A cross-service approach to identify mental health problems in 3–5-year-old children using the Strengths and Difficulties Questionnaire

ELISABET FÄLT
Dissertation presented at Uppsala University to be publicly examined in Universitetshuset, Biskopsgatan 3, Uppsala, Friday, 20 September 2019 at 13:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish. Faculty examiner: Professor Lars Wallin (Högskolan Dalarna, Dalarna University).

Abstract

The Child Healthcare Services (CHS) in Sweden offer regular health check-ups and reach almost all 0–5-year-old children. Although one of the objectives of the CHS is to detect mental health problems, evidence-based methods are not used for this purpose at the Child Health Clinics (CHCs). Therefore, an evidence-based instrument to assess children’s emotional and behavioural problems through parent and teacher reports, the Strengths and Difficulties Questionnaire (SDQ), was introduced, as part of the Children and Parents in Focus trial, run between 2013 and 2017 in Uppsala, Sweden. The overall aim of this thesis was to evaluate the introduction of the procedure, including the facilitation strategies provided to support implementation, and to provide inter-rater correlations and norms for the SDQ in this population.

Data were collected through individual interviews with nurses, parents and preschool teachers; group interviews with nurses; and a survey performed at the end of the trial to evaluate nurses’ experiences of the SDQ-procedure and the implementation process. In addition, delivery, response rate and population coverage of the questionnaires were calculated. Quantitative data were analysed using descriptive statistics, Pearson correlations and Intraclass Correlation Coefficients (ICC), and qualitative data using Grounded Theory and content analysis.

Results showed that nurses found it useful for their assessment to have access to preschool teachers’ SDQ-ratings. Parents were also positive to the procedure but had concerns regarding confidentiality of the responses. Preschool teachers were least positive, fearing labelling of children and negative parental reactions. Significant, albeit poor, agreement (ICC) was found between parent and teacher ratings and good agreement between parents’ ratings. Teachers were found to report lower levels of problems compared to parents. Cut-off values differed for age and were somewhat higher for boys (lower for prosocial), suggesting that boys display more behaviour problems. Nurses perceived facilitation strategies used by the research team useful to support implementation and delivered the procedure, essentially, as intended. However, response rate remained lower than expected, around 50%.

The findings suggest that implementing the SDQ to aid CHC-nurses’ assessment of 3-5-year-olds’ mental health is feasible, but requires further effort in regular services to reach all children.

Keywords: Child, Preschool, Child Health, Child Health Services, Child Behaviour, Clinical Trial, Implementation, Mental Health, Mental health disorder, Nursing Assessment, Strengths and Difficulties Questionnaire

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To Isa, Nicolina and Malte
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


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# Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ADHD</td>
<td>Attention-Deficit/Hyperactivity Disorder</td>
</tr>
<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
</tr>
<tr>
<td>ASQ:SE</td>
<td>Ages and Stages Questionnaire: Social-Emotional Scale</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CBCL</td>
<td>Child Behaviour Checklist</td>
</tr>
<tr>
<td>CD</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>CHC</td>
<td>Child Health Clinics</td>
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<td>CHP</td>
<td>Child Healthcare Programme</td>
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<td>CHS</td>
<td>Child Health Services</td>
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<tr>
<td>CP</td>
<td>Conduct Problems</td>
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<tr>
<td>EBM</td>
<td>Evidence-Based Medicine</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-Based Practice</td>
</tr>
<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
</tr>
<tr>
<td>EPOC</td>
<td>Effective Practice and Organisation of Care Group</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>ICC</td>
<td>Intraclass Correlation Coefficient</td>
</tr>
<tr>
<td>i-PARIHS</td>
<td>Integrated Promoting Action on Research Implementation in Health Services</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>NBHW</td>
<td>The National Board of Health and Welfare</td>
</tr>
<tr>
<td>ODD</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>PARIHS</td>
<td>Promoting Action on Research Implementation in Health Services</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>TRAS</td>
<td>Tidig Registrering av Språkutveckling (Early registration of children’s language development)</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

The Child Health Services (CHS) in Sweden offer regular health check-ups and reach almost all 0–5-year-old children (1). The CHS could therefore play a pivotal role in the detection of mental health problems in children. The CHS programme includes surveillance and control of children’s health and development, and the efforts related to children’s physical health have proven to be successful. However, although one of the objectives of the CHS is to detect mental health problems (2, 3), evidence-based methods are not used for this purpose at the routine check-ups at the Child Health Clinics (CHCs). Instead, the clinical assessment relies on the parent’s description of their children’s everyday functioning, or on the nurse’s clinical ability to identify problems during the visit.

In Sweden, more than 90% of all 3–5-year-old children attend preschool (4). Preschool teachers have extensive knowledge about child development and have been recognised as important informants in identifying symptoms of behavioural or emotional problems in children (5). Despite this, preschool teachers are only consulted by the CHC-nurse if parents express concerns regarding their child or if the nurse perceives the child as having difficulties and hence, wants to get a clearer picture of the severity of the symptoms. This is unsatisfactory as contextual variations in children’s behaviour (6, 7) suggest that different informants should provide input for mental health assessments of children.

The importance of increasing the use of evidence-based methods within the CHS has been emphasised (3, 8), and experts have concluded that non-evidence-based methods within the CHS should be seen as temporary (9). Research on healthcare constantly produces new findings, methods and tools which, if translated into practice, can contribute to improve the quality and effectiveness of healthcare in general as well as child healthcare specifically. However, implementation of new practices is often complex and challenging (10).

The four studies in this thesis explore different aspects concerning the implementation of an evidence-based tool in the CHS to assess children’s emotional and behavioural problems through parent and teacher reports. Studies I and IV were designed to evaluate the introduction of the new procedure. Studies II and III focused on the psychometric properties of the screening tool when used within the Swedish CHS.
Background

Implementation of new practices

Evidence-based practice

In 1992, a new way of teaching and practicing medicine, evidence-based medicine (EBM), was introduced by a group of researchers and clinicians in Canada (11). The intention was to replace unsystematic clinical decision-making based on experience, intuition and peer influence, with decision-making based on evidence from clinical research. Sackett et al. (12) defined EBM as: ‘The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’.

Evidence-based medicine (EBM) has developed into evidence-based practice (EBP) and spread to fields beyond medicine (13). The description of what EBP means has changed over time. The so-called Sicily statement (14) published in 2005 states: ‘Evidence-Based Practice (EBP) requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources’. This definition implies that practising EBM means combining the best available research evidence with clinical expertise and patient preferences.

The principles of EBP have also been adopted in the field of nursing. Cullum and colleagues (15) defined evidence-based nursing as ‘the application of valid, relevant, research-based information in nurse decision-making’. The authors argue that nurses should use research evidence, together with their knowledge of the specific patient’s preferences and circumstances and available resources in decision-making. Moreover, nurses should also use their expertise and judgement.

Keeping pace with the latest research, critically appraising it and incorporating it when making decisions takes time and can be challenging (13). Hence, achieving a more evidence-based healthcare practice by relying solely on individual practitioners’ use of research might not be realistic. Another more
practical approach can be to provide practitioners with summarised research findings (e.g. clinical guidelines) (13) or specific evidence-based practices (e.g. methods). By synthesising research evidence and developing methods based on clinical research, practitioners can more easily work in accordance with EBP. However, most often, merely informing practitioners about research findings or a new method will not result in them using it (16). Implementation of a new practice can be a complex and unpredictable process, requiring various efforts to encourage desired practice (10, 17).

Implementation science

Implementation science is a field of research investigating different aspects of integrating evidence-based practices within healthcare (17, 18) but also outside the domains of healthcare (13). Eccles and Mittman (19) defined Implementation science as ‘the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care’. The field includes focus on the patient level as well as on the provider, organisation and policy level of healthcare (17).

Research in implementation science mainly involves studies to describe and analyse barriers and enablers for implementation of new practices and to evaluate the effectiveness of specific strategies to achieve desired changes in practice (13, 20).

Implementation science as a field today is vast and includes a whole range of theories, models and frameworks. A narrative review by Nilsen (21) proposed a taxonomy of five categories of theories, models and frameworks used in implementation studies: Determinant frameworks, Classic theories, Implementation theories, Process models and Evaluation frameworks.

Determinant frameworks, classic theories and implementation theories can be used to understand and/or explain what influences implementation outcomes. Process models can be used to describe and/or guide the process of translating research into practice. Evaluation frameworks can be used to evaluate implementation endeavours (21).

Studying implementation outcomes

The determinant frameworks specify different types of determinants (i.e. factors) influencing the implementation process and outcomes (21). One such framework is the integrated Promoting Action on Research Implementation in Health Services framework (i-PARIHS) (22, 23), a revised version of the PA-RIHS framework published in 1998 (24). The i-PARIHS framework describes
four types of determinants (referred to as “constructs” in PARIHS): the innovation itself, the recipients, the context and the facilitation. The framework also includes sub-elements describing characteristics to be considered within each construct. Harvey and colleagues (22) propose that the interplay between all four core constructs and their characteristics (described below) have impact on the implementation process and outcomes.

The innovation represents the knowledge that is planned to be introduced. Knowledge encompasses evidence based on research as well as clinical, patient and local experience. The i-PARISH framework (22) also suggests specific innovation characteristics to consider when planning or evaluating an implementation process, namely its underlying knowledge sources, clarity, degree of fit with existing practice and values (compatibility), usability, relative advantage, trialability and observable results.

The recipients are proposed to be defined as ‘people who are affected by and influence implementation’ (22) (p. 4). The framework emphasises that both individual recipients and teams of recipients, respectively, can influence the implementation process and that their influence can either be positive or negative, depending on their perceptions of the innovation. Recipients may include stakeholders such as patients, healthcare staff and their managers. Proposed characteristics to be considered in relation to the recipients include e.g. their motivation, values and beliefs, skills and knowledge (22).

The context can be divided into internal and external context (22). The internal context relates to the local and organisational setting (i.e. the specific CHC and the CHS, respectively). Proposed characteristics to be considered within the internal context include e.g. formal and informal leadership support, culture and organisational priorities. The external context focuses on the health system’s influence on the implementation process and relates to e.g. policies, regulations and inter-organisational relationships.

Facilitation can be defined as ‘a technique by which one person makes things easier for others’ (24) (p.152). In the i-PARIHS framework (22), the concept of facilitation refers to the people helping individuals and teams through the change processes (the facilitators) and the actions taken by the facilitators to enable implementation (the implementation strategies). According to the framework, facilitation stands out as the active and probably most important construct to support implementation of new knowledge into clinical practice. Harvey and Kitson (22) state that ‘facilitation is the construct that activates implementation through assessing and responding to characteristics of the innovation and the recipients (both as individuals and in teams) within their contextual setting’. (p.6). The i-PARIHS framework emphasises the importance
of having facilitators (internal or external to the organisation) with good understanding of: the innovation that is intended to be implemented, the recipients who are meant to use the innovation and the context in which the innovation is meant to be used, i.e. the what, who, where components of implementation. The framework also points to the value of providing less experienced facilitators with adequate support and mentoring from more experienced facilitators.

There are several strategies that can be applied to support implementation of new practices, and implementation efforts may involve one single strategy or a range of strategies (25). Widely used strategies include, for example, printed educational materials, educational meetings, educational outreach, local opinion leaders, audit and feedback, computerised reminders and tailored interventions (26). Three of the strategies are described below.

- Educational meetings: Courses, conferences, lectures, workshops and seminars aiming to change the behaviour of healthcare professionals (27).
- Educational outreach: ‘trained people visit clinicians where they practice and provide them with information to change how they practice’ (28) (p.2).
- Audit and feedback: ‘any summary of clinical performance of healthcare over a specified period of time’ (29) (p.5). The performance of the practitioners being audited is measured and compared to set targets and then reported back to them.

Research on implementation strategies has shown that they have a positive but modest effect on changes in behaviour, and that their observed effects tend to vary across studies (26, 30). This is not surprising given that the effect of the strategies, to a large extent, depends on the contextual factors, the manner in which the strategies are delivered (16) and the extent to which they address barriers in the study (26).

Determining whether an implementation process has been successful or not requires evaluation of implementation outcomes. Proctor et al. (31) define implementation outcomes as ‘the effects of deliberate and purposive actions to implement new treatments, practices, and services’ and propose a taxonomy of implementation outcomes, including acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration and sustainability.

Health services often use interventions built up by a number of interacting components, which all may contribute to the intervention’s effect. In addition, healthcare interventions sometimes require specific behaviour and skills from those delivering the intervention, or target more than one group or organisational level. This type of interventions can be defined as complex (32). As
pointed out by Harvey and Kitson (22), facilitating implementation of an intervention can, in itself, be referred to as a ‘complex intervention, involving one or more individuals in the role of facilitator, applying a combination of improvement and team-focused strategies to enable and support change’ (p.7).

The effects of complex interventions are difficult to evaluate (32), and outcome evaluations should preferably be complemented by a process evaluation. A process evaluation is ‘a study which aims to understand the functioning of an intervention, by examining implementation, mechanisms of impact, and contextual factors’ (33). Process evaluation efforts can be of assistance when trying to gain insight into why intended effects of e.g. a new method, or the facilitation of its implementation, were or were not found (34).

The Medical Research Council (MRC) has published a framework providing guidance on the development, evaluation and implementation of complex interventions to improve health (35). In 2015, Moore et al. published a framework (36) providing guidance on conducting process evaluation, building on the 2008 MRC guidance.
Mental Health Problems - Emotional and behavioural problems

Mental health problems in preschool children include a number of emotional and behavioural problems and related disorders, ranging from experiencing minor symptoms to severe conditions, meeting the criteria for a diagnosis (37, 38). The symptoms can be something that the child experiences and is bothered by (subjective) or something that is mainly observed by people who are in contact with the child (objective) (39).

Emotional and behavioural problems that affect the child’s well-being, development and everyday activities for a longer period require support and care (39). Early identification and treatment of mental health problems in young children may play an important role in reducing later negative psychosocial (40), mental health (41) and academic (40, 42, 43) outcomes. Identifying and treating mental health problems at an early stage can also have a positive impact on the child’s quality of life (43) as well as result in socio-economic benefits (44, 45). The need for early identification is also highlighted by research indicating that mental health problems, which present early tend to persist into adolescence (46) or adulthood (40-42, 47).

Mental health problems can be categorised into externalising and internalising problems (48). Externalising problems are directed towards the child’s environment and include e.g. hyperactivity and conduct problems. Internalising problems, in contrast, occur within the child and include emotional problems such as anxiety and depression (49). In general, signs of internalising problems in a child are not as evident as signs of externalising problems (39). In addition, peer problems (i.e. problems with peer relationships) are common occurrences among preschool-aged children (50).

Symptoms of mental health problems in a child can sometimes be related to the parents and the family’s psychological well-being and social situation (39). In order to determine the reasons for the problems, it is therefore necessary to also consider the child’s overall situation, besides the actual symptoms. Minor mental health problems can often be handled by providing support to the child and the parents through the CHC or the preschool. However, more severe problems might require further investigation and specialist care.

Prevalence

Mental health problems in children are common worldwide; research indicates prevalence rates between 10–20% (51). In an overview of child mental health policies and practices across 15 European countries (52), experts on child men-
tal health concluded that one in five children suffer from emotional or behavioural problems, and one in eight children have a mental disorder. However, the prevalence varies according to the definition used. Empirical research on the epidemiology of the mental health of preschool children in Sweden is limited (53). Investigations conducted in groups representative of the population have shown that between 4 and 40% of children in Sweden have mental health problems (54). Regarding psychiatric diagnoses, the prevalence is approximately 10%, and the most common conditions are ADHD, depression and autism (54). Reports from official authorities and organisations indicate that mental health among children and adolescents is deteriorating (55-57). Because most investigations conducted in Sweden have not used validated instruments, it cannot be stated whether the prevalence of mental health problems has changed. However, it is clear that the number of children and adolescents that have been in contact with the healthcare system due to mental health problems (i.e. the health care consumption) has increased over time (54).

The Swedish Child Health Services

Sweden has universal Child Health Services (CHS), delivered by nurses at Child Health Clinics (CHCs) (1). The CHCs are free of charge, and have contact with virtually all families with 0–5-year-old children (1, 3). The national Child Healthcare Programme (CHP) includes surveillance and control of children’s health and development from birth until school entry (3). Children are offered vaccinations within the vaccination programme (58) and regular health and developmental check-ups by nurses and general practitioners at the CHC. If needed, children are referred to specialised services. The CHS work to ensure that all children have good conditions for healthy growth, development and well-being.

