionals to keep up with research. Research needs to be translated to reach practice and result in practical action. Here are three examples from the Nordic countries in which intervention and research results are presented in the field of children and young people; Ungsinn in Norway, Videnportalen in Denmark and Metodguiden in Sweden.

- [www.ungsinn.uit.no](http://www.ungsinn.uit.no)
- [www.vidensportal.servicestyrelsen.dk](http://www.vidensportal.servicestyrelsen.dk)
- [www.socialstyrelsen.se/evidensbaseradpraktik/metodguide](http://www.socialstyrelsen.se/evidensbaseradpraktik/metodguide)

### WHAT DO YOU DO WHEN THERE IS NO RESEARCH?

There are a large number of initiatives to support the mental health of children and young people. In 2009, the National Board of Health and Welfare in Sweden identified 103 social services-based interventions in outpatient care to support children. Ten of these were evaluated in Sweden in such a way that it is possible to assess their effects. The situation is similar in preschool and primary and lower secondary school. Virtually none of the educational methods used for children's mental health have any scientific basis. Nor is it likely that all of these interventions will be evaluated in the foreseeable future.

An intervention can be effective even if it is not evaluated. Therefore, methods other than evaluations of effects are required to assess whether a certain intervention is reasonably effective. One approach is to use criteria that research has systematically identified as important. This is the background for a British database on parental support intervention that is designed for professionals and parents. The interventions described in the database have been examined by a panel of

Read more at:  
[www.education.gov.uk/  
 commissioning-toolkit](http://www.education.gov.uk/commissioning-toolkit)

researchers with the focus on three central quality aspects, each of which is graded in five stages. Each of these three dimensions has been shown to predict whether interventions have positive effects for the target group. High points are given when there are:

### **1. A delimited target group**

There is a clear description of the target group's needs, a method for recruitment and ensuring that it is the right target group, a method for continuously measuring whether the target group's needs are being met and guidelines for whether and when others should be contacted to provide other support.

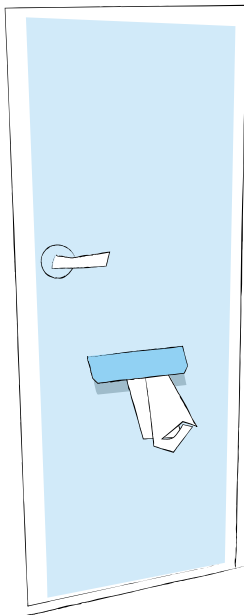
### **2. Theory rooted in research**

The theory for why the intervention will lead to change is based on research into risk and protective factors, there is research to support the fact that the intervention changes parents' interaction with their children and the short-term and long-term effects are theoretically realistic.

### **3. Well-defined training and implementation**

The requirements for prior knowledge for those who are to use the method are clarified and the training is structured with a clear format, scope and intensity. There is a written manual that explains what leads to change and what effects should be expected. There is also a method for examining whether the intervention is being used as intended. Supervision must be offered as support when you start to use the method and the supervisor's necessary qualifications are clear.

As interventions that score high points on these criteria are more likely to work, the assessment may form the basis for activities to consider introducing a new intervention. The dimensions are no guarantee but they increase the likelihood of the intervention being effective. *If the choice is between several different interventions, those that meet few or none of the above criteria should be avoided, for example those that claim to work for all types of problem, those with no theory about why they work, those with unclear scientific support and those with brief training (for example one-day training).*



## Promising interventions for parents with very young children

The interventions in *Parental support* in the Nordic region cover parents with children from the age of around 3. The following are examples of early support for parents with infants.

### SUPPORT FOR PARENTS IN THE FIRST FEW YEARS

Secure attachment between infants and parents is a protective factor that counteracts ill-health later in life. The likelihood of an infant developing a secure attachment to his or her parents increases if the interaction between the infant and the parents was satisfactory. This means that the parents are aware of the child's signals, interpret them correctly and react adequately to them. There is scientific support for this.

Under this heading we have collected knowledge about support for parents during a child's first year of life. We know from research that not many evidence-based methods have been implemented in the Nordic countries in respect of small children. Major interventions already take place in maternity care and child healthcare and from family centres. However, there is no research from Nordic environments. A great deal of the interventions that produce good results in studies from the USA may have a different target group. The Nordic universal support for new parents may be more extensive than the US interventions.

### WHAT DOES THE RESEARCH SAY ABOUT INTERVENTION FOR CHILDREN AGED 0-3?

In 2011, the Danish research institute SFI, the Danish National Centre for Social Research, prepared a research overview on early intervention for vulnerable and at-risk children aged 0-3 and their parents (including pregnant mothers). The research overview covers interventions that aim to reduce or compensate for the following risk factors: maternal addiction, neglect, violence in close relationships, mental illness in the parents, early parenthood and combined problem profiles. The aim is to develop knowledge that can contribute to evidence-based practice in social policy. SFI has reviewed effect research that includes RCTs, quasi-experimental studies and studies with measurements before and after.

Read more at:  
[www.sfi.dk](http://www.sfi.dk), 'Intervention  
 for vulnerable 0-3 year-  
 olds and their  
 parents'

The survey showed 81 research studies in which interventions produced effects. Most of the studies are from the USA (55) while 10 are from Europe. *There was no research from the Nordic countries concerning this group. It can therefore be said that the results primarily concern North American environments.*

### **IMPORTANT CHARACTERISTICS OF EARLY INTERVENTION FOR PARENTS WITH CHILDREN AGED 0-3:**

**Target group**—Early intervention should be targeted at parents and, in particular, mothers—not children

**Organisation**—Intervention must be organised as multifaceted intervention, i.e. it must consist of several different activities such as discussions, practical help, group discussions and other activities.

**Duration and intensity**—Early intervention should be relatively long, six months or more, and involve close contact between users and therapists.

Surveys also show that if you work with a parent with a particular risk factor, for example addiction, support should be offered that is particularly targeted at this risk factor.

### **IMPORTANT CHARACTERISTICS OF INTERVENTION AGAINST PARENTAL ADDICTION:**

**Target group**—Most effective interventions are targeted at mothers with addiction problems and work for parents with children in different age groups.

**Organisation**—The interventions are multifaceted and are primarily individual.

**Duration and intensity**—The interventions are usually long-term and last for more than 6 months. The intensity varies from daily intervention to several times a month.

## THE IMPORTANCE OF EARLY INTERACTION AND EARLY ATTACHMENT

According to attachment theory, the care a child receives during his or her early years has far-reaching consequences for his or her development. The theory assumes that a child needs care that is both predictable and emotionally oriented towards the child's needs. In practice, it is about how everyday care is implemented. When a child cries with hunger, the parent needs to have the capacity both to meet the child's physical need for food and the child's emotional need for affection and security. It is not enough only to meet the child's physical need to ensure the child's development. If a parent is irritated and heavy-handed or indifferent and mechanical when he or she feeds the child, this will affect the infant negatively. However, if the parent is calm and loving, this will have a positive effect on the child.

During the child's first year of life, it is more adequate to talk about early interaction than about early attachment. At the age of around one, a child has developed his or her first working model of human interaction, i.e. a model for how he or she can express needs and feelings, and what response can be expected. This internal working model is not stable. It is developed throughout a person's life. The first fundamental model is the basis on which later experience is based. Negative experience during this period affects a child's development in two ways. The child becomes more vulnerable to later negative experiences and it also becomes more likely that the child will have such experiences. This is because the child has developed negative strategies for interaction with the parent. Negative strategies can be maintained by:

- Early experience affecting the structure and function of the brain
- Internal working models affecting how the child interprets interaction (both verbal and non-verbal)
- Painful experience leading to defensive action that is an obstacle to new experience
- Insecure children are often aggressive or negative and behave in a manner that arouses irritation and anger rather than sympathy in adults and other children
- The negative reactions of others enhance the child's negative working models

The structural development of the brain takes place from the first few weeks of pregnancy until the person is a young adult and is genetically driven. The functional development of the

brain continues throughout a person's life and is affected by experience. *New research confirms that feelings are central to how the brain develops.* During the first nine months, the paths between the more primitive parts of the brain and the parts of the brain that control emotional reactions also develop. Harmful emotional experiences during these first few months may damage or impede this development, which may, in the long term, lead to impulsive aggressiveness. This may also be the reason for later personality disorders.