The national guidelines for child healthcare (59) state that the objectives of the CHS are:

- To promote children’s health and development,
- To prevent ill-health in children, and
- To identify and address problems related to health, development and home environment as soon as possible.

The core of the CHP (described above) is provided on a universal basis, i.e. to all children and parents. The current CHP is also designed to reduce inequalities in child outcomes, by directing services to families in response to their needs (59). Consequently, in accordance with the CHP, families with additional needs should be offered targeted services such as more scheduled appointments at the CHC to follow up on the child’s health and development and to get advice or support. Targeted services may also include referrals to appropriate specialists.
(e.g. speech and language therapists, psychologists, physicians and dieticians) (3, 59). Contact with the preschool and social services is initiated when required. Referrals occur with parents’ consent, except for mandatory reporting to social services if maltreatment or neglect is suspected (60).

The visits at the Child Health Clinic

Routine check-ups occur frequently during the child’s first year of life, but become yearly visits once the child turns 18 months (59). The check-ups are performed by the CHC-nurse and include a number of key elements. The focus of the check-ups is determined by the child’s age and needs (3). The content of the CHC-visits according to the CHP are presented in Table 1. Key elements include assessment (and monitoring) of the child’s growth and development, vaccination, language screen, hearing and vision assessment. Parents are also provided with information, advice and support on a variety of issues, including child health and development, child behaviour, nutrition, sleep and accident prevention.

Table 1. CHC-visits according to the Child Healthcare Programme.

<table>
<thead>
<tr>
<th>The child’s age</th>
<th>Number of visits (place)</th>
<th>Key elements*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 weeks</td>
<td>2-3 (Home/CHC)</td>
<td>Medical examination by GP</td>
</tr>
<tr>
<td>4 weeks</td>
<td>1</td>
<td>Development</td>
</tr>
<tr>
<td>6-8 weeks</td>
<td>2</td>
<td>Development</td>
</tr>
<tr>
<td>3-5 months</td>
<td>3</td>
<td>Edinburgh Postnatal Depression Scale (EPDS)</td>
</tr>
<tr>
<td>6 months</td>
<td>1</td>
<td>Vaccination (3 months + 5 months)</td>
</tr>
<tr>
<td>8 months</td>
<td>1 (Home)</td>
<td>Medical examination by GP</td>
</tr>
<tr>
<td>10 months</td>
<td>1</td>
<td>Development</td>
</tr>
<tr>
<td>12 months</td>
<td>1</td>
<td>Medical examination by GP</td>
</tr>
<tr>
<td>18 months</td>
<td>1</td>
<td>Vaccination</td>
</tr>
<tr>
<td>2.5-3 years</td>
<td>1</td>
<td>Body Mass Index (BMI)</td>
</tr>
<tr>
<td>4 years</td>
<td>1</td>
<td>Language screening</td>
</tr>
<tr>
<td>5 years</td>
<td>1</td>
<td>Body Mass Index (BMI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hearing screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Body Mass Index (BMI)</td>
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<td></td>
<td></td>
<td>Epicrisis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vaccination</td>
</tr>
</tbody>
</table>

* = All visits include assessment of the child’s growth, health and family circumstances (psychological and social situation).
The CHC-nurse (district nurse or paediatric nurse) is the main provider of the service delivered at the CHC (1, 61) and plays a vital role in identifying children in need of extra support or further assessment. General practitioners (GPs) act as consultants (59). They also examine the children at four specific timepoints as stipulated in the CHP (Table 1).

**Collaboration between the CHC and the preschool**

The service delivered at the CHC focuses on children’s physical as well as mental and social health. This overall focus requires collaboration between the CHC-nurse and other professionals within the healthcare system (e.g. physicians and psychologists) and other organisations such as the preschool, school and social services (61).

The national guidelines for child healthcare stress the importance of collaboration between CHC-nurses and preschool teachers to promote children’s physical and mental health (61). They also describe that collaboration may take place in relation to an individual child as well as at a general level (62). Further, the guidelines clearly state that any contacts between the CHC and the preschool concerning an individual child must be approved by the child’s legal custodians (61). However, the practical details of the collaboration between the CHS and the preschool are not regulated in any legal framework (3). A number of years ago, it was common that CHC-nurses had regular contact with the local preschools as part of their responsibility within their own regional area. In recent years, however, the conditions for collaboration have changed. Since 2010, parents are free to choose any child healthcare provider (public or private) within the county council (63). Parents are also free to choose any preschool within the municipality. This freedom of choice has led to a situation wherein many children do not have their preschool and CHC in the same area, meaning that although some CHC-nurses have regular contact with the local preschools in general matters, the collaboration regarding individual children has become more challenging (3). In 2019, a national survey of the collaboration between the preschool and the CHC (64) showed that systematic and structured cooperation between these parties is very rare. Moreover, 86% of the survey informants (CHC-nurses, preschool managers and teachers) reported that they believe that collaboration between the CHC and preschool is important or very important (64). The report concluded that there is a need for stricter regulation of the collaboration, related to preschool children’s mental health, since an overall responsibility in relation to this joint mission is lacking.
Evidence-based content of the CHC services

In 1999, a consensus conference (8) underlined the absence of evidence-based content of the CHC services. In 2014, the NBHW also recognised the importance of increasing the use of evidence-based methods within the CHS (3). The recently updated CHP was therefore designed to increase the use of evidence-based methods within the CHS (59). The launch of the programme was preceded by a comprehensive cooperation between representatives of the CHS and the NBHW, initiated in 2012 (59). The collaboration resulted in a national guideline document (3, 65) providing information about which tasks should be performed, and the CHP (59) describing how the tasks should be performed. A few evidence-based methods, suggested by experts in the consensus conference in 1999 (infant hearing screening, language screening and screening for postnatal depression), are now part of regular CHP. However, there is still a need to improve the methods and services offered by the CHS. For example, the CHP does not include methods to identify mental health problems in children. Presently, identification relies on the nurse’s clinical ability to identify these types of problems during the visit, or on the parents to make the CHC-nurse aware of any problems. As previously described, nurses need to address numerous tasks during the relatively short CHC-visit, making it difficult for the nurse to engage in all relevant issues. It might, for example, be difficult to find enough time to discuss the child’s emotions and behaviour, and the nurses’ ability to identify emotional and emotional problems might therefore be limited.

Current strategies within the preschool and the CHS

In Sweden, more than 90% of all 3–5-year-old children attend preschool (4); internationally, the Swedish preschool is highly regarded because of its high quality and ambition to integrate educational and care-giving practices (66). Several aspects of children’s health and well-being are mentioned in the curriculum (67, 68) and in a preschool document developed to help preschool staff to work in accordance with the curriculum (69). However, the concept of mental health is not mentioned.

In 2009, a national survey, investigating programmes and methods used within Swedish preschools to identify and support children displaying symptoms of mental health problems (70), revealed that less than half of the participating preschools used structured methods for identification of such problems. The preschools that worked with structured methods for early detection reported that they conducted, for example, health discussions or used Swedish research-based materials named TRAS for early registration of children’s language development (71). A majority of the participating preschools reported
that they had developed local recommendations to be followed if signs of mental health problems are detected in a child. The recommendations included adjusting the child’s preschool environment, informing the head of the preschool and contacting external experts (e.g. psychologist, support team or the CHC in the presence of parental consent). More than half of the preschools also reported that they worked with either established parenting programmes or self-developed structured methods to support children with mental health problems (70). In their conclusions, the NBHW highlighted the importance of using structured methods within the preschool to identify mental health problems in children and of increasing the cooperation between the preschool and the CHC (70).

According to one of the preschool policy documents (69), developmental screening methods based on normative principles of developmental psychology are not consistent with current preschool curriculum and pedagogical work. This is also emphasised in a clarification made by the Ministry of Education (72), stating that individual children’s stages of learning and development should not be used to categorise and compare children. However, the Education Act is quite explicit regarding the preschool’s obligation to give children extra support if needed (73). Moreover, the curriculum states that preschool teachers are responsible for documenting and analysing each child’s development and learning in order to make it possible to evaluate if the preschool has managed to create good conditions for learning and development (67, 68). Preschools are also obliged to continuously inform parents about their child’s development and learning at individual meetings intended for that purpose (68, 73). A related policy document (69) underlines that the choice of assessment and evaluation method is crucial and that the preschool teachers should critically examine any suggested method to ensure that the best interests of the child are not jeopardised.

**Health surveillance**

To regularly follow children’s health and development, the CHS use a working method called health surveillance. This means that the CHC-nurse, at every contact with the family, should assess the child’s health, development and family circumstances. The purpose is to, without unnecessary delay, identify children who, in any respect, are in need of support or targeted services (3). Health surveillance includes a number of different tasks such as conversation with the parents about the child's health and development, assessment of the child’s development and growth, respectively, and screening assessments (3). The CHC-nurse weighs the clinical observations together with the parents’ description of their child. The CHC-nurse also considers what the child expresses at the CHC-visit as well as any questions posed by the parents. An important part of the health surveillance is that the CHC-nurse should obtain information regarding the child’s behaviour (3). Currently, this is
achieved by the nurse asking the parents general questions about their child’s behaviour. However, this information could also be obtained in a more structured way, for example, by using an instrument. The CHS national guidelines also recommend asking questions according to structured instruments (3).

Parents are the primary source of information for the CHC-nurse since they know their own child the best. However, it can be difficult for parents to know if their child has behavioural or emotional problems. The child might not display symptoms in the home environment or parents’ ability to recognise problems might be limited, e.g. if it is a first child and no same-aged relatives are available for comparison. In addition, cultural and language barriers, depression and social circumstances are known to affect parents’ capacity to recognise problems (74). It can also be difficult for parents to consider their child’s situation objectively. Obtaining information about the child from both parents and teachers is therefore considered best practice, when it comes to assessing young children’s mental health (75-78). Providing the CHC-nurses with teachers’ perspectives of the child’s behaviour could therefore contribute to the CHCs current health surveillance.

Using instruments to assess children’s mental health

The purpose of methods used for early identification of mental or physical problems is to detect concerns or potential risk factors related to the child’s health and well-being during an early phase of the problem development (3). Early identification may, in turn, enable early intervention or treatment to improve child outcomes. In relation to mental health, concerns might include e.g. emotional symptoms or behavioural problems.

It can be difficult for CHC-nurses to determine whether a behaviour or symptom in a child signals a problem, especially given that the same behaviour or symptom can be normal reaction to an event in the child’s everyday life (3). In order to create conditions for CHC-nurses to identify children with actual mental health problems, it is therefore important to provide them with a reliable method that also demonstrates adequate utility.

Reliability

Reliability represents a method’s ability to produce consistent results from one occasion to another (79). There are different forms of reliability that can be measured e.g. test-retest reliability, internal consistency, intra-rater reliability and inter-rater reliability.

Test-retest reliability refers to the extent to which a measure that is expected to be consistent over time actually produces a similar result, for an individual, over time (79). A correlation of at least .80 indicates acceptable reliability.
Internal consistency represents the extent to which items in a test are consistent with each other (79). The Cronbach’s alpha statistic is commonly used to establish internal consistency. Alpha may be reported for separate domains within an instrument or for the entire instrument. The alpha should exceed .70 in order to demonstrate adequate internal consistency (80). Intra-rater reliability and inter-rater reliability reflect how consistent the same or different assessors are in their ratings on different occasions (79). Consistency between two assessors (inter-rater reliability) can be studied using both correlation and agreement. However, there is an important distinction between these two statistical techniques: a high correlation (e.g. Pearson) provides information about the direction in which the ratings move in relation to each other but does not indicate if the raters’ scores actually match (79). A high agreement, on the other hand, requires both correlation and matching scores.

Agreement can be tested using, for example, the Intraclass Correlation Coefficient (81). It is worth pointing out that although, in general, it is preferred that inter-rater reliability be as close as possible to 1.0 (perfect correlation), this is not the goal when it comes to measuring agreement between different types of informants (e.g. parents and teachers). Previous research has shown that children’s behaviour is dependent on the setting in which the child is observed and that correlations between parents and teachers’ reports can, therefore, be expected to be modest (76, 77). The reason for obtaining assessments from both types of informants is to get access to information about the child’s behaviour in different environments; hence, modest correlations should not be confused with low reliability.

**Clinical utility**

Clinical utility is a concept used within the field of medicine, referring to the usefulness and relevance of an intervention or method in patient care (82). Assessment of the clinical utility of a method often includes elements such as economical aspects and clinical effectiveness. However, practitioners’ opinions about the method’s benefits or drawbacks have also been suggested to be an important aspect to consider (83).

Clinical utility of assessment instruments is often discussed in terms of usefulness and feasibility (84). Usefulness relates to how well the particular instrument provides necessary information for a clinical assessment compared with other instruments or methods (85). To be regarded as useful, the instrument also needs to be considered relevant and worthwhile by practitioners (84). Feasibility has been defined as ‘the extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting’ (31) (p 69). A feasible method needs to be compatible with the common constraints of clinical practice. This means that the instrument has to be quick and easy to administer (i.e. score and interpret) (84).
Norms

Obtaining parent and teacher reports about children’s behaviour and social situations using instruments is a common method to identify mental health problems in young children (76). When using such instruments, a child’s item scores are usually summarised into one total scale or a number of subscales and thereafter compared to average scores (i.e. norms) of children in the same age group (85).

Valid norms should be derived from studies based on samples matching the characteristics of the population at large. Important characteristics to consider in the matching procedure include e.g. age, gender and parental socio-economic status (85, 86). These variables are known to produce differences in scores. Given that mean scores have shown some variation between cultures, country-specific norms should be used whenever possible.

Relating to age differences in behaviour characteristics, norms are commonly presented by age (varying intervals). Because of known gender differences in behaviour, norms can sometimes also be gender referenced (85).

Cut-off values

Cut-off values can be used to depict a child’s scores, relative to the normative sample, by defining scores as normal or abnormal (cases). The cut-off values can be calculated in different ways. In general population samples, cut-offs are usually set at the 90th percentile (87), indicating that the child’s score is the same or higher than 90% of the norm group. Cut-off values are useful because they provide information about which individuals might need further evaluation or extra support. However, it is important to remember that cut-off values only provide information about probabilities, meaning that some individuals with positive test results do not have problems, and some individuals with negative test results actually do have problems.

Types of instruments

Numerous instruments have been developed for mental health assessments of children and adolescents. Some are designed to be used for screening (i.e. to quickly identify cases in need of further investigation), others to establish a diagnosis or rate specific symptoms. Screening instruments are designed to identify a wide variety of emotional and behavioural problems, not specific disorders. Using instruments with adequate accuracy (sensitivity, specificity, positive predictive value) to screen for mental health problems in paediatric primary care has been proposed as a way to identify mental health problems (88-91). Available screening instruments include e.g. the Strengths and Difficulties Questionnaire (SDQ) (92), Child Behaviour Checklist (CBCL) (93) and Ages and Stages Questionnaire: Social-Emotional Scale (ASQ:SE) (94).
The Strengths and Difficulties Questionnaire

Screening for behavioural and emotional problems within routine CHS requires the use of a reliable and validated mental health screening instrument. The SDQ (92) is a well-known instrument, commonly used by clinicians and researchers worldwide. The SDQ is free of charge, relatively brief and available for 2–17-year-olds in both parent and teacher versions. From the age of 11 years, children can complete the self-report version. The questionnaire includes 25 items, focusing on positive as well as negative behaviour, supposedly increasing the acceptability among informants and being suitable for use in the general population (95). The original English version of SDQ is considered to be an instrument with adequate psychometric properties (75, 96). The Swedish translation (SDQ-Swe) has also demonstrated good psychometric properties, and been validated for parental use among 6–10-year-old children (97). Furthermore, acceptable construct validity was recently concluded for parents and teachers’ ratings of 3–5-year-old children (98). The self-report version of SDQ has been evaluated in 14–15-year-old adolescents (99).

The SDQ consists of 25 items, focusing on the following dimensions of children’s behaviour (subscales): emotional symptoms, conduct problems, hyperactivity/inattention, peer problems and prosocial behaviour. (92). Each dimension is assessed with five items, scored on a 3-point Likert scale, with 0 = not true, 1 = somewhat true and 2 = certainly true. Subscale scores range between 0 to 10. The total difficulties score ranges from 0 to 40 and is calculated by summing the scores from the four problem subscales. Higher scores indicate more problems, except in the subscale on prosocial behaviour in which a higher score indicates more positive behaviour. SDQ is also available in versions with an impact supplement (100), which comprises items capturing perceived burden and distress.
Rationale for this thesis

Mental health problems in children are common, and much evidence points to the benefits of early identification and intervention. Because CHC-nurses in Sweden have contact with almost all 0–5-year-old children, they are well-positioned to identify young children with emotional or behavioural problems. However, such problems can be hard to identify, especially during short CHC visits encompassing many other health monitoring tasks. Hence, without using a structured and reliable method, nurses may fail to detect children who could benefit from early intervention or treatment. Introducing an evidence-based screening method to assess children’s mental health within routine child healthcare could, therefore, be a valuable part of the Swedish CHSs programme for surveillance.

Although the need for increased communication between healthcare and preschool has been evident for decades in Sweden, previous attempts for structured exchange through standardised forms have not been integrated into routine practice. This can partly be understood, given the current philosophy of preschools in Sweden, which opposes a normative view of children’s development and instead focuses on children’s competencies and their interactions with the environment. In this light, even filling out a structured questionnaire with fixed responses can be perceived as a violation of that philosophy.

Nevertheless, if the CHS’s goal is to successfully identify children with mental health problems and preschools really aim to provide children with the best possible education based on their individual developmental needs, then health and educational services need to find effective ways to communicate about children’s developmental and mental health needs between them. CHC-nurses need reliable methods and information about the child in more than one environment so that healthcare resources might work in tandem with educational services to provide early intervention or treatment.

This thesis provides empirical data on how stakeholders perceive the routine use of SDQ before the annual CHC check-up, as well as the specific properties of the instrument used and ways that might facilitate implementation and maintenance of the procedure.
Overall and specific aims

The overall aim of the studies constituting this thesis was to evaluate the introduction of a new procedure, including the facilitation strategies provided to support implementation, at CHCs to assess 3–5-year-old children using parent and teacher SDQ-reports, and to provide norms and inter-rater correlations for the SDQ in this population. The specific aims were:

I. To explore nurses’, preschool teachers’ and parents’ experiences of the new information sharing procedure using SDQ.

II. To examine both degree of correlation and agreement between parent and teacher SDQ reports, in a community sample of preschool-aged children in Sweden.

III. To establish Swedish parent and preschool teacher SDQ norms for children aged 3–5, using data from a large community sample.

IV. To describe and evaluate the facilitation programme developed to support the introduction of SDQ in clinical practice.
General method

Study design
The four studies comprising this thesis were all part of the Children and Parents in Focus study, which ran between 2013 and 2017 in Uppsala, Sweden. This large-scale trial aimed at evaluating the effectiveness and cost effectiveness of a universally offered parenting programme in the Swedish context (101). An additional aim was to generate data on the mental health of preschool aged children in Sweden. The study used both cross-sectionally and longitudinally collected data to investigate 3–5-year-old children’s health and behaviour, born between 2008–2012, by means of questionnaires completed by mothers, fathers and preschool teachers.

The head of primary health care in Uppsala and the preschool leadership in the municipality agreed to allow their employees to participate in the study.

Recruitment
Outcome measures were collected through the regular CHS in Uppsala county (first year of the study) and Uppsala municipality (second, third and fourth year of the study). All CHCs serving these geographical areas were invited to participate in the recruitment of parents of 3, 4 and 5–year-old children. Information about the study was provided to the CHC-nurses and the heads of all CHCs at a meeting held in April 2013. Shortly thereafter, the Senior Child Public Health Officer in Uppsala sent written information to each CHC. The managers of the local healthcare centres were thus given the opportunity to decline participation (opt out) within a specified period; thereafter, participation was presumed. All, except two, of the invited CHCs agreed to participate (43 out of 45). One of these CHCs declined participation because of another ongoing study, and the other declined because of time constraints. The number of participating CHCs varied over the duration of the trial (range 18-19); specifically, the sampling frame changed, where two CHCs joined the study and two CHCs were closed at different timepoints during the trial. Over trial duration, no CHCs, except the two CHCs opting out in the first year, declined participation in the study. Out of approximately 260 preschools in the county (195 in the municipality), three private preschools declined participation.
The CHC-nurses consecutively recruited parents of 3–5-year-old children before their regular health check-ups. Hence, each year, a new cohort of 3-year-olds joined the study. Children who were 3–4-years-old in the first year of the study were invited each year until they were 5-years-old. Parents consented to participate by signing a form attached to the study questionnaire, including their child’s registration number and the name of their child’s preschool.

**Training and support**

Before the launch of the study, nurses at all participating CHCs received introductory training on how to use the study questionnaires. The training was provided via one-hour educational outreach visits from one or two members of the research team. Nurses who were employed during the trial were offered similar training (individual training session). The researchers were available to answer questions by e-mail and phone throughout the trial. Facilitation strategies used to support the implementation of the information sharing procedure are described in paper IV.

**Inclusion and exclusion criteria for the study**

All parents of children 3, 4 and 5-year-old, enrolled at a participating CHC, were invited to participate in the study. Because data were collected by questionnaires and translated versions were only provided in three languages (Arabic, Somali and English), parents who did not understand Swedish or any of the above-mentioned languages had to be excluded.

**Sample and response rates**

The total number of children enrolled at the participating CHCs was 6,882 (study year one), 7,056 (study year two), 7,316 (study year three) and 7,689 (study year four). All of these children were eligible for the study. The proportion of enrolled children participating in the study was 48% (study year 1), 45% (study year 2), 51% (study year 3) and 50% (study year 4). When adding all four study years together, the total number of questionnaires collected from parents and teachers was 28,546. A total of 9,497 unique children (51.2% boys) consented to participate in the study. Socio-demographic data for the participating parents are provided in Table 2.
Table 2. Socio-demographic characteristics of the parents in the Children and parents in Focus study (n=15,860).

<table>
<thead>
<tr>
<th>Socio-demographic variables</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent’s gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (mother)</td>
<td>8,437</td>
<td>53.2</td>
</tr>
<tr>
<td>Male (father)</td>
<td>7,423</td>
<td>46.8</td>
</tr>
<tr>
<td><strong>Parental highest level of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>5,069</td>
<td>32.0</td>
</tr>
<tr>
<td>University</td>
<td>10,208</td>
<td>64.3</td>
</tr>
<tr>
<td>No information</td>
<td>583</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Parent’s country of birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>13,131</td>
<td>82.8</td>
</tr>
<tr>
<td>Other</td>
<td>2,399</td>
<td>15.1</td>
</tr>
<tr>
<td>No information</td>
<td>330</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Parent’s age (mean, SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td>35.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Fathers</td>
<td>38.2</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Data collection

The study questionnaires

The study questionnaires included both established instruments and study specific questions. The main outcome measure in the Children and Parents in Focus study was SDQ (92, 100), collected from mothers, fathers and teachers. Parent questionnaires included SDQ but also items regarding the child’s physical health, language, healthcare consumption and if the child received any continuous assistance/support in the preschool or at home. Furthermore, parents rated their own mental health using the General Health Questionnaire (102). They also answered four items relating to their interaction with the child (103) and five items asking how often the parent was responsible for performing child-related activities. Parents also reported demographic information (age, ethnicity, marital status, education and employment) and completed background questions, including their relation to the child, their child’s living arrangement, the number of children in the family and when they were born. Teacher questionnaires included SDQ and age specific questions about language. For 5-years-old children, teachers also responded to items relating to the child’s motor development.
Modified wording of three SDQ items

Discussions held with preschool representatives prior to the launch of the study showed that they disapproved of the wording in some SDQ items, which they thought focused on children’s traits rather than their behaviour. Hence, before the preschool leadership agreed to take part in the information sharing procedure, some items had to be slightly modified (Table 3). It is known that even seemingly small changes to structured instruments may have large effect on mean scores (104). However, altering the wording was considered essential to proceed with the implementation process. Also, the modifications made were considered to harmonise well with the Swedish preschool’s views on children’s behaviours as well as with Goodman’s original intention of designing an instrument surveying behaviours exhibited by the child (92). Furthermore, the construct validity and internal consistency of the modified version of the SDQ have been investigated in a previous study (98), showing good internal consistency and support for the original SDQ structure with five sub-scales (92).

Table 3. Modified items in SDQ-Swe

<table>
<thead>
<tr>
<th>Item</th>
<th>Standard SDQ item</th>
<th>Modified SDQ item</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Generally obedient, usually does what adults request</td>
<td>Usually does what adults request</td>
</tr>
<tr>
<td></td>
<td>Som regel lydig, följer vanligtvis vuxnas uppmaningar (In Swedish)</td>
<td>Följer vanligtvis vuxnas uppmaningar (In Swedish)</td>
</tr>
<tr>
<td>17</td>
<td>Kind to younger children</td>
<td>Considerate of younger children</td>
</tr>
<tr>
<td></td>
<td>Snäll mot yngre barn (In Swedish)</td>
<td>Omtänksam mot yngre barn (In Swedish)</td>
</tr>
<tr>
<td>22</td>
<td>Can be spiteful to others</td>
<td>Can behave spitefully to others</td>
</tr>
<tr>
<td></td>
<td>Kan vara elak mot andra (In Swedish)</td>
<td>Kan bete sig illa mot andra (In Swedish)</td>
</tr>
</tbody>
</table>

The information sharing procedure

As obtaining information from preschool teachers was not routine before the Children and Parents in Focus study, a new procedure was introduced in all participating CHCs for information sharing between the CHC and the preschool. The new procedure had a twofold purpose of not only collecting outcome measures for the study but also facilitating children’s annual check-ups by providing nurses with valuable knowledge from preschool teachers about the children.

As part of the standard procedure in Sweden, parents are invited to their child’s annual check-up at the CHC about three weeks before the child’s birthday. Following the information sharing procedure, nurses attached three study questionnaires (one for each of the child’s legal custodians and one for the
preschool teachers) about the child’s health and behaviour to the standard invitation letter. Parents were asked to complete the questionnaires and return them when attending their child’s CHC visit. They were also asked to take the teacher questionnaire to their child’s preschool. Preschool teachers were instructed to fill in the questionnaire and then return to the child’s CHC-nurse in a prepaid envelope. Parents consented to the information sharing by signing a consent form on the first page of the teacher questionnaire.

Nurses reviewed the questionnaires prior to, during, or in some cases after the CHC-visit. The nurses discussed the SDQ assessments with the parents at the visit and used them as a basis for their assessment of the child’s mental health. After the visit, nurses collected the parent and teacher questionnaires along with consent forms in separate boxes, which were regularly transported to the research team by research team members. Completed questionnaires with written informed consent for research were de-identified and registered for further analysis. Completed questionnaires without written informed consent for research were anonymised and registered for response rate counts.

Ethical considerations
The Children and Parents in Focus study was approved by the Regional Ethical Review Board (Dnr 2012/437). The parents/legal guardians were given written study information sheets together with the study questionnaires, and the parents/legal guardians of all participating children provided written informed consent on behalf of their children.
Study I: Exploring nurses’, preschool teachers’ and parents’ perspectives on information sharing using SDQ in a Swedish setting – a qualitative study using grounded theory

Aim
The aim of study I was to explore nurses’, preschool teachers’ and parents’ experiences of the new procedure introduced at CHCs to assess 3–5-year-old children using parent and teacher SDQ reports.

Methods
The study explored nurses’ (n = 10), preschool teachers’ (n = 13) and parents’ (n = 11) perspectives on the new procedure to assess children through parent and teacher SDQ reports. Data were collected through interviews using semi-structured interview guides. The interviews were conducted between March 2014 and June 2014, i.e. about six months into the study. Participants were sampled purposively within the Children and Parents in Focus trial. To be eligible for participation in the study, nurses and preschool teachers had to have 1) at least two years of professional experience and 2) experience with the information sharing procedure. Parents were recruited by five nurses working at three different CHCs. Three interview guides were developed by the researchers: one for nurses, one for teachers and one for parents. The interview guides were developed to reflect the research aim of exploring each stakeholder’s experiences of the information sharing procedure. The interviews were conducted by the first author (EF) and two undergraduate nurse students (SK, CR). The interviews (15–50 minutes) were audio recorded and transcribed verbatim by the first author (EF) and the students (SK, CR).

Transcripts of the interviews were analysed by two researchers (EF, HF) using the constant comparative method according to grounded theory, as described by Strauss and Corbin (105). The categories developed during the first step of the coding (open coding) were sorted into the building blocks of the emerging theoretical model during the second step of the analysis (axial coding). These
blocks were ‘causal conditions’, ‘context’, ‘strategies’ and ‘consequences’. In the final step of the coding (selective coding), ‘core categories’ were formulated. The core categories were formulated based on all the categories, thus, representing the stakeholders’ central ideas about the information sharing procedure. A description of the coding procedure is provided in the full article. Diffusion of innovations (106) was applied to understand how the characteristics of the new practice affected its approval, and how nurses, preschool teachers and parents experienced the information sharing using the SDQ.

Results

Nurses’, teachers’ and parents’ perspectives on the information sharing are shown in the final theoretical model (Figure 1).

The results showed that the nurses were very satisfied with having access to preschool teachers’ SDQ ratings for their assessment of children’s behaviour and mental health. They thought it was valuable to get information from both parents and teachers since they see the child in different settings that entail varying demands. The nurses also felt that the SDQ constituted a basis for a more complete evaluation of the child, and acknowledged that they gained knowledge of the child, which they probably would have missed had they not used the SDQ. However, the nurses experienced that socially vulnerable families, and families with a child where problems were suspected refrained from completing the forms more often than other families.

The preschool teachers thought the information sharing procedure could be a good method to identify children displaying symptoms of mental health problems, and that it could result in children getting help at an earlier stage. They regarded themselves as being competent to assess children’s behaviour, and suggested that assessments made by different informants who see the child in different settings are necessary in order to get a complete picture of the child’s behaviour. Preschool teachers believed the information sharing using SDQ may benefit the preschool by giving the preschool teachers a more detailed picture of each child, and by generating important collegial discussions about individual children. However, the interviews also revealed that nurses regard the use of structured forms to assess children as contradictory to the preschool’s philosophy and policy documents. Furthermore, the nurses feared making incorrect judgements, labelling children and facing negative reactions from parents.

Parents were positive towards the new procedure and looked forward to take part in the preschool’s assessment at the CHC visit. They believed that pre-
school teachers are qualified to assess children’s behaviour and that the pre-
school assessments could provide a complement to their description of the 
child at the CHC visit. The parents thought that the SDQ made them reflect 
on their child’s situation and that completing the SDQ could lead to valuable 
discussions with the other parent, which they would not have had otherwise. 
However, some parents felt that it took too much time to complete the SDQ 
and that some items were difficult to interpret. Furthermore, parents had pri-
vacy concerns regarding the use of the SDQ data. They were afraid that the 
information they provided through SDQ might result in negative conse-
quences for the child in a long-term perspective.

Figure 1. Theoretical model showing the categories organised into the building 
blocks of the emerging theoretical model and the interrelationships of the categories. 
The ‘core categories’ reflect the central ideas among (N) Nurses, (PT) Preschool 
teachers and (P) Parents.

Conclusion
The model developed in the grounded theory analysis described that although 
the causal conditions and current context of child healthcare in many ways 
advocate for the introduction of information sharing using SDQ, successful 
implementation also requires further efforts to address barriers.
Study II: Agreement between mothers’, fathers’ and teachers’ ratings of behavioural and emotional problems in 3–5-year-old children

Aim
The aim of study II was to examine both degree of correlation and agreement between parent and teacher SDQ reports in a community sample of preschool aged children in Sweden.

Methods
Data were obtained from the first and second year of the Children and Parents in Focus study. The sample comprised 4,469 children 3–5-years-old (51.4% boys) who had been assessed by two (n = 1,509) or three (n = 2,960) inform- ants. For the purpose of this paper, children assessed by one single informant (n= 1,167) were excluded. The main outcome variables were the SDQ sub-scale scores and the total difficulties (continuous). A dichotomisation of the first item in the SDQs impact supplement asking whether the respondent thinks the child has difficulties in one or more of the subscale areas was used as a supplementary measure. The item is scored on a 4-point Likert scale with 0 = no, 1 = Yes, minor difficulties, 2 = Yes, definite difficulties and 3 = Yes, severe difficulties, and was dichotomised as follows: 0 = not case and 1, 2, 3 = case. Missing subscale scores were pro-rated if at least three items were completed. When three or more items were missing in a subscale, then that subscale was excluded. Hence, missing data were handled in accordance with the guidelines recommended by the SDQ developers.