When a child receives a positive response from parents who, with their sensitive, calming presence, organise and give words to their baby's feelings, the child develops a secure attachment to his or her parents. This happens at the age of around one year. A secure child seeks the presence of his or her parent when he or she is frightened, upset, hungry or in pain. However, a child is also curious and keen to explore his or her environment. If a parent's care has been emotionally negative or based more on the parent's state of mind and needs than the child's, the child cannot use his or her parent to control his or her feelings in the same way a secure child can. In extreme cases, the child has not been able to establish any organised model for how interaction works at all.

Harmful experience (severe lack of care, abuse and other traumatising experiences) leads to both structural and functional changes in a child's brain (Glaser 2000). These changes include reduced brain volume, abnormalities in the nervous system and hormonal changes. Harmful childhood conditions may also reduce memory capacity and therefore present a risk of later learning difficulties (Wolf 2009). Finally, we now know that stress during childhood presents a risk of contracting immunological diseases such as diabetes and cardiovascular diseases (Dube et al. 2009).

The positive aspect of this is that the period that is most important to a child's development is also the most favourable in terms of intervention. Research shows that early support for parents, preferably during the first pregnancy, has favourable, long-term effects on parenting skills and on children's development and health.

## EXAMPLES OF PROMISING INTERVENTION FOR NEW PARENTS

### The Edinburgh method

The Edinburgh method is an evidence-based form of parental support with the aim of identifying depressed new mothers. Between 10 and 15 per cent of all new mothers become depressed during the first six months after childbirth. One problem is that women suffering from postnatal depression seldom seek help. It can be very difficult to say that life feels difficult when you and others expect life to be full of joy.

The method involves screening with EPDS (Edinburgh Postnatal Depression Scale) and close follow-up. It is user-friendly and has to be supplemented with other support measures.

The method consists of three parts: 1) Offering the opportunity for mothers to complete a self-assessment form, an EPDS form, with 10 questions at a visit to the child health clinic when the child is 6-8 weeks old. The questions concern how the woman felt in the past week. 2) A feedback discussion with the midwife directly after the mother has completed the form. 3) In the event of mild depression, the woman is offered a series of sessions by the midwife, non-directive counselling. If the problems are more extensive, the woman is referred to a specialist.

Several studies indicate that this form of early intervention produces effects in a vulnerable group of women. With relatively limited intervention, more extensive problems can be prevented. Offering rapid support for women with postnatal depression at as early a stage as possible is cost-efficient and can prevent the woman developing long-term depression. The important factor is for intervention to take place directly after the depression has been diagnosed.

Using the Edinburgh method, combined with support discussions, is expected to produce alleviation of symptoms in mild to moderate depression. Several publications support this, including a new RCT by Morell et al. (2009) based on 3,000 new mothers. The study showed positive effects both 6 months and 12 months after childbirth. The effect for the child remains unclear but it is assumed that parents are more sensitive to their children's needs when the symptoms decrease. Good mental health protects against other risk factors such as serious disease, stress and unhappiness at work.

The Edinburgh method has been implemented in more than 130 municipalities in Norway. Implementation will be extend-



Read more about  
The Edinburgh method  
in the report  
'Low spirits and depression  
in connection with birth' ...

... which can be  
downloaded at the website  
of the Norwegian Institute of  
Public Health. The EPDS form is  
available there in Norwegian,  
English and Arabic.

ed to more municipalities in the years to come. The Infants' Network (Spedbarnsnettverket) is responsible for spreading and implementing the method in Norway. An implementation method has been developed, the OSS model. The process of implementing the Edinburgh model takes 2 years and includes gaining acceptance from managers, training, guidance for at least one year after implementation and experience seminars.

### **The Parenthood First programme**

The origin of the programme is the Yale Child Study Center, New Haven, USA. The target group is parents expecting and giving birth to their first child. The families are recruited from antenatal groups. The groups of parents meet 12 times during a 24-week period. The aim of the groups is for parents to think together about the feelings and needs infants express via their behaviour and about various aspects of parenthood. If necessary, the families may be referred to additional support measures. The groups are targeted at both parents, who come with their child. They are targeted at all families but the model is applicable to risk groups.

The theory behind the intervention is rooted in attachment theory. A parent with high reflective capacity can respond to a child's feelings and needs without being seized with anxiety or frustration himself or herself. The child is regarded as a separate individual and the parents are trained to consider the child's feelings with the child's behaviour.

There is scientific evidence that both group-based and individual-based interventions can be used to boost parents' reflective capacity in risk situations. In Finland, case-control research is carried out by senior lecturer Mirjam Kalland of Mannerheims Barnskyddsförbund. 200 families who participate in the 'Parenthood First' parents' group are compared with 1,500 families who receive standard advice in the child healthcare service.

The training requires no prior knowledge. It takes five days plus one group session held under supervision. In-service training days are arranged after this. Staff from child health centres, healthcare professionals, social workers and family therapists have participated.



## SCHOOL PREPARATION PROGRAMMES AS EARLY INTERVENTION

*Based on the  
Hippy intervention*

### HippHopp programme

In Denmark, the government has set aside funds for the development and documentation of parental programmes. One of the programmes tested is HippHopp, a school preparation programme in which the target group is children aged between 5 and 6 who have not yet started school and their parents. The programme is offered to families who may derive particular benefit from being prepared for the challenges of starting school. Some of the children have language difficulties and parents of non-Danish backgrounds. HippHopp is a structured programme that lasts 30 weeks with activities in which the parents participate and which they carry out with their children. HippHopp is designed to contribute to children developing their language, exploring and solving problems with others, developing gross and fine motor skills and studying children's culture in the form of literature, games and play.

All families participate voluntarily and recruitment is via preschools. For 30 weeks, the parents have to set aside 20 minutes of every working day for activities. The programme starts in October in the year before the children start school and ends in May. It prepares both children and parents for school. HippHopp consists of five parts that make up the programme. 1) A coordinator who is responsible for giving instructions to HippHopp guides. 2) HippHopp guides who visit six families each week, supply material and go through the activities with the parents. 3) Books, material and activities. 4) Group-based activities with other families participating in HippHopp. 5) A website which functions as inspiration for the parents and provides tips on activities.

The idea of HippHopp is for children to acquire skills by playing. The tasks should be fun and varied for the children. Each weekday has a theme, for example language development, social skills, nature and natural phenomena and cultural forms of expression. The programme is based on the philosophy that there are many paths to learning. There are no right answers for the tasks set.


The parents' role is to encourage and inspire their child rather than to value and assess the child's contribution. All activities are based on interaction between parents and children. The parents who set aside 20 minutes every weekday with their child must then preserve the routine when their

child is at school. Each week, the parents are visited at home by a HippHopp guide to go through the week's activities and the material that is needed for the week's exercises.

HippHopp coordinators and HippHopp guides undergo five days of training before they can start to work. It is absolutely possible to involve volunteers or, for example, students as HippHopp guides.

The original programme, Hippy, was developed in Israel and implemented in the USA, Australia, New Zealand, Germany, Austria, Canada, South Africa, El Salvador and Israel. There are US evaluations with control groups that show the effect of the programme. On behalf of the National Board of Social Services in Denmark, the consultancy firm Rambøll carried out an evaluation of HippHopp. The evaluation shows that children developed positively in relation to the skills with which the programme works. Children's language and motor and cultural skills developed. Children became better at concentrating on tasks and the children whose parents have a mother tongue other than Danish developed their language in particular. The participating parents indicate that they are very satisfied with the programme, particularly the home visits, activities and material.

HippHopp was tested in four Danish municipalities and evaluated directly after the end of the programme, with follow-up 4-6 months after the end. The basis of the evaluation is limited and more research is needed. However, it is an interesting programme that is appreciated by parents and children and may be a good option for vulnerable families or families who have immigrated from other countries. The importance of school as a protective factor is high and if the intervention can contribute to more children thriving and developing at school, it may be an intervention that can be implemented more widely at a limited cost.