Data analysis
Descriptive statistics were performed to calculate means and standard deviations of scores on SDQ reported by parents and teachers. One-way repeated measures ANOVAs were run in SPSS 22 (107) to compare parent and teacher mean scores for the subscales and for the total difficulties. The magnitude of
the effect sizes was examined using Partial Eta Squared. The effect sizes were interpreted using the cut-offs presented by Cohen in 1988 (108).

Agreement between informants (mothers versus fathers, mothers versus teachers, fathers versus teachers) was investigated by Pearson correlations in all subscales and on the total difficulties score (continuous). The significance of the difference between the Pearson’s correlation coefficients computed and the meta analytic means reported by Achenbach et al. in 1987 (76) was tested using the Fisher’s z’ transformation (109). Fisher’s z’ values and statistical significance were calculated in Microsoft Excel 2016 (110), using Fisher’s exact test.

Intraclass correlation coefficients (ICC) were used to examine agreement and degree of correlation between mothers, fathers and teachers’ SDQ reports in all subscales, on the total difficulties score (continuous) and on the impact supplement’s first item (dichotomised). The ICC-values were interpreted using the guidelines presented by Cicchetti in 1994 (86). The differences between the ICCs computed were compared to each other using the Fisher’s z’ transformation (109).

Results

The one-way repeated measures ANOVAs showed that SDQ ratings of teachers were generally lower compared to ratings of both mothers and fathers, and that SDQ ratings of mothers were generally lower compared to ratings by fathers (p < 0.001). Effect sizes were large for differences between teachers and parents for total difficulties, emotional symptoms and conduct problems. Effect sizes for the differences between mothers and fathers were predominantly small.

Agreement analyses (Pearson and ICC) showed low (p < 0.001), albeit significant, levels of agreement between parent and teacher ratings and good agreement between parents’ ratings. Pearson’s correlation coefficients between parent and teacher SDQ reports are displayed in Table 4. Intraclass correlation coefficients between parent and teacher SDQ reports are displayed in Table 5.

Agreement between mother and father ratings was highest for the total difficulties scale, the hyperactivity scale and the conduct scale, and lowest for the peer problem scale and the prosocial scale. Agreement between parent and teacher ratings was highest for hyperactivity and peer problems (fathers) / hyperactivity and total difficulties (mothers), and lowest for the emotional symptoms scale.
Correlations (ICCs) for the impact scores were highest between mother and father ratings, and lowest between father and teacher ratings.

Gender and age specific ICCs between parent and teacher ratings are presented in the full article.

Table 4. Pearson inter-rater correlations for SDQ scores.

<table>
<thead>
<tr>
<th>SDQ scales</th>
<th>Mother and father (n = 3,712)</th>
<th>Mother and teacher (n = 3,574)</th>
<th>Father and teacher (n = 3,100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional symptoms</td>
<td>.53 (.52)</td>
<td>.22 (.21)</td>
<td>.18 (.16)</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>.57 (.56)</td>
<td>.32 (.28)</td>
<td>.25 (.23)</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>.61 (.55)</td>
<td>.40 (.34)</td>
<td>.32 (.27)</td>
</tr>
<tr>
<td>Peer problems</td>
<td>.51 (.46)</td>
<td>.32 (.25)</td>
<td>.30 (.23)</td>
</tr>
<tr>
<td>Prosocial behaviour</td>
<td>.53 (.52)</td>
<td>.27 (.25)</td>
<td>.21 (.19)</td>
</tr>
<tr>
<td>Total difficulties</td>
<td>.62 (.60)</td>
<td>.37 (.31)</td>
<td>.28 (.26)</td>
</tr>
<tr>
<td><strong>Meta-analytic mean</strong></td>
<td><strong>0.60</strong></td>
<td><strong>0.27</strong></td>
<td><strong>0.27</strong></td>
</tr>
</tbody>
</table>

*From the meta-analysis conducted by Achenbach et al. (1987)*

The Fisher’s z’ transformation showed that correlations for the total difficulties scale between mother and father reports as well as between parent and teacher reports were comparable (p <0.001) to the meta analytic means reported by Achenbach et al. (76).

The Fisher’s z’ transformation conducted to compare the ICCs between the different informants revealed that ICCs between mother and father ratings were significantly higher than those between parent and teacher ratings for all subscales and total difficulties.

Conclusion

The low, albeit significant, correlations between parent and teacher SDQ ratings suggest that in order to judge agreement between different informants, correlation alone is not sufficient. The discrepancies found may be explained by contextual variations in children’s behaviour, suggesting that parent and teacher reports are complementary. Hence, when using the SDQ as a method to identify mental health problems in young children, both parent and teacher
reports should be considered. In contrast, inter-rater agreement between mothers and fathers was good, indicating that data from a single parent informant may be sufficient.
Table 5. Inter-rater agreement for SDQ scores

<table>
<thead>
<tr>
<th>SDQ scales</th>
<th>Mother and father ratings (n=3,712)</th>
<th></th>
<th>Mother and teacher ratings (n=3,574)</th>
<th></th>
<th>Father and teacher ratings (n=3,100)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICC</td>
<td>Lower Boundary</td>
<td>Upper Boundary</td>
<td>ICC</td>
<td>Lower Boundary</td>
<td>Upper Boundary</td>
</tr>
<tr>
<td>Emotional symptoms</td>
<td>.69</td>
<td>.67</td>
<td>.71</td>
<td>.32</td>
<td>.22</td>
<td>.41</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>.73</td>
<td>.71</td>
<td>.74</td>
<td>.43</td>
<td>.27</td>
<td>.55</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>.75</td>
<td>.73</td>
<td>.77</td>
<td>.56</td>
<td>.53</td>
<td>.59</td>
</tr>
<tr>
<td>Peer problems</td>
<td>.67</td>
<td>.65</td>
<td>.70</td>
<td>.48</td>
<td>.44</td>
<td>.51</td>
</tr>
<tr>
<td>Prosocial behaviour</td>
<td>.69</td>
<td>.67</td>
<td>.70</td>
<td>.42</td>
<td>.37</td>
<td>.45</td>
</tr>
<tr>
<td>Total difficulties</td>
<td>.76</td>
<td>.74</td>
<td>.71</td>
<td>.50</td>
<td>.36</td>
<td>.60</td>
</tr>
<tr>
<td>Impact*</td>
<td>.68</td>
<td>.67</td>
<td>.71</td>
<td>.42</td>
<td>.38</td>
<td>.46</td>
</tr>
</tbody>
</table>

*Note: ICC = Intraclass correlation coefficients
All correlations significant at P < 0.001
Results of ICC are calculated using absolute agreement, two-way random-effects model
Interpretations of ICC values: values < 0.40 = poor agreement, values between 0.40 and 0.59 = fair agreement, values between 0.60 and 0.74 = good agreement, values > 0.75 = excellent agreement
* = Assessed with a single question
Study III: Swedish norms for the Strengths and Difficulties Questionnaire for children 3-5 years rated by parents and preschool teachers

Aim
The primary aim of the study was to establish Swedish parent and teachers’ SDQ norms for 3–5-year-old children. Furthermore, we investigated gender differences and the impact of background variables on SDQ scores.

Methods
Data were extracted from all four years of the Children and Parents in Focus study. For purposes of this study, only children who had scorable data on all sections of the SDQ (at least three items per subscale filled in) were included. Mothers and fathers’ scores were combined into a single ‘parent’ score, consisting of either the mothers or the father’s ratings. If data were present from both mothers and fathers, the most complete questionnaire was selected. Data included 11,196 parent SDQ ratings and 9,083 teacher SDQ ratings, representing 12,245 children aged 3–5.

Descriptive statistics were used to generate age specific cut-off values, means and standard deviations for the full sample as well as for girls and boys separately. Possible gender differences when using the full sample cut-offs were investigated by assessing the proportion of girls and boys scoring at abnormal levels (total score). Univariate ANOVAs were performed to assess gender differences in mean scores for all subscales and for the total difficulties. In these analyses, the effect sizes for all significant differences were examined using Partial Eta Squared. The magnitude of the effect sizes was interpreted using the cut-offs presented by Cohen (108).

Age specific multiple linear regression analyses were conducted to assess the relationship between SDQ total scores and relevant background variables (child’s gender, parental education level, parent’s gender and parent’s country of birth).
Results

Proposed parent and teacher reported cut-offs for the two bands, borderline (80th/20th percentile) and abnormal (90th/10th percentile), for the full sample are presented in Table 6. Gender-specific cut-offs are presented in the full article.

The patterns of the cut-off values showed that scores decreased with the age of the children and that teachers generally reported lower levels of difficulties compared to parents. The results from the univariate ANOVAs revealed that mean scores differed significantly between girls and boys on total difficulties and most subscales across ages and rater categories. However, effect sizes ranged between insubstantial and small. The cut-offs derived from the full sample (general) had a wider range of identified cases (~7–16%) compared to the gender specific cut-offs (10–13%) and resulted in an increased number of boys exceeding the 90th percentile across all ages.

Male gender of the child, low parental education and ratings by parents born outside of Sweden were significantly associated with more difficulties (across child age). For 3-year-olds, ratings of fathers were significantly associated with higher parent SDQ scores.
Table 6. Cut-off values for the SDQ scales for the full sample set at the 90th and 80th percentiles (10th and 20th for the prosocial scales).

<table>
<thead>
<tr>
<th></th>
<th>Parents</th>
<th></th>
<th>Preschool teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Borderline</td>
<td>Abnormal</td>
<td>Borderline</td>
</tr>
<tr>
<td>3-year-olds</td>
<td>n=3,590</td>
<td></td>
<td>n=2,938</td>
</tr>
<tr>
<td>Total score</td>
<td>10</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Emotional symptoms</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Hyperactivity/inattention</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Peer problems</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Prosocial</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

| 4-year-olds | n=3,856 |         | n=3,145 |         |
| Total score | 9 | 12 | 6 | 9 |
| Emotional symptoms | 2 | 3 | 1 | 2 |
| Conduct problems | 4 | 4 | 2 | 3 |
| Hyperactivity/inattention | 4 | 5 | 3 | 5 |
| Peer problems | 2 | 2 | 1 | 2 |
| Prosocial | 7 | 6 | 6 | 5 |

| 5-year-olds | n=3,750 |         | n=3,000 |         |
| Total score | 9 | 11 | 6 | 9 |
| Emotional symptoms | 2 | 3 | 1 | 2 |
| Conduct problems | 3 | 4 | 2 | 3 |
| Hyperactivity/inattention | 4 | 5 | 3 | 5 |
| Peer problems | 1 | 2 | 1 | 2 |
| Prosocial | 7 | 6 | 7 | 5 |

Conclusion

The results demonstrated that teacher ratings were generally lower than parent ratings. Cut-off values were somewhat higher for boys (lower for prosocial), suggesting that boys display more behaviour problem symptomatology than girls. SDQ scores were affected by parents’ education level and country of birth. The norms and cut-off values provided can facilitate the use of SDQ within the CHS.
Study IV: Facilitating implementation of an evidence-based method to assess the mental health of 3–5-year-old children at Child Health Clinics: a mixed-methods process evaluation

Aim
Study IV aimed to describe the facilitation programme developed to support the introduction of SDQ in clinical practice, and evaluate the facilitation programme delivered by assessing implementation outcomes and exploring how nurses perceived the facilitation strategies used.

Methods
Multiple data sources were drawn upon, including research group documents, study materials, monitoring data, the trial database, focus group interviews with nurses ($n = 16$), and a survey performed at the end of the trial to evaluate nurses’ ($n = 52$) opinions and experiences of the new procedure and the implementation process. The components evaluated and the data sources used are presented in Table 7. The structuring of the data was guided by Moore et al.’s framework for process evaluation (36). Two key components of process evaluation were investigated: implementation and mechanisms of impact.
<table>
<thead>
<tr>
<th>Component</th>
<th>Subcomponent</th>
<th>Data source</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation</td>
<td>Facilitation strategies and adaptations</td>
<td>Research group documents*, Study materials**</td>
<td>• Number and content of newsletters</td>
</tr>
<tr>
<td></td>
<td>(Implementation efforts delivered)</td>
<td></td>
<td>• Number and content of educational outreach visits at the local CHCs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number and content of educational meetings with all nurses involved in the trial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Assistance provided to CHCs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Adaptations made in study questionnaires and implementation activities</td>
</tr>
<tr>
<td>Dose</td>
<td>Monitoring data***</td>
<td></td>
<td>• The proportion of children enrolled at each CHC receiving the study questionnaires</td>
</tr>
<tr>
<td>Reach</td>
<td></td>
<td>Trial data</td>
<td>• Response rate: the proportion of children receiving the study questionnaires who had at least one parent or the preschool teacher SDQ returned to the CHC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Population coverage: the proportion of enrolled children who had at least one parent or the preschool teacher SDQ returned, irrespective of whether they had received the study questionnaires</td>
</tr>
<tr>
<td>Mechanisms of</td>
<td>Participant responses</td>
<td>Survey data, group interviews</td>
<td>• Nurses’ ratings of facilitation strategies used (Survey – see Table 2 in the full article for items)</td>
</tr>
<tr>
<td>impact</td>
<td>(How nurses perceived the facilitation programme and the intervention)</td>
<td></td>
<td>• Nurses’ ratings of the intervention’s characteristics (Survey – see Table 2 in the full article for items)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Nurses’ perspectives on the intervention (Focus group interviews, Survey – see Table 2 in the full article for items)</td>
</tr>
</tbody>
</table>
Results

Implementation

Figure 2 provides an overview of the facilitation strategies used during the study. The examination of research group documents and study materials showed that the facilitation strategies used in the first and second year of the study needed to be complemented by additional strategies in order to address implementation challenges.

*Implementation outcomes.* Descriptive statistics revealed that although nurses sent questionnaires to, on average, 77–91% of all children enrolled at the CHCs, response rate remained between 54 and 63% and population coverage at around 50%, throughout the study period. Significant changes between study years are displayed in Table 8. Implementation outcomes varied greatly between the CHCs.

Table 8. *Changes in implementation outcomes over study duration.*

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numbers (n)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled children</td>
<td>6882</td>
<td>7056</td>
<td>7316</td>
<td>7689</td>
</tr>
<tr>
<td>Received the study questionnaire</td>
<td>5281</td>
<td>5895</td>
<td>6628</td>
<td>6708</td>
</tr>
<tr>
<td>At least one SDQ returned</td>
<td>3314</td>
<td>3197</td>
<td>3725</td>
<td>3880</td>
</tr>
<tr>
<td><strong>Percentages (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose</td>
<td>77</td>
<td>84</td>
<td>91</td>
<td>87</td>
</tr>
<tr>
<td>Response rate</td>
<td>63</td>
<td>54</td>
<td>56</td>
<td>58</td>
</tr>
<tr>
<td>Population coverage</td>
<td>48</td>
<td>45</td>
<td>51</td>
<td>50</td>
</tr>
<tr>
<td><strong>Change compared to previous year</strong> (χ²)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose</td>
<td>101.7*</td>
<td>159.3*</td>
<td>42.7*</td>
<td></td>
</tr>
<tr>
<td>Response rate</td>
<td>83.2*</td>
<td>4.9</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Population coverage</td>
<td>11.3*</td>
<td>45.2*</td>
<td>0.3</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Dose is the percentage of enrolled children receiving study questionnaires (the proportion of the intervention delivered). Response rate is the proportion of children receiving the study questionnaires who had at least one parent or preschool teacher SDQ returned to the CHC. Population coverage is the proportion of enrolled children who had at least one parent or preschool teacher SDQ returned, irrespective of whether they had received the study questionnaires *p < 0.001*
Figure 1. Overview of the strategies used during the study years to facilitate implementation.
Mechanisms of impact

A complex interaction was found between the facilitation process and factors affecting nurses’ thoughts about the intervention. The results indicate that nurses were in favour of using the SDQ in clinical practice and, perceived the facilitation strategies used by the research team as being useful to support its implementation (Table 9). The nurses believed that the new routine resulted in more structured check-ups, with an increased focus on the child’s mental health, and that the preschool assessment was important for their assessment of the child’s mental health. Furthermore, they considered the score sheet for SDQ to be useful for their interpretation of the results. However, nurses also described barriers at the organisational and individual level. They found that preschool assessments were often lacking at the time of the children’s visits, and that some preschool teachers had been unwilling to assess children using the SDQ throughout the intervention period. Furthermore, more than half of the nurses reported experiences of negative reactions from preschool teachers and parents. Unexpected consequences included difficult situations relating to diverging parent and teacher SDQ assessments, parents not participating in the intervention because of the taxing procedure, and nurses finding it difficult to discuss SDQ with parents when the child is present.