Read more about  
HippHopp and the evaluation  
at [www.socialstyrelsen.dk](http://www.socialstyrelsen.dk)

## **SUCCESSFULLY IMPLEMENTING NEW METHODS**

In the Nordic countries, a lot of resources are spent on developing the area of early intervention. New methods are often implemented in relatively short projects. After the end of the project, it is fairly common for the new working method to cease being used. New managers arrive, project managers end their employment or there is no money. A huge waste of resources, in other words. In recent years, implementation research has acquired new knowledge about how to successfully implement new methods effectively. A leading researcher in this area is Dan Fixsen,

who has prepared an overview of knowledge in the area, among other things.

With knowledge about implementation, an average of 80% of the planned change work is carried out after three years. Without such knowledge, 14% of the change work is carried out after 17 years on average! (Fixsen, Blase et al. 2001).

Implementation concerns the procedures used to introduce new methods in ordinary activities which ensure that the methods are used as intended and on a permanent basis.

A long-term strategy is required for successful change work. It often takes several years before a new method has been integrated and become part of the ordinary work. Researchers usually talk about 2-4 years. Change work passes through four phases:

### **1. Inventory of requirements**

Change work should start with an inventory of the requirements in relation to new methods. Which area needs to be improved and which methods exist that are supported by research. It is important not to stop using a method that works just because implementation has failed. It is often the case that there is no desire to change an existing method because it is found to work well. More facts are often needed to make a decision. This can be achieved, for example, by means of local follow-up that shows whether children/families are actually better off after the intervention has been completed.

### **2. Installation of the method**

Before installation begins, the change work must be accepted at all levels. The support of politicians and managers is essential to the success of implementation. Staff must have enough time to prepare themselves for change work. When a decision has been made to introduce a new method, the next step is to ensure the necessary resources. This concerns premises, time and activities, new material, staff recruitment and training. It is important to identify potential obstacles and success factors before the start.

### **3. Use of the method**

When the new method starts to be used, professionals sometimes feel uncomfortable and uncertain. Change work

therefore often fails in this phase. There is a risk that professionals then revise the method as they see fit. Supervision may be a good way of preventing this. Each method contains core components that constitute the essence of the method. An important part of the implementation is to use the core components as intended. If you do not work with the method as intended, the method is no longer supported by the research.

#### **4. Maintenance of the method**

When more than half of the professionals are using the method correctly, it can be said that the method has been implemented. After another 1-2 years, the new method has become routine.

*It may seem like a great deal of work to succeed with implementation. It is necessary to consider that failed implementation may result in poorer support for children and families. In addition, it is an inefficient use of tax revenue when implementation fails on account of a lack of knowledge about change work.*

### **MORE EFFECTIVE WITH NATIONAL IMPLEMENTATION**

In the Nordic countries, municipalities have a high level of autonomy when it comes to deciding on the support provided for children and families. Therefore, the range of early intervention varies greatly between municipalities. Government initiatives are often taken today in the form of project funding that is handed out during project periods. Evaluations have shown that many of the projects that are started end after the end of the project period.

Norway has chosen a model of government management by means of implementation support for development in preventive work, among other things. The Norwegian Center for Child Behavioral Development carries out research, implementation, training and further development of methods in the work to prevent severe behavioural problems among children and young people. There is a national implementation organisation, regional centres of expertise that train and supervise staff in the methods used by society. The municipalities choose whether they want to participate and the municipalities that do participate receive free training and supervision.

It can be difficult for an individual municipality to implement evidence-based methods. Certain effective interventions only have manuals in English. Some methods

are licensed and require the municipality to pay fees to use them. Sometimes municipalities solve the problem by working with a number of other municipalities. Many of the Nordic municipalities are small, and implementing new working methods may entail difficulties. Few people can be trained and if they end their employment, it may be difficult to maintain the methods.

How many methods does a country need? Sometimes we describe it as 'let a thousand flowers bloom'. A varied range of interventions is good but there are currently around 100 different interventions in the Nordic countries. Most are not evaluated. Nor will there be sufficient resources to evaluate all in the future. Increased Nordic collaboration on early interventions for children and young people could give rise to pan-Nordic research. The Nordic countries are small and have much to gain from collaboration. Implementing a limited number of interventions in the Nordic countries at the same time and carrying out joint evaluations could contribute to raising quality and better use of resources. In parallel, it is important for welfare services to be developed and preserved in a way that allows for equal support in all regions of the Nordic countries.

### EARLY INTERVENTION IS WORTHWHILE

In 2012, the Danish Ministry of Social Affairs and Integration published the report 'Analysis of the economic consequences in the area of vulnerable children and young people'. The report focuses on whether it is economically profitable for society to invest in evidence-based interventions. It is well documented that vulnerable childhood and adolescence also have consequences in adult life. A child (in Denmark) who has been placed in a foster home or institution will cost society an average of DKK 6.7 million (EUR 900,000) more than a child that was not placed there. Compared with the normal population, such children more often have addiction problems and mental problems and commit crimes. More live on benefits and many have no education beyond primary and lower secondary school (39% of children placed in foster homes or institutions had education beyond primary and lower secondary school, compared with 76% of the normal population). It is especially young people who are convicted of a crime who fare worse. The analysis shows that there are great economic gains from switching intervention to more effective intervention and intervention that enhances parenting skills.

Four interventions with strong support from research have been selected in the analysis:

- **The Incredible Years**—a family support programme that aims to enhance parenting skills
- **Placing children with relatives and networks** as an alternative to placing them in foster homes
- **MST (Multisystemic therapy)**—a programme that supports parents of young people with extensive social problems
- **MTFC (Multidimensional Treatment Foster Care)**—a programme for young people with severe behavioural problems. Brief placement in specially trained foster homes and intensive support for parents.

The analysis described in the report shows that these interventions could be applied to roughly 1/3 of the children who are currently the object of such types of intervention. If society switched its intervention to these evidence-based programmes, they would result in a social gain, even if some of the interventions are expensive in the short term.

One problem in this connection is that the authority that invests the money, the municipality, does not always see the return on the money invested. The programme The Incredible Years takes around four years to become profitable according to calculations in the report. Early intervention with The Incredible Years can save DKK 52,000 (EUR 7,000) per child in a period of more than four years. The figure is based on only 15% achieving a positive life change. This does not include the cost of extra resources at school, special tuition for example.

A saving that is directly worthwhile is placing children with relatives instead of in traditional foster homes. Network placements have proved to produce good results. A number of international studies show that children fare better in the homes of relatives. A Danish study shows that there is no difference in terms of results between the types of placement. Not all children who need to be placed can be placed with relatives but the potential is significantly higher than the 5% of children placed who live with relatives in Denmark. A change of direction may be needed in many municipalities.

Increased use of intensive and systematic family therapy (MST) for young people with severe behavioural problems will be one expense in the first year. In 2-3 years' time, this produces a gain for the municipality.

Increased use of systematic family therapy for the most severely affected young people (MTFC) is expensive, costing nearly one million per young person. This is a major cost for a small municipality and may be difficult to prioritise. It takes around 2 years for a municipality to recoup the cost. However, in the long term the earning may be approximately DKK 341,000 (EUR 45,000) per placement. The social costs may, of course, fall even further if you include the costs of health care, treatment for addiction, unpaid tax revenue, etc.

The most vulnerable group is that of children placed who have also been convicted of crimes. *Theoretically, it can be said that an intervention costing DKK 100,000 (EUR 13,000), which produces results for 1 in 10 young people, is profitable from a socioeconomic perspective.* In summary, it can therefore be worthwhile, often in the short term and definitely in the long term, to invest in evidence-based programmes that enhance parenting skills. The most important argument, of course, is that these young people have the opportunity to live their lives with a higher quality of life. Some of the families have a history of social problems passed down through several generations. Breaking a family's negative life trajectory can have positive effects for future generations as well.





## IMPLEMENTATION OF PMTO IN ICELAND WITH LIMITED RESOURCES

The PMTO parental support programme has been implemented in Iceland since autumn 2000. The background is that increasing numbers of children needed support from special services on account of abnormal behaviour. The implementation of the programme has now been studied.

The aim of the study was to examine whether PMTO could be implemented in a society with limited resources and a lack of national support. Experience from the Norwegian national implementation of PMTO was used for purposes of comparison. In Norway, the programme had received ministerial support and significant financial and professional support right from the start in 1999. There was no such support in Iceland.

The study in Iceland was carried out between 2000 and 2010. Similarly to the Norwegian study, three 'generations' of professionals who were given training in PMTO were followed up. The interest of the study was primarily focused on knowing whether the degree of faithfulness to the study would differ from that in the Norwegian study or whether the result would be comparable despite differences in resources and national support. High faithfulness to the programme is desirable and means that the users follow the available manuals and instructions for implementation.

Faithfulness to the programme was measured using the FIMP instrument, which measures knowledge, structure, teaching, process skills and general development. 16 people received the training. Twelve of these graduated from the training during the 2000s.

The results of the study in Iceland tally with the results of the Norwegian study. This means that the first (G1) and the third generation (G3) who were trained demonstrated a high degree of faithfulness to the programme. There was a small decline in faithfulness to the programme between the first and second generations (G2). The degree of faithfulness to the programme rose again after this.

The period between the first and the second generation coincides with the time at which the material was adapted to cultural conditions. This included a great deal of translation work.

*The results indicate that it is also possible to implement PMTO in societies with limited resources. However, it is necessary to attach sufficient importance to previous experience of critical phases in the implementation process.*

## Interview

### EXAMPLE: PMTO WITH SOMALI AND PAKISTANI PARENTS—INTERVIEW

Despite great efforts being made, very few Somali and Pakistani parents in Oslo participated in the municipality's parental support programme. There was great frustration among professionals. The situation changed when the social services changed their recruitment method and offered a specially adapted version of PMTO.

"We succeeded by having direct contact with the mothers," says Monica Flock, psychologist and project manager of the Minority project, which was implemented in two districts of Oslo in 2009. Initially, the families were very sceptical. They were very afraid of the social services.

All 720 Somali and Pakistani families received a letter and were then telephoned with an invitation to a meeting at a school.

The premises were well known by the participants, an open preschool that many had visited before. Childminders were employed to look after the children while the mothers attended the course. To encourage the participants to come on time, a lottery was arranged at the start of each session. This became very popular. Each of the 18 2.5-hour sessions included a 30-minute food break with the children.

Words such as 'problems' and 'behavioural difficulties' were not used either in the invitation or later during the implementation of the programme. Nor did Monica Flock mention that she is a psychologist until right at the end of the course.

"Psychologists are associated with electric shocks and very serious problems," she says. "We used positive words to describe the training and focused on the fact that the training enhanced parental skills and meant development. We used roleplay to show the meaning of good interaction in a concrete manner."

A number of so-called link workers underwent a short version of the training to learn the basics of PMTO. They had the same ethnic backgrounds as the mothers participating, were known by everyone and had a good reputation. They were a link between the course leaders and the mothers, a type of cultural mediator. For example, they helped describe words such as 'aggression', which does not exist in Somali, or the difference between 'reward' and 'bribe', which are the same word in Somali.

"They also helped us become more sensitive to different topics," says Monica Flock. "For example, we understood that Somali women never talk about their husbands when other women are present."

All the course material was translated into the participants' languages but was otherwise adapted to the target group surprisingly little.

"PMTO has a clear theoretical foundation but is also a very flexible method," says Monica Flock. "We retained all its components, consulted the originators when we needed to do so and carefully documented our adaptation of the manual."

All the components of PMTO were retained: collaboration, encouragement, setting limits, problem solving, emotional control and supervision.

## CONCLUDING WORDS

Early intervention for vulnerable families can take place in different ways. Up to now, the Nordic welfare model has had a broad, universal range of services for all families, child health care, maternity care and family centres in many municipalities. Society today demands a great deal of parents. Offering high quality preschools to all children is perhaps the most preventive intervention in the Nordic countries. Divorce rates are high and there are children who do not fare well at home.

Parental support programmes are an effective intervention for parents who need extra support. Parental support is now available in many municipalities but the families at risk of marginalisation are often missed. With examples, we show that they can be reached. A national strategy for implementation has proved to be a success factor when it comes to introducing new working methods. Project funding that is granted for 1-2 years at a time seems to be a difficult way of achieving lasting improvements. Many projects end when the money runs out. Implementation requires a long-term strategy if it is to succeed.

The Norwegian intervention TIBIR shows how research, development and implementation can be linked together. It is difficult to expect all the small municipalities we have in the Nordic region to invent the wheel themselves and manage to implement/train/evaluate new working methods. Early intervention is worthwhile, however you calculate the costs. In Denmark, it has been possible to gain joint financing for Family Centres, which are targeted at vulnerable young mothers, with the employment service. This is a good example of collaboration across borders.



Read more in  
the inspiration booklet:  
Children in the Nordic  
region—Development of  
Nordic family centres

## Risk and protective factors in relation to future psychosocial problems among preschool children—what we know from research and how it can be applied in practical work



What takes place in the life of a small child can affect future development, health and well-being for the rest of his or her life. From research we now know that many of the problems people experience in adolescence and adulthood can be linked to risk and protective factors that emerge at preschool age. There is now knowledge about the characteristics, behaviour, relationships and circumstances that increase and reduce the risk of long-term psychosocial problems. However, practical use of this knowledge in the health service, preschool, social services and psychiatry remains limited.

*Based on a research overview carried out by Anna-Karin Andershed, Henrik Andershed & David P. Farrington on behalf of the Nordic Centre for Welfare and Social Issues. The research overview is available in full at [www.nordicwelfare.org/tidigainsatser](http://www.nordicwelfare.org/tidigainsatser).*

This overview has two aims:

- 1) To identify the risk and protective factors for children of preschool age (up to 6) that are important for the development of psychosocial problems. Problems in the form of acting-out (externalised) and internalised problems are included in the overview.
- 2) To discuss how risk and protective factors can be used by professionals who work with children and their families.

## **FOCUS ON ACTING-OUT AND INTERNALISED PROBLEMS**

Two of the most common problems in young people are externalised and internalised problems. Externalised problems include disturbing, defiant, aggressive, abnormal, criminal behaviour, as well as the use/abuse of alcohol and other drugs. Internalised problems are defined as anxiety-related and depressive symptoms or behaviour. Both types of problem are related to the majority of negative consequences in adulthood.

Therefore, it is important in research to identify risk and protective factors for these problems and then use this knowledge in practical work with children and their families. Early identification of children at risk of problems later in life is a major challenge for professionals who work with children. *'Wait and see' is not a good strategy. With increased knowledge, people who work in a preschool, a family centre or child health care can give children a much better chance of a good life.*

It is also important to emphasise that research shows that adults who have externalised problems such as criminality also very frequently have other problems, for example addiction and mental illness. A Swedish study of around 500 young adult women showed that it is statistically more common than you might expect (among those who have problems) to have several different problems at once. For example, many women with addiction problems also showed criminal behaviour and had mental illness (Wångby et al. 1999). The same study showed that it is actually extremely rare only to commit criminal acts and not also suffer from addiction and mental illness in adulthood. *The conclusion of this is that factors that are risk factors for externalised problems may frequently also be risk factors for other psychosocial problems.*

## WHAT ARE RISK FACTORS AND PROTECTIVE FACTORS?

Many of the evidence-based prevention programmes are based on research into risk and protective factors. Risk factors increase the probability of a problem occurring. Protective factors mean that the probability of problem behaviour decreases when risk factors are present. Risk and protective factors affect the probability of problem behaviour. They do not guarantee a reduction or increase in problem behaviour. Individual risk factors do not necessarily always mean any markedly increased risk. However, several concurrent risk factors often do. Many prevention programmes therefore try to affect *several* risk and protective factors.

Risk and protective factors may be linked to individuals, families, friends, preschool, residential area, etc. Many risk factors are also linked to other risk factors. One example is that families with a low level of education more frequently live in socially deprived residential areas where violence and addiction are more frequent.