Table 9. Nurses’ perceptions on facilitation strategies used within the facilitation programme.

<table>
<thead>
<tr>
<th>Facilitation strategy</th>
<th>Nurses’ ratings of facilitation strategies (n = 52)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not important*</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
</tr>
<tr>
<td>Educational meetings</td>
<td>-</td>
</tr>
<tr>
<td>Educational outreach visits</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Newsletters</td>
<td>8 (4)</td>
</tr>
</tbody>
</table>

* The response alternatives ‘Not important’ and ‘Slightly important’ combined.
Conclusion

The facilitation program was successful in supporting the implementation of the desired practice. Flexibility regarding facilitation strategies was critical to target the complexities surrounding the intervention.

The nurses appreciated the intervention itself and the facilitation strategies used, but the implementation outcome of overall population reach remained around 50%. These findings suggest that systematically executed facilitation strategies are useful in supporting implementation in routine care, but also indicate that further effort is required in regular services to maintain the practice and increase coverage to reach all children.
Methodological considerations

This thesis contributes to previous knowledge about introducing new practices within child healthcare and about the SDQs psychometric properties when used in a large community sample of Swedish preschool children. The studies in this thesis used a combination of qualitative and quantitative methods to investigate the introduction of a procedure to assess children’s mental health, using the SDQ, within the routine CHS. Important methodological considerations of the studies are presented below.

Paper I

Paper I explored nurses’, preschool teachers’ and parents’ perspectives on the SDQ information sharing procedure using interviews. In qualitative research, trustworthiness is often applied to consider the quality of the knowledge. The level of trustworthiness can be judged from the following four criteria: credibility, dependability, confirmability and transferability (111).

Credibility. The concept of credibility refers to how consistent the findings are with reality (111) i.e. how well the researcher has represented the stakeholders’ perceptions. Credibility also concerns the degree to which the research is carried out in an adequate manner. In order to enhance credibility in study I, the interviews were conducted using interview guides (published together with the paper). Individual interviews were chosen because we thought this would reduce the risk of the respondents being afraid of expressing their true opinions about the SDQ procedure. Furthermore, the findings were discussed with representative stakeholders.

Dependability. Dependability refers to the quality of the research process and addresses the question if corresponding results would be found if the study were to be repeated (111). To achieve dependability in study I, three analysts were involved in the analysis process and the phases of the research process were described in detail. Furthermore, we strived to carefully follow the principles of Grounded Theory, as described by Strauss and Corbin (105). The theoretical model developed was discussed at a research seminar with other researchers knowledgeable in qualitative methods.
Confirmability concerns the issue of researchers’ biases. Specifically, it addresses the questions regarding to which extent are the results grounded in the collected data and has the researcher managed to remain neutral when interpreting the results (112). This implies that the researcher needs to consider his or her own preunderstanding (105). Although EF had the same profession and training as the district nurses, she herself was not involved with CHS. However, given that the respondents knew that the interviewers were either a nurse or a nursing student involved in the introduction of the SDQ procedure, there is a risk that the respondents portrayed themselves as being more positive about the intervention than they really were. To minimise such effect, the respondents were encouraged to tell us about their positive as well as negative thoughts about the intervention.

Transferability. Transferability refers to the generalisability of the results of the work (111, 112). The nurses and preschool teachers participating in study I varied in age and country of birth and were recruited from different parts of the county (rural and urban areas). The socio-demographic characteristics of the parents varied e.g. age, gender and education level.

Not all of the nurses and preschool teachers that were contacted participated. The most common reasons for rejecting participation were lack of experience with the SDQ and lack of time. However, it is likely that nurses and preschool teachers participating in the interviews had a more positive view of the intervention. If so, selection bias cannot be ruled out.

Although nurses were encouraged to invite parents who were positive as well as parents who were negative about the information sharing procedure, no parents who disapproved of the intervention were recruited (selection bias). This is a limitation of the study. Interviews with those parents would probably have resulted in a more nuanced understanding of the barriers involved in parent participation. More knowledge about why parents choose to abstain from participation would have been desirable, given that the population coverage was lower than expected.

Among the preschool teachers interviewed, there were individuals supportive of the information sharing as well as individuals who were sceptical towards it, probably resulting in a less biased picture of preschool teachers’ perception about the SDQ procedure. With regard to nurses, all respondents were quite positive about the new method. Hence, one might think there is a risk of selection bias. However, in the survey conducted after the trial (VI), all participating nurses strongly agreed (79%) or somewhat agreed (21%) with a statement saying that the information sharing procedure using SDQ is a good method to identify mental health problems in children. Furthermore, almost all nurses found the parent and teacher SDQs to be important for their assessment of the child (IV). Given that 91% of all nurses involved in the trial participated in the survey, it is reasonable to think that nurses in general were positive about the intervention.
Papers II and III

In quantitative research, validity, reliability and generalisability are often applied to assess the quality of the research (113). The psychometric properties of the SDQ have been thoroughly evaluated, and the instrument has proved to be both valid and reliable (75). However, the generalisability of the results in studies II and III as well as their strengths and limitations need to be discussed.

Study II has a number of strengths such as the large sample size of children rated by multiple informants and it being embedded in the routine CHS setting. Furthermore, in the study, the SDQ was used in the setting of the regular CHC, i.e. not anonymous and as a basis for nurses’ assessment of the child. This is a strength of the study since the results reflect the instrument’s characteristics when applied in a “real-world” setting. However, because the sample was skewed towards highly educated parents born in Sweden, the generalisability of the results to populations with different socio-demographic characteristics might be limited.

Mothers and fathers were asked to fill in their SDQs before their child’s CHC visit. The intention was for mothers and fathers to answer their SDQ separately. However, it is possible that some parents discussed their answers before returning the completed forms. This means that there might be some degree of misreporting, leading to falsely high inter-parent agreement. This is a limitation of the study that needs to be considered when interpreting the results. With regard to preschool teachers, there is a risk that they reported falsely low levels of problems, resulting in inadequate correlations. Such misreporting could be related to preschool teachers’ resistance to using structured assessments of children’s behaviour. Misreporting could also relate to the teachers’ worries about facing parents’ reactions to the preschool’s SDQ assessment and the preschool teachers’ concerns about possible negative consequences for the child. However, results from study II have high ecological validity when application concerns introducing SDQ in a non-clinical context.

Study III contributes to previous knowledge about the SDQ by providing normative data for 3–5-year-old children. Data from a community sample representing 11,647 children were included in the analysis. The large size of the sample is a strength of the study. The fact that the SDQ data was obtained from both mothers and fathers is another strength. However, there was an overrepresentation of parents with high education and born in Sweden. Hence, due caution must be applied if generalising the results to populations with different characteristics.

A major limitation of the study is the relatively large number of parents not participating in the Children and Parents in Focus study, and the samples skewedness towards highly educated parents born in Sweden. Parents with
lower education and parents not born in Sweden rated higher levels of behaviour problems. Thus, it is possible that the cut-offs derived in study III are lower than they would have been if all parents had participated i.e. given that there might be a higher proportion of children with problems amongst those families that did not participate.

As described above, there might be some misreporting from the preschool teachers. This may have influenced the norms presented in paper III and could therefore be a limitation of the study. However, it should be noted that the preschool teachers’ SDQ ratings are not necessarily falsely low. The patterns of the cut-off values (decreasing with the age of the children) were quite similar for both teachers and parents, suggesting that preschool teachers’ ratings are based on sincere assessments of the children’s behaviour. Furthermore, the norms derived in study III reflect the stakeholders’ ratings when the SDQ is applied in a real-world setting which means that the norms have ecological validity.

Paper IV

Study IV used a mixed-methods approach to describe and evaluate the facilitation programme developed to support the introduction of the information sharing procedure at the CHCs. The combination of qualitative and quantitative methods created conditions for broad understanding of the implementation process. However, there are some limitations of study IV that should be mentioned.

The study used a non-experimental approach which means that the findings do not allow for any conclusions to be drawn about the effect of the facilitation programme. However, this approach was necessary since collection of the Children and Parents in Focus trial outcome measures was conducted through all CHCs participating. Furthermore, the total population approach used provides high ecological validity for the findings. As suggested by Grol and Jones (114), practitioners who are willing to participate in research are likely to have a higher level of readiness to change compared to the total target group of practitioners. This implies that studies are sometimes performed in non-representative samples. The Children and Parents in Focus trial was introduced at almost all CHCs in the municipality and involved all nurses working at those CHCs, reducing the risk of the findings in study IV being biased.

The barriers and enablers investigated through the survey questionnaires included in the process evaluation were selected based on the interviews conducted in 2014. However, it cannot be stated whether all relevant determinants have been included in the survey questionnaires. Some factors influencing the nurses’ perception of the intervention might have been overlooked. Investigating e.g. nurses’ self-efficacy before and after the facilitation process would
have been useful as an outcome in our evaluation of the facilitation programme.
Discussion

This thesis concerns the introduction of a new procedure at CHCs to assess 3–5-year-old children using parent and teacher SDQ reports. In order to increase the understanding of how the implementation of this specific innovation may have been influenced by the prevailing conditions, the key findings from studies constituting this thesis are discussed below. This is done in relation to the i-PARIHS framework’s four core constructs: the innovation, the recipients, the context and facilitation i.e. the what, who, where and how components of implementation (22).

The innovation – using SDQ in routine care

Underlying knowledge sources. The SDQ is a well-known, much evaluated instrument for assessing behavioural and emotional problems in children. Previous research offers evidence of the instrument’s strong psychometric properties (75). However, the psychometric properties of an instrument are closely related to the population in which it is applied (115, 116). This means that in order to use SDQ within the CHSs programme for health surveillance, the instrument’s psychometric properties need to be studied in the Swedish CHS setting. Papers II and III in this thesis add to previous knowledge about the psychometric properties of the SDQ by providing inter-rater correlations (Pearson and ICC) between mother, father and teacher’s reports and by providing norms for Swedish children aged 3–5 rated by parents and preschool teachers. In paper II, inter-rater agreement between mother, father and preschool teacher’s SDQ reports were examined using both Pearson and ICC. The results suggested predominantly fair agreement between mother and teacher reports and predominantly poor agreement between father and teacher reports. ICCs between mothers and teachers ranged from .32 on the emotional symptom scale to .56 on the hyperactivity scale. ICCs between fathers and teachers ranged from .26 on the emotional symptom scale to .46 on the hyperactivity scale. The ICCs for the total scale were .50 between mothers and teachers and .38 between fathers and teachers. The agreement between mother and father reports was generally good, with all coefficients for the subscales being .67 or higher (highest for hyperactivity). For total difficulties, the ICC was .76, indicating excellent agreement. These findings are in line with previous research on the SDQ showing low, albeit significant, parent-teacher correlations and higher mother-father correlations (76, 77). The results of paper
II are also consistent with previous research on the SDQ indicating higher agreement for externalising rather than internalising behaviours (75, 117, 118). ICCs between mother, father and teacher’s reports on all SDQ subscales were generally similar across ages and for both genders (except for peer problems). These findings are inconsistent with previous studies on SDQ inter-rater agreement reporting higher agreement between mother-father (117, 119) and parent-teacher (119) ratings of boys compared to girls.

In order to determine whether a specific SDQ score indicates that the child has a problem, norms derived from the general population are needed. Hence, the purpose of paper III was to report on norms and cut-off values for the population in which the SDQ was intended to be used i.e. Swedish 3-, 4- and 5-year-olds. Norms and cut-offs were presented for the teacher as well as for the parental version of the SDQ. Since the agreement between mothers and fathers’ ratings previously had been classified as good or excellent (paper II), their ratings were combined (randomly selected) and used to generate “parent” norms, which turned out to harmonise well with previous Swedish norms (120). The results in paper III showed that mean scores differed for both gender and age. It could also be shown that preschool teachers’ ratings, in general, were lower than parents’ ratings. Furthermore, the cut-off values set at the 80th and 90th percentile (10th and 20th for prosocial) were slightly higher for boys (lower for prosocial), suggesting that boys exhibit more behavioural problems than girls. The cut-off values presented in paper III were lower or similar to those found internationally (121-123).

The norms and cut-off values developed in paper III make it possible to introduce scoring as a way for nurses to interpret the parent and teacher SDQ assessments. However, introducing SDQ scores and cut-off values for nurses’ interpretation of the SDQ assessments would probably approach universal screening as a method which is a topic of controversy (74, 124). Attention has been focused on the advantage of using standardised method as part of health surveillance to detect developmental and behavioural problems (125). However, Glascoe (91) proposes that screening of these types of problems should be performed repeatedly since the problems can occur at different ages and be linked to environmental risk factors that can change over time. Although the use of standardised methods as part of health surveillance has been suggested to be beneficial, it is important to consider that introduction of such a procedure may result in negative psychological consequences. For example, while a false positive result may lead to parents experiencing unnecessary worries or affect the parents’ perception of their child, a false negative result might cause a false sense of security, possibly hampering or delaying necessary treatment for the child in question (3). Furthermore, if a large number of children without actual problems are followed-up at the CHC or referred to specialists
for further investigation, this will use up limited resources and mean unnecessary costs for the healthcare system. The number of screen-positive children exceeding the healthcare services capacity is a recognised concern related to universal screening programmes for mental health problems (124). However, it is important to note that the SDQ is intended to be used as a part of the nurses’ overall clinical assessment, and not in isolation. The question whether introduction of SDQ within CHS is suitable is elaborated on in the ‘Implication for clinical practice’ section of this thesis.

Early identification of physical and mental health problems is an important part of CHSs programme for surveillance (3). In order to achieve this, CHC-nurses need to be equipped with adequate methods. Although the NBHW recognises that screening as a method may sometimes be part of a surveillance programme (126), they emphasise the importance of the WHO criteria for evaluating screening programmes (127). The NBHW has also developed a model for assessing any proposed screening programme (128). This model has been highlighted in the CHSs national guideline document (3), suggesting that a universal screening programme (i.e. assessment of all children in a specific age group) should only be implemented if a number of criteria are met. Out of these, three are described as key criteria: 1) The method can reliably discriminate between children with and without the condition it is intended to detect, 2) There is effective treatment available and accepted by those identified and 3) The costs related to the screening procedure are considered reasonable (3).

The SDQ is extensively evaluated and investigated in terms of both validity and reliability, and it has also proven to perform well as a screening instrument (75). With regard to the SDQs ability to identify individuals who truly have a psychiatric disorder (sensitivity) and to correctly identify individuals without the condition (specificity), parent-rated total difficulties has shown satisfactory sensitivity (82.4%) and specificity (85.4%) when used in a sample of 5–15-year-old Swedish children with the cut-off for total difficulties set at 11 (the optimum cut-off according to ROC analysis) (129). When setting the cut-off at the 90th percentile, sensitivity was 91% and specificity 70%. The value of obtaining SDQ reports from parents and teachers has been demonstrated in a study on a community sample of 5–10-year-old British children wherein sensitivity reached 62.1% for parent and teacher reports combined, but dropped to 29.8% and 34.5% when solely parent or teacher report, respectively, was used (78). Adequate sensitivity and specificity in an assessment instrument are essential to avoid over-referrals as well as under-detection (91).

Regarding the availability of treatments and the costs related to those treatments, it is likely that the introduction of the information sharing procedure has resulted in increased number of children being referred to specialists. The waiting time to see specialists such as psychologists, speech and language
therapists and physicians could sometimes be long, depending on available resources within the healthcare system. Findings in paper III indicated that parents with lower education and parents born outside of Sweden tended to report more emotional and behavioural problems (across child age). The parents participating in the Children and Parents in Focus study were, in general, more likely to be well educated and born in Sweden (III). In a situation wherein a higher proportion of parents from other groups participate (i.e. if barriers for parents’ participation are addressed), this would probably increase the burden on, and hence, costs for the healthcare system even more. This assumption is supported by previous research showing that lower education and lower socioeconomic status are associated with more problems (130). For screen-positive children with symptoms fulfilling criteria for a psychiatric diagnosis, treatments are available within specialist care. Screen-positive children referred but not fulfilling criteria for diagnosis, and children with milder problems (considered not in need of referral), can instead be offered advice and support at their respective CHC, at their preschool or through parental support programmes. However, according to the NBHW, there is not sufficient evidence for any specific early intervention to prevent mental health problems in young children to recommend its use within the routine child CHS (2). As previously pointed out by Goodman (78), it would make no sense to use the SDQ to identify more children with problems if there are no effective methods to be offered or if there are not enough resources in the healthcare system to meet the increased needs. Furthermore, regarding the acceptance of available treatments among those identified, it is important to consider if the time needed to perform the test and possible further investigation is reasonable (128). Participating in the information sharing procedure with SDQ requires families’ time and effort, and additional visits to specialists would require even more of their time. Hence, if healthcare services are already overstretched and families cannot be offered effective early interventions, the information sharing procedure is most likely not considered acceptable by parents.

Clarity. Cut-offs were not used in the information sharing procedure reported on in this thesis. Instead, nurses were instructed to use the SDQ as a basis for their discussion with the parents, and to interpret the SDQ reports by using a transparent overlay indicating items with “high scores” using colour-coding. The nurses were instructed to review parents and teachers’ responses to all subscale items and the SDQs first impact item asking whether the informant thinks that the child has difficulties in one or more of the subscale areas. Furthermore, the nurses were informed that if the parents’ responses, on several items, indicated that the child might have a behavioural or emotional problem, the child should be considered a screen-positive. However, the number of items needed in order to be classified as screen-positive was never specified. One might therefore think that nurses would find it difficult to, based on these
relatively unclear instructions, interpret the SDQ results. However, neither the survey (IV) nor the interviews (I, IV) conducted with nurses mentioned experiences relating to such difficulties. Rather, results in paper IV showed that nurses used the score sheet regularly and found it helpful to identify possible areas of concern. Moreover, in the survey conducted after the trial (IV), all participating nurses agreed somewhat (67%) or totally (33%) that the method of information sharing was easy to work with. On the other hand, it is possible that they would consider calculating scores and interpreting them using cut-offs to further increase the clarity of the information sharing using SDQ.

Degree of fit with existing practice and values. In paper I (131), results from interviews with nurses, preschool teachers and parents were discussed in relation to the five attributes of innovation, which according to Rogers (106) determine the level of its adoption (relative advantage, compatibility, complexity, trialability and observability). The nurses’ perceptions about the innovation were followed up in a survey conducted soon after the end of the Focus study (IV). The results showed that almost all nurses thought that the information sharing was compatible with CHSs current needs and that they could fit the use of the SDQ forms to their own way of working. These results indicate that the innovation, from the nurses’ point of view, suited the CHSs existing practice and values. The perceptions among preschool teachers were different. Results from the interviews with preschool teachers conducted in 2014 (I) revealed that they were reluctant when it came to using the SDQ, because they viewed structured forms as not being compatible with the curriculum and preschool philosophy. In fact, preschool teachers’ resistance to using structured assessments proved to be a main barrier for the information sharing throughout the study years. Results in paper IV revealed that more than 50% of the nurses had experienced negative reactions from preschools, mainly concerning the lack of fit with the existing values within preschool.

Usability. To be considered useful, a method needs to be perceived as relevant and worthwhile by practitioners (84). Intended users also need to find the method easy to use. Findings in paper I and paper III showed that the nurses thought that the SDQ reports served an important purpose. Specifically, they provided a good basis for the nurse’s assessment of children’s mental health. Furthermore, the nurses found it useful to be provided with information from both parents and preschool teachers. Additionally, results in paper IV showed that 67% of the nurses found the information sharing easy to work with. However, the multi-informant approach can be discussed considering the innovation’s usability. An important aspect of an instrument’s usability is how easy it is to administer (i.e. to score and interpret). Assessing children’s behaviour using reports from different informants is not easy due to informant discrepancies. Meta-analyses on inter-rater agreement (76, 77) have reported fairly low correlations (0.28) between different types of informants (e.g. mothers
and fathers). Results in paper II showed that the correlations between parents and teachers’ SDQ ratings were low, albeit significant. Results also demonstrated large effect sizes for differences between parents and teachers’ ratings of total difficulties, emotional symptoms and conduct problems. This means that nurses had to deal with situations wherein parents and teachers disagreed in their SDQ assessments. This was viewed as problematic, as confirmed in the group interviews and the survey in paper IV. In paper II, it could also be shown that fathers reported more problems than mothers in all subscales except for emotional symptoms (p < .001). This finding is in line with a study by Davé et al. (117) suggesting that fathers report higher SDQ mean scores for conduct, hyperactivity and total difficulties. The higher mean scores reported by fathers might to some degree be explained by a lower tolerance among fathers for some types of emotional and behaviour problems. However, ANOVA analyses in paper II showed that the differences found between parent mean scores were small; therefore, it is unlikely that dealing with discrepancies between mother and father reports has been challenging for nurses. Findings in previous research on discrepancies between mother and father assessments are somewhat mixed, and mothers have also been found to report more behavioural problems than fathers (132).

The nurses experienced that the preschool’s SDQ was often missing at the time of the child’s CHC-visit (IV) and that parents often forgot to return their SDQs or refrained from participating in the information sharing procedure (I). Furthermore, nurses found that it was quite common that those parents whom they most wanted to reach (socially vulnerable families or families with a child that nurses suspected had problems) were often those who decided not to participate (I).

It is likely that the difficulties handling informant discrepancies, missing parent and teacher SDQ reports and (some) parents not participating in the information sharing have had a negative impact on the nurses’ perception of the innovation’s usability. It is probably crucial to address these issues if we are to proceed with the information sharing procedure since practitioners make personal judgements about clinical utility, and hence usefulness, when they decide to use or resist a new method (83).

In paper III, combined gender norms and gender-specific norms are provided. Although both types of norms can be helpful, given that they can be used to answer different research questions (85), using combined gender norms are likely to be easiest for nurses to use in practice. On the other hand, this could lead to unnecessary over-referral of boys. Thus, careful consideration needs to be given to these aspects before introduction of norms in routine practice.
Relative advantage. Findings in papers I and IV indicate that while nurses had noted a number of relative advantages relating to the information sharing procedure, teachers were hesitant about assessing children using structured forms and did not seem to identify many benefits of the new method (I). Although preschool teachers acknowledged that using the SDQ could be beneficial for the preschool by providing the teachers with a clearer picture of each child’s behaviour and peer relationships (I), they might have considered the efforts related to the new routine as outweighing the advantages. Teachers participating in the new procedure had to put aside their potential concerns about structured assessments, spend time in doing the actual SDQ assessment and thereafter face any possible reactions from parents after their CHC-visit, and in most cases without feedback from the CHC-nurse. On the other hand, the information sharing provided them with a possibility to give the CHC-nurse information about the child, i.e. a way to communicate that did not exist before.

Parents could recognise advantages of the information sharing procedure. They believed that parent and teacher reports could complement each other and wanted to know about the preschool teachers’ experiences of their child (I). It is possible that parents’ perception of the relative advantage of the innovation could be enhanced if their annual review discussion at the preschool were to be held soon after the child’s CHC-visit. This would give them an opportunity to ask any questions related to the preschool assessment.

Trialability can be described as the degree to which the innovation can be tested and modified to fit the users’ conditions (106). Testing an innovation on a small-scale before full-scale implementation has been described as beneficial in the innovation literature (23). Before the launch of the Children and Parents in Focus study, four CHCs in Uppsala participated in a five-month survey (May – Sept 2013) to test the method and procedure intended to be used in the Children and Parents in Focus study. The survey provided information about what could be an expected response rate in the full-scale trial and resulted in an awareness about reasons why parents choose to abstain from participation. The most common reasons reported were lack of interest (to participate in the survey) and lack of time. Fifty-nine per cent of the children receiving the questionnaire had at least one parent or preschool teacher SDQ returned, hence, population coverage in the full-scale trial was expected to exceed 50%. About two months after the survey (i.e. in connection with the launch of the actual trial), nurses’ experiences of working with the information sharing procedure were explored through brief telephone interviews. Nurses described that many parents expressed disapproval of the over-reactivity sub-scale items in the Parenting Scale (part of the set of questionnaires collected from parents) and had decided against participation because of these specific items. In order to modify the procedure to fit parents, the Parenting Scale was removed. No other modifications were made between the survey and the main
trial, meaning that the number of questions were about the same, hence, requiring an equal amount of time for parents to complete.

*Observable results.* Observability refers to ‘the degree to which the results of an innovation are visible to others’ (106) (p.16). If the results of an innovation are easy to see, it will be adopted more rapidly (106). Results of the information sharing procedure, in terms of child mental health outcomes are not easily observed. As part of the survey conducted after the end of the trial, 85% of the nurses strongly agreed (and 15% somewhat agreed) with a statement saying ‘the advantages of the information sharing procedure are apparent to me’ (IV). They were not asked to specify the perceived advantages; however, results in paper I showed that nurses observed (experienced) that the SDQ provided important information about the child and helped them in their conversations with parents. They might also have noticed other results such as, for example, them being able to be more specific in referrals to specialists, or parents being more receptive to nurse’s concerns about a child after being informed about the preschool assessment. Preschool teachers had similar experiences of the SDQ being helpful when discussing children’s behaviour and social relationships with parents (I). However, given that preschool teachers were not provided with any feedback on their SDQ assessments (unless parents informed them of the results, for example, any referrals), it is likely that the results of the intervention have been less apparent to preschool teachers than to nurses and parents. If so, this has probably affected the intervention’s rate of adoption among preschool teachers negatively. Further, if healthcare services are overstretched and therefore not able to provide support and treatment to children identified with problems by preschool teachers, this might hamper the adoption of the SDQ procedure among preschool teachers. However, if the information sharing continues and the preschool teachers, in the years to come, observe that the children identified by them actually get help at an early stage, their willingness to participate in the procedure might increase over time.

**Recipients**

*Compatibility with values and beliefs.* Results described in paper I showed that both CHC-nurses and preschool teachers had the ambition to identify and support children exhibiting signs of mental health problems. However, they doubted that there was an appropriate and reliable way to assess children’s behaviour and emotions (I). The CHC-nurses and preschool teachers also viewed structured instruments for that purpose differently. While the nurses did not share any concerns regarding the use of such instruments, the preschool teachers expressed a clear resistance to using assessments based on a normative view of children’s development. According to the teachers, this
type of assessments is considered outdated and not compatible with the preschool curriculum (I). An innovation not perceived as being compatible with recipients’ values and beliefs can delay its adoption (106). As previously mentioned in this discussion, preschool teachers’ resistance to using structured assessments persisted throughout the trial, indicating that it was a strongly held belief among teachers. Teachers not being aware several months into the trial that they were allowed to fill in the SDQ might reflect difficulties faced by the preschool leadership in communicating their approval to front line workers. However, it may also be related to teachers consciously or unconsciously avoiding information about the SDQ procedure, which they perceive is in conflict with their existing beliefs i.e. a matter of selective exposure (106).

Results in paper II revealed that preschool teachers reported lower SDQ mean scores compared to parents (large effect sizes for total, emotional, and conduct problems). Paper III also reflected preschool teachers reporting lower levels of problems than mothers and fathers. These results differ from studies performed in Denmark (133, 134) and Finland (121), where the parent and teacher scores were relatively similar. The lower ratings by the preschool teachers found in this thesis could, to some extent, be due to their resistance to using structured instruments in assessing children’s behaviour. Preschool teachers were also afraid of labelling children and that their assessment might result in negative consequences for the child in a long-term perspective (paper I). The fear of labelling children has also been presented in other projects reporting on information sharing procedures between educational and healthcare services using the SDQ in Scotland (135) and New Zealand (136). Concerns about labelling children in mental health screening programmes have also been noted by Levitt et al. (124). Furthermore, from the preschool teachers’ perspective, symptoms displayed by a child are often likely to be related to the child’s environment. This could also be an explanation for the teachers’ lower ratings. As discussed in paper III, it is possible that preschool teachers are successful in adapting the preschool environment to fit the children’s needs, resulting in them displaying fewer problematic behaviours. However, the SDQ-scores reported by teachers in the Children and Parents in Focus study (III) were lower than those previously presented by Gustavsson et al. (137). There might be various reasons for the different results, for example, Gustavsson et al. combined the norms for 1–5-year olds, making comparisons with our norms difficult. Further, findings in paper I highlight another factor, namely the preschool teachers’ concerns about facing parents’ reactions to the preschool assessment. An important consideration is whether parents in the study by Gustavsson et al. were informed about the preschool teachers’ assessments. If not, this could be a key explanation for the different results.
With regard to parents as recipients, detection of a child’s symptoms currently relies upon the parents’ recognition of any problems. However, findings in paper I indicate that parents believed the preschool teachers were qualified to assess children’s behaviour, and that the parents looked forward to getting information from the preschool’s assessment of their child. Hence, parents seemed to be positive in letting preschool teachers contribute to the identification of mental health problems in children. This would be beneficial since using multiple informants results in the best sensitivity and specificity when SDQ is used in community samples (78).

**Motivation.** Results from both paper I and paper IV showed that the nurses found that using the SDQ increased the quality of the 3–5-year-old visits by, for example, making them more structured and focused on children’s mental health. Nurses also thought that the information sharing resulted in them getting important information about the child, which they probably would not have received without the SDQ (I, IV). A majority (84%) of the nurses also did not consider the information sharing procedure to be too taxing for them to apply (IV). However, some nurses believed that the information sharing placed high demands on parents, in relation to the somewhat complicated procedure and their language skills (I). In paper IV, results revealed that the percentage of nurses perceiving the procedure as being too taxing for parents was 14%, while 74% of the nurses did not believe so. However, more than half of the nurses reported experiences of difficult situations when parents’ and teachers’ assessments diverged (IV). In addition, nurses noticed that parents of children whom the nurses suspected as having problems more often resisted participation in the study (I). The representativeness and non-response bias must be considered when interpreting trial outcomes. This was clearly demonstrated in a study to test the psychometric properties of the SDQ in a community sample of 4–6-year old children in Finland (119). A similar procedure was used to collect SDQ from mothers, fathers and teachers prior to the child’s regular check up at the CHC. To control for bias, nurses rated their concerns for all children’s mental health, based on their clinical observations. Results revealed that the nurses considered significantly more children to have definite or severe difficulties among the non-participating children.

Although nurses in general seemed to appreciate the intervention (I, IV), it is possible that their experiences of the SDQ procedure being too complicated and not attracting the families with the greatest needs had a negative impact on nurses’ trust, and hence, motivation to use the information sharing procedure with all families.

Most of the interviewed preschool teachers thought that the information sharing procedure could provide an opportunity for children in need of support or further evaluation to be identified at an early stage (I). The teachers also found
themselves being competent assessors of children’s behaviour, having deep knowledge about each child’s situation (I). These two conditions might have served as motivators for preschool teachers during the intervention period. The interviews underlying the results in paper I revealed diverging opinions among preschool teachers regarding the information sharing, indicating personal underlying factors rather than factors on the organisational level. According to Greenhalgh et al., individual traits can be related to recipients’ propensity to use a new innovation (138). In this context, this means that preschool teachers’ individual values and motivation level might be an explanation for their different views. Possible reasons underlying a higher level of motivation in some preschool teachers could be, for example, a better understanding of behavioural and emotional problems or them having identified a need for the information sharing procedure.

An important aspect relating to parents’ motivation to participate in the information sharing procedure was that they found that the SDQ made them reflect on their child’s behaviour and situation (I). Further, the SDQ items initiated discussions with the other parent about things they did not usually talk about (I). Although the findings in paper I indicate that parents as recipients probably can be considered as being open to the use of SDQ, they also expressed worries about the SDQ information resulting in unexpected, possibly negative, consequences for the child. Further, low parental education was found to be associated with more problems, as were ratings from parents born outside Sweden (III). An association between higher levels of problems and lower education has also been shown in previous research (130). This means that children not participating in the information sharing procedure, might to a higher extent have problems. There may be several possible factors explaining why parents were not motivated to participate, for example, language problems, lower level of health literacy or an unwillingness to have their child’s problems confirmed (for themselves or to the CHC-nurse) through the preschool assessment.