The opposite is when parents fail to supervise and show interest in their child. Serious conflicts between parents or between parents and children also entail a risk factor. Other serious risk factors are violence and assault, as well as other circumstances such as financial problems. There are risk factors that can be linked to the child before he or she starts school. Defiance and aggressiveness, in particular, have proved to be serious risk factors in the long term. This behaviour may, in turn, have other negative consequences such as problems in relationships with friends or with teachers and school, which reinforce negative development. It is common for children in the risk zone to have learning problems.

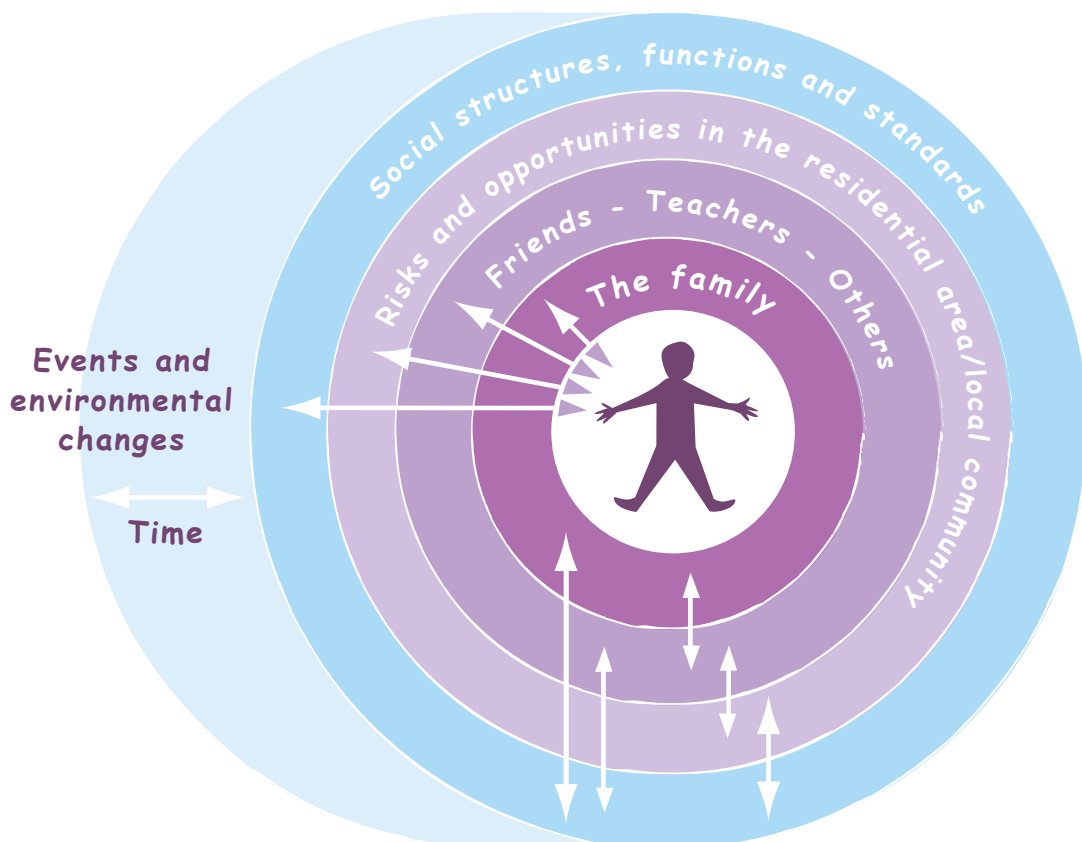
There is less research on protective factors than on risk factors. A protective factor, for example, is a character trait, behaviour, relationship, characteristic, event or circumstance which reduces the probability of future psychosocial problems. This means that protective factors may make a child more resistant to risk factors and may make it easier for the child to develop positively despite the presence of risk. A protective factor may be that a child receives positive attention when he or she does prosocial things. It is more important to highlight children's positive actions than their negative actions as it increases the probability of positive actions. Preventive parental support programmes are often based on these principles. A protective factor may be parents' ability to set limits for the child and have clear expectations of the child's

behaviour. It is also important to spend time and have fun with the child.

Children who grow up in negative childhood environments will experience many risk factors. Therefore, it is an important task for parents and professionals who work with children to enhance and maximise the protective factors in and around a child and not only work to reduce the risks.

### **RISK AND PROTECTIVE FACTORS EXIST AT MANY LEVELS**

To understand the development of behaviour, it is necessary to start from an approach that covers both the individual and the environment. The holistic-interactionistic perspective provides such an approach. This means that behaviour develops as a result of continuous interaction between the individual and the individual's social environment. In Figure 1, the arrows show how factors at various levels can affect each other. The child may, for example, affect the family/parents and the parents may, in turn, affect the child.



*Figure 1. An ecological model of bidirectional effects between levels or layers of risk and protective factors.*

There are several different ways of categorising risk and protective factors and one of these ways, which has clear practical consequences, is division into factors that can be changed (dynamic) and factors that cannot be changed (static). Dynamic factors such as the behaviour of the child or the relationship between the child and the parents can be affected via support intervention. Static factors such as gender affiliation or ethnicity or previous events cannot be affected. In other words, intervention has to focus on dynamic risk factors.

### WHAT ARE THE RISK AND PROTECTIVE FACTORS IN PRESCHOOL CHILDREN?

The risk and protective factors identified in the overviews are shown in Table 1. It is important to note that the table does not entail any ranking of risk and protective factors. That could not be implemented. In other words, Table 1 is a list, without any inherent order, of risk and protective factors in preschool children that, in empirical research, have been shown to be linked to future problems.

What is clear in Table 1 is that a relatively large number of factors have been identified as risk and protective factors as early as at preschool age. The factors are primarily in the child and his/her immediate social environment, for example in the family and among friends. It is also clear that many factors can be taken into consideration in practical work with children as they are potentially changeable. *In other words, this means that it is possible to influence or do something about most of these risk factors that can be identified in preschool children.*

Several, perhaps many, risk factors have a limited so-called predictive value before the age of 3 years. Therefore, it is difficult, on the basis of assessments of small children under the age of 3, to say anything about how they will be in later life. The assessments tend to become more and more reliable with increasing age. For example, behavioural problems assessed before the age of 3 are less stable than when the assessments are made between the ages of 3 and 6. This indicates that caution should be applied to using current knowledge about risk factors for *risk assessment* before the age of 3. However, it is less problematic to use the knowledge as a means of changing the situation here and now.

### CAN US RESEARCH BE APPLIED TO NORDIC CHILDREN?

Most of the research included in the overviews and summarised in Table 1 was conducted in the USA. However, there are few



Table 1.

Risk and protective factors among children at preschool age for future externalised and internalised problems.

Parental factors	Risk factors	Protective factors
Parental factors	Parents' mental illness	Positive parent-child relationships
	Criminality	Secure attachment between parents and child
	Alcohol abuse	Parents' responsiveness
	Low IQ	Parents' acceptance
	Low level of education	Few parent-child separations
	Dependent on social benefits	Parents' ability to meet the child's needs for security and stimulation
	Low socioeconomic status	
	Large family	
	Crowded home	
	Stress	
	Marriage problems	
	Conflicts	
	Separations	
	Violence in the family	
	Children witness violence	
	Physical punishment of children	
	Lack of supervision	
	Young motherhood	
	Single parent	
	Foster home placement	
	Insecure attachment	
	Deficient parenting skills	
	Low engagement	
	Mother's negative control	
	Low affection	
Child factors		
	Behaviour problems, aggressiveness and defiance	High IQ
	Temperament difficult to handle	
	Fearlessness and tension-seeking behaviour	
	Impulsiveness and inhibition problems	Temperament easy to handle
	Sleep problems	Effective emotional control
	Malnutrition	
	Depression	

The complete summary is available at [www.nordicwelfare.org/tidigainsatser](http://www.nordicwelfare.org/tidigainsatser)



reasons to believe that risk and protective factors at individual and family level, i.e. the type of factors that, according to the research, seem to be most important among preschool children, vary greatly between children in different Western countries. Environmental factors such as poverty, crime, availability of weapons in some residential areas or availability of health care and social security systems may vary more, which means that we should be cautious about basing assessments on generalisations from these factors.

### BEHAVIOURAL PROBLEMS, ONE OF THE STRONGEST RISK FACTORS

There is scientific support for a link between psychosocial ill-health and all the individual risk and protective factors among preschool children that have been identified in research and are presented in Table 1. However, the effect of each individual factor is limited. This means that *most of the children who experience or express only one of these risk factors will have good potential to avoid developing problems in the future. The single strongest risk factor for future problems is externalised problems in a child.* Few studies have examined the long-term effects of risk and protective factors in preschool children. One of these few is the 1970 British Cohort Study, in which around 16,000 preschool children were monitored with measurement of risk factors at the age of 5, up to the age of 10 and in adulthood (30-34). (Murray et al. 2010).

Among the factors identified as risk factors at the age of 5, behavioural problems/externalised problems were the strongest risk factor for behavioural problems at the age of 10. Behavioural problems at the age of 5 increased the risk of the same problem behaviour at the age of 10 by a factor of four. The other risk factors at the age of 5 increased the risk of behavioural problems at the age of 10 by a factor of around 1.5-2. This was true for both boys and girls.

In terms of the risk of adult criminality, behavioural problems did not stand out as much. All risk factors increased the risk of criminality in adulthood roughly equally, by a factor of 1.5-2 each. *In other words, it seems that externalised problems in a child are the single most important risk factor for problem behaviour in adolescence.* Without intervention, therefore, the risk of problems increases, primarily in teenage years but also later in life.

## MANY RISK FACTORS MEANS HIGHER RISKS

Research shows that both risk and protective factors tend to have cumulative effects, i.e. the more risk factors the higher the risk and the more protective factors the better the protection. For example, the 1970 British Cohort Study showed that the higher the number of risk factors a child has at the age of 5, the higher the risk of developing problems in adolescence was. For children who did not express or were not exposed to any of the risk factors measured, 2% of the girls and 5% of the boys demonstrated problems in teenage years. *For children who expressed or were exposed to five or more risk factors, the risk of behavioural problems in teenage years increased by 38% for girls and 54% for boys!* In terms of predicting criminality in adulthood, the tendency was the same. 3% of the girls and 17% of the boys who did not express or were not exposed to risk factors developed criminality in adulthood. With more than 3 risk factors, the proportion of people with convictions in adulthood increased to 11% for girls and 44% for boys.

## SIMILARITIES BETWEEN BOYS AND GIRLS IN TERMS OF RISK AND PROTECTIVE FACTORS

Although boys are clearly overrepresented in terms of behavioural problems at preschool age, the same risk factors seem to be important regardless of gender. Nor are there any clear or strong indications that protective factors are very different between boys and girls. However, there is research that indicates that boys are often exposed to a higher number of risk factors and higher levels of risk of externalised problems than girls, although the risks in themselves are largely the same. The practical consequence of this is that an assessment of risk and protective factors does not need to be different for boys and girls.

## INHERITANCE AND ENVIRONMENTAL ASPECTS OF RISK AND PROTECTIVE FACTORS

The majority of studies show that genetic and environmental factors are important for the development of externalised and internalised problems. One way of understanding this is that an individual's genetic makeup affects the early development of the nervous system, which creates the inclination, sensitivity or vulnerability for the individual to develop certain risk factors. Several of the risk factors that have proved to be risk factors in research, for example hyperactivity, attention problems and restlessness, are at least partially genetically based. However, it is important to note that these problems, partially genetically

based risk factors, can still, of course, be influenced in a positive direction via various types of intervention. *The fact that behaviour is partially inherited does not need to mean that it cannot be changed!*

## APPLYING KNOWLEDGE OF RISK AND PROTECTIVE FACTORS IN PRACTICE

This publication presents available evidence of risk and protective factors at preschool age for various types of problem. This evidence is based on groups of children. This means that many children who express or are exposed to a certain risk factor will never develop problems. This is where a professional's ability to analyse risk and protective factors adequately comes in and is central to the planning and success of intervention. A professional has to examine how important a risk factor is for this specific child and how the protective factors observed can affect this specific child. This requires training, which we will return to below.

## RISK-FOCUSED PREVENTION AND TREATMENT WORK

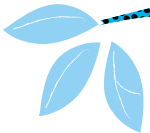
A very concrete way of integrating the best available evidence in practical work is to use knowledge about risk and protective factors in the planning and implementation of preventive or therapeutic intervention. Doing this can be called *risk-focused prevention and treatment work* (Farrington & Welsh 2007). This working method is based on the idea that changes in risk factors will lead to problems decreasing. In the same way, enhancement of protective factors for a specific problem will act as a buffer against or change the effects of risk. Risk-focused prevention and treatment work is based on two stages:

### 1. Describe and assess risk and protection factors.

Identify children with risk factors and/or with weak protective factors. Describe/assess risk and protective factors in the specific child and the family to obtain as detailed a picture as possible of the risk and protective factors that need intervention.

### 2. Plan and implement intervention targeted at the risk and protective factors in question.

Plan and implement interventions to reduce/eliminate the risk factors in question and enhance/maximise the protection factors.



Working in this way involves a very solid method of combining research, practice and policy creation which several Western governments have considered to be both feasible and practical (Farrington & Welsh 2007).

### NOT AN EXACT SCIENCE

The research gives us a relatively extensive list of risk and protective factors. A difficulty and a limitation of this research are that we do not currently know which of these factors cause externalised and internalised problems. It is also important to note that the same risk factors can lead to different consequences in different children.

Therefore, we cannot be certain about whether a specific risk factor actually *causes* externalised or internalised problems. It *may* of course be the case but it is difficult to prove it reliably. We can be sure that the risk factor increases the risk of the outcome but not whether it will be the case for the specific individual.

### THREE PRINCIPLES OF RISK-FOCUSED PREVENTION AND TREATMENT WORK

When applying risk-focused prevention and treatment work in practical work, there are three principles that are very useful; the principles of risk, need and responsiveness. Research shows that the use of these three principles increases the probability that intervention will be effective.

#### The risk principle

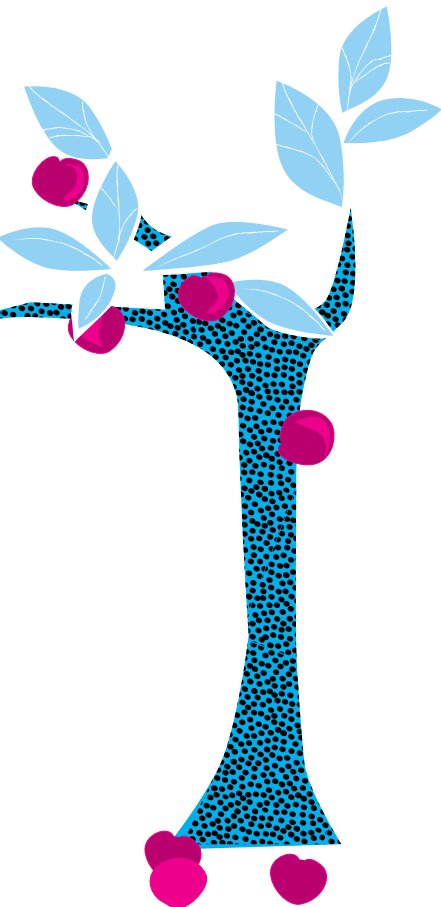
The risk principle means that an intervention will be more effective *if the most intensive efforts focus on children with a high risk of future problems*. As we described earlier, children with several risk factors, for example, run a higher risk of problems than children with fewer or individual risk factors.

#### The need principle

The need principle means that interventions are more effective if they are formulated and tailored to focus on the specific child's most relevant needs, the most important risk and protective factors of the child and his/her family. Interventions should be targeted at *influencing what causes and maintains the problem or problems that are to be reduced*.

#### The responsiveness principle

The responsiveness principle means that implementation of an intervention must be tailored so that the child/family



responds to the intervention. To be effective, it must be adapted to the child's and the family's abilities, learning styles, preferences, wishes and motivation.