Context

Internal context

The recipients’ propensity to use new methods is not sufficient to explain the success or failure of an implementation process. Contextual factors at the local, organisational and external health system level also affect the rate of an innovation’s adoption (22). For an implementation process to be successful, the organisation needs to be receptive for change and open to implementing new innovations. The i-PARIHS framework proposes that formal and informal leadership support and organisational priorities are two of the characteristics to consider within the internal context (22).
Formal and informal leadership support. The leaders play an important role in change processes, and to actively involve and consult them might enhance the success of the implementation (138). In the project reported on in this thesis, the formal leaders i.e. the managers of the local healthcare centre and preschool had the possibility to comment on the information sharing procedure or opt-out. However, since the senior leaders within the CHS and the preschool approved the information sharing procedure and advocated for its use, the local managers might have perceived their influence in the formal decision to participate as being limited. Furthermore, they were not actively consulted during the intervention period. Hence, the level of support from the local managers is to a large extent unknown. However, it is possible that some local managers considered the information sharing procedure to be e.g. too time-consuming or that it should not be prioritised considering the CHC-nurses’ workload. If so, focusing more on attracting local managers’ support and attempting to engage them might have had a positive impact on the change process. With regard to informal leaders, there are some individuals who have the ability to influence other peoples’ attitudes or behaviour, also referred to as opinion leaders (106, 138). Opinion leadership is earned and maintained by the individual’s status, representativeness and credibility among peers, and their impact on the change process can be either positive or negative (138). In the Children and Parents in Focus study, one self-elected nurse at each local CHC functioned as a contact person regarding the information sharing procedure. To magnify the facilitators’ efforts, the focus was placed on their communication activities with the contact nurses. They were encouraged to forward the information and provide support to their peers when needed. However, we do not know who the true opinion leaders were. If the self-elected contact nurses were not opinion leaders, their influence on their peer’s willingness to follow the new routine may have been small. Engaging true opinion leaders as contact persons could instead potentially have had a greater impact on the implementation process. However, identifying and using opinion leaders to facilitate implementation processes has proven to be difficult (138).

Organisational priorities and absorptive capacity. High employee turnover and concomitant major changes in nurses’ work procedures (introduction of the new national CHP) may have affected the CHCs ability to implement the new SDQ procedure. Also, many preschools in Sweden struggle with a shortage of registered preschool teachers (139) and teachers caring for too large groups of children in relation to the preschool curriculums’ ambitions (140). This means that although the preschool organisation recognises need for preschool teachers to have more knowledge about mental health problems in children (70) indicating the importance of the topic, and preschool teachers want to help these children (I), the implementation of the information sharing procedure might not be considered a priority.
External context
The responsibility to identify children with mental health problems is currently shared between a number of different actors, whereof the CHS and preschool are central. An increased collaboration between CHC-nurses and preschool teachers would likely provide the best possible conditions for early detection and intervention of mental health problems. Using a valid and reliable instrument could enable a structured communication between the different professions, and hence promote an increased collaboration. However, results in paper IV reveal that the resistance among preschool teachers has continued during the study period and that the SDQ assessments are often lacking at the time for the child’s CHC-visit. This resistance is likely to function as a barrier for collaboration between the CHS and the preschool. In a review summarising evidence regarding approaches to early identification of developmental and behavioural problems, Oberklaid proposes that ‘communication between disciplines is often hampered by lack of any shared conceptual understanding of child development and its determinants’ (74) (p.1010). As previously discussed in this thesis, CHC-nurses and preschool teachers view normative assessments differently (I). Furthermore, cooperation between the CHS and the preschool is currently limited (70). However, results from paper I as well as a national survey conducted in 2019 (64) showed that there is a willingness among CHC-nurses and preschool teachers to collaborate. Also, both parties should react and take necessary action when children with mental health problems are identified (3, 73). However, to be able to successfully implement an instrument to use for collaboration, an agreement has to be reached in terms of which instrument to use.

Facilitation
According to i-PARIHS (22), facilitation constitutes the how component of changing practice. The concept of facilitation includes the facilitator and the facilitation process (strategies and actions to support implementation). A facilitation programme was developed to support the implementation of the SDQ procedure introduced as part of the Children and Parents in Focus trial. The following discussion relates to the facilitation process and highlights what can be learned from it.

The facilitators
Harvey and colleagues (22) describe the importance of having skilled facilitators for successful implementation. The facilitator needs to demonstrate project management and process skills along with a range of personal attributes (e.g. good communication skills, active listener, respectful) (23, 141). A facilitator also needs to have adequate knowledge about what is intended to be
implemented (the innovation), who with (the recipients) and where (the context) (22). The complex role of the facilitator means that there are clear advantages of providing novice facilitators with support and mentoring from more experienced facilitators (23). In the implementation process evaluated, the two facilitators had good knowledge of the instrument to be implemented (SDQ). Although they were members of the research team, and hence, external to the organisation, both facilitators were registered nurses and one of them worked clinically as a district nurse at a health clinic participating in the trial. This implies that they had an understanding of the attitudes and behaviour of the recipients as well as the context in which the SDQ procedure was to be implemented. However, they were not trained in facilitation techniques and did not have experience in facilitating implementation. The facilitators were instructed to ensure that all CHC-nurses working at the participating CHCs were adequately informed about the information sharing procedure, and worked with the SDQ procedure as intended. The number of participating CHCs and CHC-nurses, the staff turnover, CHCs in need of additional support and the amount of questionnaires that regularly needed to be distributed, collected and transported back to the researchers, made the facilitators’ tasks complex and time-consuming.

It is possible that the above-mentioned challenges, in combination with facilitators being inexperienced, resulted in them being more focused on CHCs performance, in terms of nurses’ delivery, response rate and population coverage than on enabling the CHC-nurses to reflect and change their ways of thinking and working. Support from experienced facilitators might have helped the novice facilitators to take on a more enabling approach as they developed their skills. Furthermore, engaging experienced facilitators with knowledge about process evaluations would probably have been valuable, in terms of planning and collecting data for the evaluation of the facilitation programme used within the trial. The facilitation programme (IV) was assumed to increase nurses’ belief in and ownership of the information sharing procedure, and hence, trigger them to change their behaviour. It was also assumed that the facilitation strategies applied would increase the nurses’ self-efficacy to assess children’s mental health using an instrument. However, the data collected for the process evaluation focused mainly on performance and nurses’ perception of the SDQ procedure. If the process evaluation was planned before the launch of the trial, and together with an experienced facilitator, perhaps the evaluation would have included other outcomes e.g. changes in nurses’ self-efficacy. This would probably have provided a more complete picture of the impact of the facilitation programme.

The facilitation strategies
A combination of strategies was applied as part of the facilitation programme developed to support the introduction of the SDQ-procedure. In an overview
of systematic reviews reporting on interventions to change the behaviour of healthcare professionals, Squires et al. (142) conclude that there is no convincing evidence to suggest that a multi-faceted approach is more effective than using single strategies. However, in general, using multiple strategies are considered to be more successful than using single strategies (26, 142). Results in paper IV showed that a great majority of the nurses regarded the three strategies used during the intervention period as being either important or very important for their motivation to work with the SDQ procedure. This supports the use of multiple strategies. It also supports the use of the specific strategies applied (i.e. educational outreach visits, educational meetings and audit/feedback) although previous research have indicated that their respective effect is limited (26). However, results in paper IV revealed that the multiple strategies used within the facilitation programme did not result in achieving the expected level of population reach (> 50%). As discussed in paper IV, this might not be an indication of failure of the facilitation programme but rather reflect, for example, parent’s lack of time, language barriers or concerns about how the data would be used (I). Furthermore, nurses reported that parents had experiences of preschool teachers being unwilling to assess children using the SDQ (IV). Hence, it is possible that the reluctance among preschool teachers to assess children using the SDQ made parents less prone to participate in the information sharing procedure. The preschool’s resistance to using behavioural assessments was known before the start of the trial and evident in the results of paper I. To create conditions for implementation of the SDQ procedure, meetings with researchers and representatives from the preschool and CHS were held regularly throughout the study years. Information about the study was also provided at meetings with all preschool managers in the municipality. However, facilitation efforts were not focused directly towards the preschool teachers. Providing them with support through e.g. educational outreach meetings might have resulted in more preschool teachers adopting the SDQ procedure which, in turn, may have increased the participation rate. Facilitating the implementation of SDQ within the preschool is probably crucial if the procedure is to be maintained.

In the survey conducted after the end of the trial (IV), 53% of the nurses reported experiences of difficult conversations with parents related to the SDQ. Furthermore, 52% of the nurses reported experiences of negative reactions from preschools, and interviews revealed that the new practice could be perceived as uncomfortable (IV). In face of these challenges, it is encouraging that the proportion of children receiving the study questionnaires (i.e. dose, a measure of nurses’ delivery of the intervention) averaged 77–91% over the study years (IV). It also serves as a reminder that achieving higher levels of dose rates requires facilitation, especially in areas with high personnel turnover, difficult caseload, or in times of competing programme implementation efforts, especially if these come without adequate support measures.
As mentioned previously, the response rate remained lower than expected throughout all study years despite the use of multiple facilitation strategies (IV). However, facilitation strategies will not lead to desired implementation outcomes if they fail to target key barriers. As part of a large scale project involving 25 municipalities in Finland (119), a procedure similar to ours was used to obtain mother, father and teacher SDQ reports before the child’s regular check-up at the CHC. Response rate reached 68.3%. A possible explanation for the higher response rate in the Finnish study is that the parents’ questionnaires included only socio-demographic questions, the SDQ and a one-question screen (based on the first item of the SDQs impact supplement). This suggests that the lower response rate found in the Children and Parents in Focus trial can, at least to some degree, be explained by the number of questions included in the study forms besides the SDQ, or the characteristics of the questions included in study forms besides the SDQ. If so, focusing greater resources on facilitation towards nurses in order to increase the proportion of children receiving the study questionnaires might have resulted in a relatively small (albeit potentially important) positive impact. This points at the importance of planning the facilitation after careful consideration of what specific barriers are most important to address, which also has been emphasised by Grimshaw et al. (26).

Yearly dose and reach measures provided a comparative overview of the extent to which the information sharing was implemented over time and across different CHCs (IV). By strategically gathering and using monitoring data to see variations in compliance, three CHCs with low dose levels were identified. Additional support efforts, in terms of facilitative administrative support, were directed towards the three aforementioned CHCs, resulting in substantially increased dose levels. Therefore, it appears that the practical assistance was successful in terms of supporting CHCs to achieve the dose score objective. However, it is likely that the increased dose levels might be difficult to maintain without the administrative support. Furthermore, one might discuss if investing greater resources in the facilitative administrative support at three CHCs was the right decision. Perhaps spending more resources on facilitating implementation at the other CHCs would have resulted in better implementation outcomes. However, not directing additional support to the CHCs located in deprived areas would not have been compatible with the CHS obligation to provide care on equal terms for the entire population (143).

Although it could be argued that a relatively large part of the facilitators’ time was spent on monitoring response rate and population coverage and ensuring CHC-nurses’ compliance with the procedure, there are reasons for this prioritisation. To make sure that all children enrolled at the participating CHCs received the study questionnaires was important from at least two perspectives: First, to ensure equal care to all children, which is central part of the CHS
mission (3, 143) and second, to optimise conditions for testing the effect of the different levels of parenting support (intervention conditions) investigated in the Children and Parents in Focus trial (101). This is of high relevance, given researchers’ responsibility to provide grant funders with high quality results.
Conclusions

The overall aim of the studies constituting this thesis was to evaluate the introduction of the new procedure, including the facilitation strategies provided to support implementation, at CHCs to assess children’s mental health using parent and teacher SDQ-reports, and to provide norms and inter-rater correlations for the SDQ in this population. The results in this thesis indicate that CHC-nurses, preschool teachers and parents concur with the idea, and recognize the value of a reliable method for early identification of mental health problems. Furthermore, the results indicate that information sharing using an instrument such as the SDQ may be feasible in child healthcare practice and could be a valuable addition to the CHS programme for health surveillance. We believe the information sharing procedure using the SDQ may not only contribute to nurses’ assessment of children’s mental health but also create conditions for an increased collaboration between the CHS and the preschool, by providing a structured method for communication in routine practice.

Importantly, identifying mental health problems in children is a complicated process requiring a reliable instrument together with the CHC-nurses’ clinical assessment of the child. The results also revealed that although the CHS needs an evidence-based method for early detection of mental health problems to support nurses in their decision making, implementing a structured assessment tool in CHS-practice is complex and requires comprehensive facilitation efforts.

This thesis studied different aspects concerning the implementation of SDQ, an evidence-based tool, in the CHS to assess children’s mental health through parent and teacher reports. Studies I and IV evaluated the introduction of the new procedure for information sharing using the SDQ. Studies II and III examined the psychometric properties of the SDQ when used within a large community sample of 3–5-year-old children visiting the CHC.

The conclusions from the four studies are listed below.

- Study I explored nurses, preschool teachers and parents’ experiences of the new information sharing procedure. The results showed that the nurses were very satisfied with having access to preschool teachers’ SDQ ratings for their assessment of children’s mental health. Parents were also positive...
to the new procedure but had concerns regarding the use of the SDQ data. Finally, preschool teachers were least positive, fearing labelling of children and negative parental reactions. Although the causal conditions and current context of child healthcare in many ways advocate the introduction of SDQ, successful implementation requires further efforts to address barriers such as the stakeholders’ aforementioned concerns and the preschool teachers’ resistance to assess children using instruments they consider to be based on normative thinking.

- Study II examined the degree of correlation and agreement between mother, father and teacher SDQ reports. The results demonstrated low, albeit significant, correlations between parent and teacher SDQ ratings, suggesting that in order to assess agreement between different informants, correlation alone may not be sufficient. Teachers were found to report lower levels of problems compared to parents. Contextual variations in children’s behaviour could be an explanation for the discrepancies found. This suggests that parent and teacher reports are complementary; hence, reports from both types of informants should be considered when using the SDQ as a method to identify mental health problems within the CHS. However, inter-rater agreement between mothers and fathers was good, meaning that it may be sufficient to obtain data from a single parent informant.

- Study III established Swedish SDQ norms for 3–5-year-old children rated by parents and teachers. Results showed that SDQ mean scores differed for both gender and age and that teachers’ ratings were generally lower than parents’ ratings. Cut-off values were somewhat higher for boys (lower for prosocial), suggesting that boys display more behaviour problem symptomatology than girls. Furthermore, the results revealed an association between children’s SDQ scores and their parents’ education level and country of birth.

- Study IV described and evaluated the facilitation programme delivered to support the introduction of SDQ in clinical practice. The findings indicated that although nurses noticed that the benefits of the information sharing procedure were challenged by a variety of factors, they were motivated by the facilitation strategies applied to support its implementation, and in favour of using the SDQ in practice. Monitoring the different CHCs compliance with the desired practice was important to identify CHCs in need of extra support. Moreover, it was necessary to adjust the level of support efforts in relation to their needs. The results indicated that nurses, in general, delivered the intervention as intended. However, response rate and population coverage remained lower than expected throughout the trial, suggesting that implementing the SDQ is feasible, but requires continued facilitation in regular services.
Implications for clinical practice

Young children displaying symptoms of mental health problems, who are not identified, and hence, do not receive support or treatment are at risk of later negative consequences in terms of psychosocial, mental health and academic outcomes. However, if the problems are identified at an early stage, it might positively impact the individual child’s quality of life, and in a longer term perspective, also result in socio-economic benefits. These arguments underscore the importance of implementing methods for early identification of mental health problems. The CHS in Sweden offer regular health check-ups and reach almost all 3–5-year-old children. The CHS could therefore play an important role in the early detection of mental health problems within this age span, but this will require a valid and reliable assessment instrument.

This thesis contributes with empirical data on how using the SDQ within child healthcare is perceived by nurses, preschool teachers and parents. Furthermore, it contributes to previous knowledge about the SDQs psychometric properties in a community sample of 3–5-year-olds. The second paper in this thesis is one of few examining agreement between mothers’, fathers’ and teachers’ SDQ reports and the first Swedish study to compare SDQ reports from different informants. Moreover, the introduction of the information sharing procedure made it possible to establish Swedish SDQ norms for 3–5-year-old children, which are presented in paper III. The results may be used to create improved conditions for its continued use (if the barriers identified in paper I are addressed) and to develop the innovation further. For example, nurses may be provided with information about expected levels of informant discrepancies for the different subscales, and the cut-off values might facilitate the use of SDQ within the CHS by enabling nurses to interpret the parent and teacher SDQ assessments using scores. The fourth paper of this thesis contributes by describing how the use of SDQ (or similar mental health screening instruments) can be implemented within child healthcare using facilitation.

Although prevailing conditions and current context in many ways endorse introduction of the SDQ procedure, the studies in this thesis give rise to important considerations if the routine is to be continued. Four of these are discussed below.
Continued use of the SDQ? An important question is whether a screening method to identify mental health problems in routine care is appropriate. In 2013, the NBHW performed an overview and compilation of systematic reviews assessing methods to identify mental health problems in children (144). It was concluded that good quality reviews are lacking, and no specific method was therefore recommended. However, the overview emphasises the need to develop strategies to work with structured methods in order to assess children’s mental health. It is obviously important to carefully consider the aforementioned criteria for screening methods when contemplating the use of the SDQ within routine CHS. However, one might also discuss if it is justifiable to choose not to introduce a method for identifying children with mental health problems even though observing the child during the visit and responding to spontaneously raised parental concerns (i.e. current practice) might not be sufficient.