### STRUCTURE IMPORTANT WHEN ASSESSING RISK AND PROTECTIVE FACTORS

When they work with risk-focused prevention and treatment, it is necessary for professionals to assess/describe risk and protective factors in the child and the child's environment. This can be done in at least two different ways; with or without the help of structured assessment instruments. Structured assessment instruments have clear definitions of the risk and protective factors to be assessed. They also have well-defined response scales for how risk and protective factors should be graded. Examples of structured instruments that concern many of the risk and protective factors presented in this publication are EARL-20B (for boys under 12), EARL-21G (for girls under 12) and Ester assessment. There are also short questionnaires, sometimes called screening instruments. SDQ and Ester screening are examples of these. They can be used in an initial situation in which professionals want to find out whether intervention and more qualified assessment or investigation are necessary.

Achieving high inter-assessor reliability or consensus is a fundamental part of a legally secure assessment. This means that two independent assessors largely agree about the assessment of a child and the child's family, which is easier to achieve when they use a structured assessment instrument. The assessment is also documented systematically and it is possible to repeat the same type of assessment in connection with follow-ups. For example, this makes it easier to answer questions such as: Have the risk factors decreased and the protective factors been enhanced after the interventions?

A recent Swedish research study showed that social workers who were trained in and used a structured instrument (in this case Ester assessment) identified significantly more risk and protective factors in an assessment of a written case about a boy with problem behaviour than social workers who worked with traditional investigation methods. This was particularly clear in respect of protective factors, which were missed to a much greater extent when social workers carried out traditional investigations. *On the basis of research, it is therefore possible to maintain that professionals should use structured instruments as tools to assess risk and protective factors in children and their parents.*

## IMPORTANCE OF EDUCATION

Professionals require adequate education and training to be able to use the knowledge about risk and protective factors in practice. Such education needs to cover fundamental knowledge about risk and protective factors, the research that exists into these factors and its strengths and limitations. It is also necessary to *include training* in how to communicate such information to the family and, in particular, how the information about risk and protection can be used to make plans for effective interventions.

Professionals who work with risk-focused prevention or treatment will probably identify and offer interventions to a larger number of children than they actually need to do. They will also miss some of the children and families who need professional support and help. These limitations in risk-focused prevention and treatment work must be known to the professionals who work with it. A very important aspect of applying knowledge about risk and protective factors to individual children and families concerns the professional's communication with the guardians. Professionals must be able to communicate risk—why certain factors are assessed, what high risk means, etc., in a very delicate manner. This is to avoid negative effects such as pigeonholing the child or negative relationships between the family and the professional.

## WHICH PROFESSIONS CAN UNDERTAKE RISK-FOCUSED PREVENTION AND TREATMENT WORK?

All professionals who work with children at preschool age and all activities that are targeted at children and families with children can, with adequate training and supervision, in practice apply the way of thinking about risk-focused prevention and treatment work. This is a very concrete way of working in an evidence-based manner. It is highly probable that the actual assessments and interventions will be implemented in different ways, depending on the activity concerned; primary care, psychiatry, preschool or social services. A social worker can use an assessment instrument in an investigation situation while a preschool teacher in a family centre can use knowledge about risk and protective factors in dialogue with the parents and to act more easily when they encounter a child at risk.

It is also probable that *effective risk-focused work requires cooperation* between different activities as they can supplement each other's interventions. Children's and parents' problems are seldom organised as the activities are

organised. This may mean that a preschool child may need interventions offered by various activities. Preschool, child psychiatry and social services may need to be involved when intervention is formulated. Collaborating activities agreeing to work in a risk-focused manner can contribute to more effective collaboration with shared definitions and objectives. This may make it possible to help the children and families who need support more effectively.

### ASSESSMENT, INTERVENTION AND FOLLOW-UP

Figure 2 shows a possible process of assessment, intervention and follow-up, demonstrating how it is possible, in practical work, to apply the knowledge about risk and protective factors. A structured assessment is first implemented by one or more trained professionals, using a structured checklist or an instrument. This generates a unique list or profile of risk and protective factors in the specific child and the child's family. Risk factors need to be changed, reduced or eliminated and protective factors that are weak need to be reinforced. The risk and protective factors are then analysed on the basis of the principles of risk, need and responsiveness.

With a municipality, there is a limited range of available interventions. It is important for a professional to know about these available interventions and the risk and protective

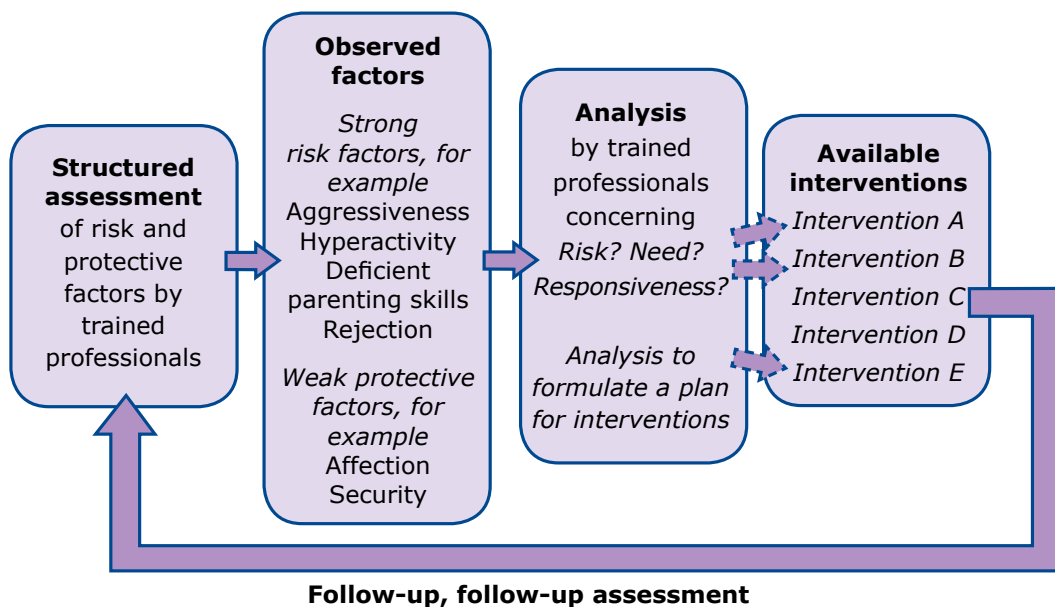


Figure 2. A process of assessment, intervention and follow-up of risk and protective factors.




factors they target, i.e. which risk and protective factors are targeted by interventions A, B and C? A professional who has this knowledge will be well placed to deliver effective interventions. When the plan is subsequently launched, the interventions are implemented. After a certain time, follow-ups and new analyses may mean that the interventions end, that they need to continue or that other interventions have to be offered. This type of circular process should be implemented in a structured manner until the final objectives of the interventions have been achieved.

### **CONCLUDING WORDS ON RISK AND PROTECTIVE FACTORS**

Research into risk and protective factors for future problems in preschool children exists today. However, knowledge is currently far from complete or perfect. There are many things we need to know more about. However, the research that exists is the best available evidence at present and should be used by well-trained professionals so that they can work in an evidence-based manner to help more children live better lives. There is every reason to identify children and families in need for support measures at an early stage. With increased knowledge about risk and protective measures, it is probable that professionals who work with children will feel more certain about when intervention is really needed in a family. The most vulnerable children can have a chance of a better life with professionals who have evidence-based knowledge. Within the Nordic countries, we have unique opportunities to identify children who need support in preschool, in child health care or in family centres.

### **PROMOTION OF DIALOGUE WITH PARENTS—EXPERIENCE FROM FINLAND**

Knowledge about risk and protective factors is important to allow a professional to function effectively in his or her professional role. In addition to this knowledge, the professional also needs to think about how he or she uses this knowledge in contact with families. The way in which professionals apply their knowledge about risk and protective factors is essential to how motivated they are to receive support measures, for example parental support programmes.



Read more about  
dialogue with parents at  
[www.nordicwelfare.org/  
tidigainsatser](http://www.nordicwelfare.org/tidigainsatser)

### **THE CHALLENGE**

Professionals are sometimes criticised for not listening to the voices of parents. There may be a culture that is characterised

by hierarchical activities in which the experts always know best and there is sometimes competition between the knowledge held by different professions. The professionals may also discuss their concern about a specific child for a long time among themselves before the family in question is actively included in the discussion. In addition to the risk of the professionals building a reality that the family does not feel they are a part of, it may lead to the family and the professionals being out of sync with each other. They are in different stages of the process and may therefore have problems finding a common language.

### PARENTS ARE SPECIALISTS IN THEIR OWN CHILDREN

The dialogic approach is highlighted as a counterweight to this. The family's role as a co-player is reinforced when the approach is dialogic. The professionals do not only see the family as a 'target for intervention'. They see it as partners with special expert knowledge. At the same time, the professionals also share their expert knowledge, for example about what research says about risk and protective factors. The family's needs and the professionals' expert knowledge are therefore combined in a new way with the objective of working and learning together.

When parents are engaged as specialists in their own children, it becomes possible to create an alliance in the best interests of the child and to arrive at support measures. On a concrete level, the professional is able to enhance a dialogic approach in the contact with the parents by highlighting the following factors:

- Regard families as equal partners in the work and experts in their own situation. What works for them? Encourage them to raise their own issues!
- Highlight the resources you see in the child and family. Do not focus only on problems.
- There is not always one shared problem. The situation may look different to different parties. For example, a child may behave very differently at home and at preschool. A discussion that leaves space for different approaches may reveal new understanding of what the issue concerns.
- As all families and situations are unique, the professional has to act flexibly and weigh up the professional assessment against the family's own alternatives.

## Interview

### RISK-FOCUSED WORK IN PRACTICE—EXAMPLE OF SJÖBO MUNICIPALITY IN SWEDEN

Why did around 20 schoolchildren aged 8-9 have special arrangements with their school, for example limited school days and home learning instead of normal schooling? For a municipality of the size of Sjöbo, the number is unusually high and the reason why the municipality participated in the Swedish Pinocchio project with the aim of improving work with children up to the age of 12 at risk of developing abnormal behaviour. The results were so good that the municipality continued to work according to the same model and principles after the end of the project.

"We realised that we had to deal with things earlier, not only from years 5 and 6," says Petra West-Stenkvis, head of individual and family care and pupil health in Sjöbo. "We simply had too many emergency interventions."

When the Pinocchio project started, discussions had already progressed a long way in Sjöbo with a view to creating better coordination. It was made easier by the fact that preschools, schools, social services and pupil health were already in the same municipal organisation.

The initiative had top-level political approval and a joint action team was created with family therapists from social services, a psychologist and a special educationalist from pupil health, a preschool teacher and two people from the school's years reception to 5.

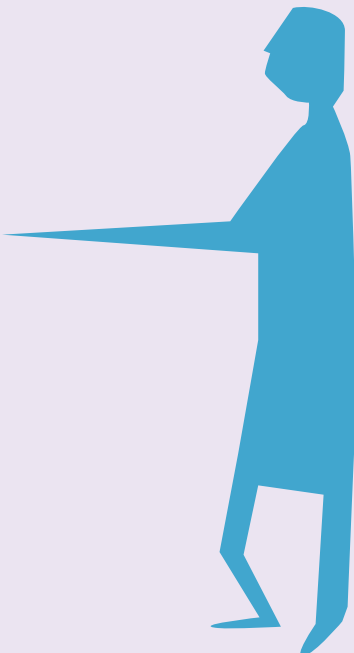
"For us, Pinocchio meant a systematic, structured way of working, agreeing about what we should do, how we should do it and being clear," says Petra West-Stenkvis. "We were not previously used to the requirements for documentation and measuring specific results."

Seven children took part in the Pinocchio project. The aim was to reduce abnormal behaviour by 50%.

"When the Pinocchio project ended in 2009, we had achieved and exceeded the objective," says Petra West-Stenkvis. "We also acquired new knowledge and became more sceptical about our classification of what is abnormal. We partially changed our approach."

Collaboration was the key to the work in Pinocchio and it remains so now that the project has passed into our everyday work."

When it is suspected that a child needs help, parents and the joint action team meet to establish a joint picture of the child and his or her situation.



"We present our views on the basis of our knowledge about risk and protective factors, while the parents present their views" says Camilla Persson, team leader in the advice and support unit. "The staff are highly skilled at identifying a child's needs at an early stage and we are trained in risk and protective factors. This expertise is essential to our work."

The children in Sjöbo do not undergo general screening. The preschool staff have undergone training in 'early identification'. The system is structured around reliance on them identifying problems when they encounter children on a day-to-day basis. If something seems wrong, the joint action team is convened and the parents are invited to a meeting. Everyone completes a multiple choice form with specific information about the child. The form is used as the basis for discussion to gradually arrive at a shared picture of the child's situation and a solution that everyone can support. An Ester assessment is carried out and subsequently repeated every six months as measurement and follow-up.

The group currently works with around 20 preschool children. The working method is the same but the solutions are very different, as the possibilities vary between homes with strong protective factors and homes and environments without such factors.

"Initially, we devote a lot of time to the child and work concertedly to enhance the protective factors and reduce the risk factors," says Petra West-Stenkvis. "The structure of our work, with continuous measurements and follow-ups, means that we feel we are doing the right things."

An important factor in working successfully is support from politicians and senior civil servants. A decision at top political level is required to ensure that the collaboration between different parts of an organisation does not come to nothing. A clear success factor in Sjöbo is that Petra West-Stenkvis, who was involved from the start, is still involved, now at a higher management level than when Pinocchio was implemented. Camilla Persson was also involved from the very start.

"One failure factor is reorganisation in a municipality," says Petra West-Stenkvis. "It is then easy for collaborations to be lost, responsibility is never reassigned and the system withdraws into itself. There is constant movement within an organisation and it is necessary to be able to monitor it from management level."

Other factors that lead to poorer results are when functioning collaboration is achieved with parents and when problems touch on child or adult psychiatry. That collaboration does not work optimally. There it is necessary for the parents themselves to come with their child and be able to formulate the problem."

"It is a verbal activity with discussion as the method," says Petra West-Stenkvis. "We work with people who sometimes require practical guidance in setting the alarm in the morning so they can get up and do not see their problems, only defining them as the child's problems."

The working method, focus on collaboration, has also spread to other areas in the organisation. Joint activities are planned for children, thus automatically enhancing the protective factors.

"Everything is easier with collaboration," says Petra West-Stenkvis. "A simple thing like educationalists being able to pick up the phone and call one of us. Thanks to our collaboration we know each other. This is a really simple way of enhancing the protective factors!"



We would like to say a big thank-you to the participants in the reference and expert groups who have contributed in many ways to the contents of this inspiration booklet:

#### REFERENCE GROUP

- Vegard Forøy, Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), Norway
- Anne Katrine Tholstrup Bertelsen, Danish Ministry of Social Affairs and Integration, Denmark
- Tórhild Højgaard, Ministry of Social Affairs, Faeroe Islands
- Lára Björnsdóttir, Ministry of Welfare, Iceland
- Súsanna Nordendal, Ministry of Social Affairs, Faeroe Islands
- Monica Norrman, National Board of Health and Welfare, Sweden
- Birgit V Niclasen, Ministry of Health, Greenland
- Anne Melchior Hansen, National Board of Social Services, Denmark
- Mia Montonen, FSKC, Finland
- Riitta Viitala, Ministry of Social Affairs and Health, Finland
- Doris Bjarkhamar, Ministry of Social Affairs, Faeroe Islands

#### EXPERT GROUP

- Anne Melchior Hansen, National Board of Social Services, Denmark
- Denise Melin, City of Stockholm, Sweden
- Eivor Söderström, City of Helsinki, Finland
- Erla Björg Sigurðardóttir, City of Reykjavik, Iceland
- Hanne Holme, RBUP, Norway
- Helene Hjorth Oldrup, SFI, Denmark
- Henrik Andershed, Örebro University, Sweden
- Knut Sundell, National Board of Health and Welfare, Sweden
- Mirjam Kalland, Mannerheims Barnskyddsförbund, Finland
- Terje Ogden, Norwegian Center for Child Behavioral Development, Norway





NORDENS VÄLFÄRDSCENTER / Nordic Centre for Welfare and Social Issues  
Box 22028, SE 104 22 Stockholm / Street address Hantverkargatan 29 / Sweden  
[www.nordicwelfare.org](http://www.nordicwelfare.org)