According to Oberklaid (74), screening programmes to identify behavioural and developmental problems do not take into account the complexity and dynamic nature of child development. He argues that screening methods resulting in children being classified as having or not having a disorder are inappropriate when assessing children’s behaviour, which can change over time. Instead, Oberklaid emphasises the importance of following each child’s progress over time. He also adds that collaboration between professionals involved during the early years is key to detecting behavioural problems in children.

The distinction between surveillance and screening is probably crucial when deciding if introduction of SDQ within CHS is suitable. Although the SDQ can be defined as a screening instrument, it is not intended to be used at one isolated occasion within the Swedish CHS. The idea is to, annually, use the instrument to provide nurses with important information about the child, and hence, a basis for the nurse’s assessment. Using SDQ at 3, 4 and 5 years of age, as has been done in the Focus study, and emphasising that it is part of the nurses’ overall clinical assessment (even if specific cut-offs are implemented) can therefore strike a balance between the need for early identification of behavioural and emotional problems and allowing for the dynamics of child development over three years in a surveillance context.

Creating a structure for collaboration. To achieve an increased collaboration between the CHS and the preschool, a structure for the actual collaboration needs to be formed. Furthermore, successful collaboration will probably require that nurses and preschool teachers gain more knowledge about, and relate to, each other’s practice and views about children’s development. More knowledge amongst the nurses and preschool teachers about mental health problems in children (i.e. the topic they are to collaborate on) would probably also benefit the collaboration. Further, it is important to consider the parents
as key stakeholders in the collaboration. Their views about mental health problems and attitudes towards the information sharing procedure will influence the act of collaboration.

Creating a well-functioning structure for collaboration between the CHS and the preschool will take time and require resources. However, in a longer term perspective, it will hopefully improve conditions for the identification of mental health problems in children and pave the way for targeted interventions.

Facilitating continued use of the SDQ. Previous research as well as this thesis has demonstrated the importance of facilitation. The maintenance of the information sharing procedure using the SDQ will probably depend on the existence of continued facilitation in routine practice. Adequate facilitation will, in turn, benefit from a network wherein skilled facilitators can guide novice facilitators in the forthcoming (possibly further developed) process of information sharing. For example, there will be increased need of facilitation during a transitional period from using the SDQ as a discussion document to the use of scores to interpret the SDQ reports.

Is measuring children’s mental health using an instrument adequate? It is important to acknowledge that using an evidence-based instrument for assessing children’s mental health was assumed to have positive impact on the quality of the CHC-visits. However, regardless of how valid and reliable an instrument is, its use can be questioned. Relying too much on measurements might possibly reduce professionals’ use of their own judgment and clinical experience. Another argument for not measuring children’s mental health is the increased administrative work related to such procedure taking time from other activities at the CHC-visits and in preschool. Hence, using the SDQ in routine practice requires careful considerations beyond the actual instrument usability and its psychometric properties. There are many things that are challenging to measure, not least, mental health. However, the value of this kind of measurements comes with previous research showing that identifying, preventing and treating mental health problems may reduce negative consequences for the child.
Future research

This thesis gives rise to a number of suggestions for further research. Some thoughts concerning future studies are presented below.

The studies in this thesis have contributed with knowledge about the feasibility of information sharing using the SDQ within the routine CHS, and insights on its implementation in clinical practice. However, the effects of the information sharing procedure will have to be evaluated in future studies. Since mental health problems are not always detected by individuals in the child’s environment, the introduction of a structured method for routine assessment of children’s mental health is likely to increase the number of children referred to specialists. One way to examine the effect of the intervention could, therefore, be to compare referral rates for children before and after the introduction of the information sharing procedure. One could also compare the referral rates among children participating in the information sharing procedure with children not participating. Furthermore, if the effect of the intervention is to be evaluated through referral rates, it might be valuable to study the adequacy of the referrals, for example, by reviewing outcomes in children’s medical records (i.e. diagnoses, prescriptions and further evaluations).

Healthcare resources are limited. Providing policymakers who are contemplating introduction of a mental health screening programme within child healthcare with information about the resource use and costs related to the information sharing procedure, and its implementation, is therefore important. Hence, further research is needed to gain knowledge about the aforementioned factors.

Research is also required to follow-up on parents and preschool teachers’ perceptions of the SDQ procedure. Several years have passed since the interviews reported on in the first study of this thesis were conducted. New interviews may result in an awareness of any possible changes in their views. Given that the SDQ procedure is no longer conducted as part of a study, the conditions have changed. For example, parents do not have to complete other forms (i.e. participation requires less time), and they are no longer asked to consent to research. Hence, if a new interview study were to be conducted, results may be different than the results from the interviews conducted in 2014. Further-
more, as no parents who were against the SDQ procedure have been inter-
viewed yet, it would be of great value if this group of parents could be re-
cruited for future interviews. An important purpose of new interviews with
parents would be to gain knowledge about the reasons behind parents’ deci-
sion to abstain from participation.

It is important to know if and how nurses continue to deliver the intervention
after the implementation efforts delivered during the Children and Parents in
Focus study were concluded. It is difficult to know what is actually happening
in the CHC-nurse’s consultation room and interviews may not provide a com-
plete picture of how the nurse works with the parent and teacher SDQ reports.
One possible way to investigate this is to observe them during actual visits.
How do the nurses talk about the SDQ with the parents and with the child?
How do they inform parents about the preschool assessment? How do they
handle parents’ reactions to diverging reports?

Results from the studies in this thesis indicate that some parents might have
decided to abstain from participation in the Children and Parents in Focus
study, and hence, the SDQ procedure because it required good language skills
and a lot of time (due to the number of items included in the study forms).
Hence, it would be interesting to follow up on participation rates by comparing
the proportion of enrolled children participating in the current routine SDQ
procedure, wherein parents are asked to answer fewer items and is less time-
consuming, with the population coverage during the end of the Children and
Parents in Focus study.

In order to create conditions for increased collaboration between the CHS and
the preschool, research is required to better understand nurses and preschool
teachers’ knowledge about mental health problems in children. Their
knowledge about each other’s profession and specifically their views about
child development is also needed to further increase collaboration. Where are
the knowledge gaps and what education or information should be provided to
the nurses and preschool teachers, respectively?

To gain more insight into the effects of information sharing using the SDQ, as
delivered within the Children and Parents in Focus trial, further research is
required. A suggestion could be to compare nurses’ ability to identify children
with mental health problems using the information sharing procedure, with
nurses assessing children according to current practice. In order to verify the
nurses’ assessments, one could compare them with a formal diagnostic assess-
ment. Since there are municipalities in Sweden that have not yet implemented
the SDQ, a comparison, such as above, could be made between a municipality
not using the SDQ procedure with a municipality that has introduced the SDQ
procedure, given that the two municipalities are comparable in population size and other characteristics.

The fourth study in this thesis describes how a mental health screening instrument can be facilitated into practice in a real-world child healthcare setting. However, given that the study used a non-experimental approach, the effects of the facilitation strategies delivered within the Children and Parents in Focus trial could not be determined. Given the importance of facilitation for implementation of new methods, focusing on obtaining data in relation to the facilitation’s effect would be of essence.
Sammanfattning (Summary in Swedish)

Barnhälsovården i Sverige når i stort sett alla 0–5 åringar (1) och har bland annat som uppdrag att upptäcka psykisk ohälsa hos barn och erbjuda insatser (3). Trots det saknar barnhälsovården evidensbaserade metoder för att identifiera psykisk ohälsa.

Mer än 90% av alla 3–5-åringar går i förskola (4), vilken i Sverige är känd för att vara av god kvalité (66) och ha välutbildad personal. Förskolan besitter mycket av den information som behövs för att kunna göra en heltäckande bedömning av barnet på barnavårdscentralen (BVC). Idag saknas dock kanaler för informationsöverföring mellan verksamheterna. Det innebär att förskolepersonalens viktiga kunskaper om barnen inte systematiskt tas tillvara inom barnhälsovården.


Föräldrar och förskollärare skattade barnets psykiska hälsa med hjälp av ”Strengths and Difficulties Questionnaire” (SDQ) (92) som är validerat i Sverige (129) men inte använts på liknande sätt. SDQ består av 25 frågor som mäter eventuella problem hos barnet med känslor, koncentration, beteende och sociala relationer. Avslutningsvis finns en fråga om bedömaren sammanfattar att barnet har problem eller svårigheter med något eller flera av områdena.

Det övergripande syftet med avhandlingen var att utvärdera införandet av ovanstående informationsöverföring mellan föräldrar, förskola och BVC. Syftet var också att utvärdera de strategier som användes för att stödja implemen-
teringen av den nya proceduren med SDQ, samt att ta fram normer och undersöka samstämmigheten mellan olika bedömares skattningar i den svenska barnhälsovårdskontext där SDQ införts.


föräldrars skattningar var däremot god, vilket inte ger stöd för att båda föräldrar behöver fylla i varsitt SDQ inför barnets BVC-besök. Studiens resultat kan bland annat användas för att utarbeta riktlinjer för hur sjuksköterskan ska hantera situationer där föräldrars och lärares bedömningar av barnet skiljer sig åt.


**Studie 4.** Trots att psykisk ohälsa är vanligt förekommande bland barn och ungdomar, och ett antal bedömningsinstrument för identifiering av psykisk ohälsa finns tillgängliga, är kunskapen om hur dessa kan implementeras i praktiken begränsad. Avhandlingens fjärde delarbete syftade därför till att beskriva och utvärdera implementeringsstödet som användes vid införandet av den nya informationsöverföringen med SDQ. Moores (36) modell för processutvärdering användes för att guida struktureringen av kvantitativa och kvalitativa data. Resultaten visade att sjuksköterskorna tyckte att informationsöverföringen med SDQ var värdefull och att de strategier som använts för att stödja införandet av informationsöverföringen var viktiga för deras motivation att arbeta med SDQ enkäterna. Men resultaten visade också att även om sjuksköterskorna levererade interventionen så som det var tänkt förblev svarsfrekvensen lägre än förväntat under hela studietiden. Sammantaget tyder resultaten på att det är möjligt att implementera proceduren för informationsöverföring med SDQ, men att eventuell fortsatt användning kommer att kräva fortlöpande faciliteringsinsatser.
Betydelse För att barnhälsovården ska få bättre möjligheter att identifiera barn som visar tecken på psykisk ohälsa, behövs ett utökat samarbete med förskolan. Att förskolepersonal skattar barns utveckling och beteende med hjälp av strukturerade formulär som föräldrar sedan diskuterar med BVC-sjuksköterskan utgör en möjlighet att främja samverkan mellan förskolan och hälso- och sjukvården. Förhoppningen är att alla primärvårdens BVC-sjuksköterskor så småningom kommer att kunna ta del av förskolepersonalens bedömning av barnet och addera denna information till föräldrarnas och deras egen bedömning. Då kan sjuksköterskan på ett mer fullständigt sätt bedöma barnets psykiska hälsa och vid behov initiera insatser i god tid.
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Frågor om ditt 3-åriga barn och dig som förälder

Endast svaren om barnet används av BVC under ert besök. Personalen får då bättre information om ditt barn.

Med ditt godkännande används svaren också till forskning vid Uppsala universitet, för att öka kunskapen om barns och föräldrars hälsa.

• Fyll i enkäten.
• Kryssa i om du samtycker till att svaren används till forskning.
• Ta med den ifyllda enkäten till BVC.

☐ Ja, jag samtycker till att delta eller vill fortsätta delta i studien.


Underskrift ___________________________ Datum ___________ - ___________ - ___________
Namnförtydligande
☐ Mamma
☐ Pappa
☐ Annat ___________________________
Adress ________________________________________________
Postnummer ___________ ___________ Ort ___________________________

Barnets namn ________________________________________________
Barnets personnummer ___________ - ___________
Namn på barnets förskola/familjedaghem
☐ Har ingen barnomsorg

______________________________________________
Barnet hade samma förskola förra året
☐ Ja
☐ Nej, förskolans namn: ________________________________________________

Namn på barnets barnavårdscentral ________________________________________________
Frågor om ditt barn inför BVC-besöket


Hur bedömer du ditt barns allmänna hälsotillstånd?
☐ Mycket bra  ☐ Bra  ☐ Någorlunda  ☐ Dåligt  ☐ Mycket dåligt

Har barnet någon funktionsnedsättning eller långvarig sjukdom?
☐ Nej  ☐ Ja. I så fall vad?

Har ni sökt läkare för barnet vid andra tillfällen än vid de ordinarie BVC-besöken under de senaste 12 månaderna?
☐ Nej  ☐ Ja. Om ja, antal gånger

För vad sökte ni läkare? Markera ett eller flera alternativ.
☐ För infektionssjukdomar, t.ex. öroninflammation, hög feber, diarré.
☐ För olycksfall/skador.
☐ Annan orsak. Vad?

Har barnet någon funktionsnedsättning eller långvarig sjukdom?
☐ Nej  ☐ Ja. I så fall vad?

Har barnet varit inlagt på sjukhus under de senaste 12 månaderna?
☐ Nej  ☐ Ja. Ange orsak, Antal dagar

Har läkare konstaterat att barnet har någon av följande sjukdomar?
Besvara för varje sjukdom.
☐ Astma
☐ Allergisnuva
☐ Allergiska ögonbesvär
☐ Allergi mot pollen, pälsdjur, kvalster
☐ Glutenintolerans
☐ Laktosintolerans
☐ Födoämnmesallergi eller överkänslighet

Kan ditt barn med lite stöd återberätta något du har läst för henne/honom eller något hon/han själv varit med om?
☐ Ja  ☐ Nej

Börjar ditt barn kunna fylla i rim i kända ramsor?
☐ Ja  ☐ Nej

<table>
<thead>
<tr>
<th>Ditt barn:</th>
<th>Stämmer inte</th>
<th>Stämmer delvis</th>
<th>Stämmer helt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deltar aktivt i låtsaslekar (spade blir flygplan, saftkalas osv.).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kan hålla sig till ämnet i ett kortare samtal.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Har svårt för ändrade rutiner.</td>
<td>☐</td>
<td>☐</td>
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</table>
Var vänlig kryssa för det alternativ (Stämmer inte, Stämmer delvis eller Stämmer helt) som du tycker passar bäst. Det är värdefullt om du besvarar alla frågor, även om du inte är helt säker eller tycker att frågan verkar konstig. Frågorna gäller barnets beteende de senaste 6 månaderna. OBS, svara på frågorna själv inte tillsammans med barnets andra förälder. 

Sätt kryss så här ☒ Svar läsas maskinellt.

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<td>Fullföljer uppgifter, bra koncentrationsförmåga</td>
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<td></td>
</tr>
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Sammantaget, tycker du att ditt barn har svårigheter på ett eller flera av följande områden: med känslor, koncentration, beteende eller med att komma överens och umgås med andra människor?

Nej □ Ja, små svåigheter □ Ja, klara svårigheter □ Ja, allvarliga svårigheter □
Om du svarade "Ja" på föregående fråga, var vänlig besvara de följande fyra frågorna:

1) Hur länge har svårigheterna funnits?
   - Mindre än 1 månad
   - 1-5 månader
   - 6-12 månader
   - Mer än 1 år

2) Oroas eller lider ditt barn av sina svårigheter?
   - Inte alls
   - Bara lite
   - Ganska mycket
   - Väldigt mycket

3) Stör svårigheterna barnets vardagsliv på något av följande områden?

<table>
<thead>
<tr>
<th>Inte alls</th>
<th>Bara lite</th>
<th>Ganska mycket</th>
<th>Väldigt mycket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemma/i familjen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med kamrater</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I inläramningssituationer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vid fritidsaktiviteter</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) Blir svårigheterna en belastning för dig eller för familjen som helhet?
   - Inte alls
   - Bara lite
   - Ganska mycket
   - Väldigt mycket

<table>
<thead>
<tr>
<th>Har barnet haft någon typ av kontinuerlig hjälp/stöd i förskolan under det senaste året? (Flera kryss möjliga)</th>
<th>Antal timmar per vecka</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Specialpedagog</td>
<td></td>
</tr>
<tr>
<td>☐ Kurator</td>
<td></td>
</tr>
<tr>
<td>☐ Psykolog</td>
<td></td>
</tr>
<tr>
<td>☐ Assistent</td>
<td></td>
</tr>
<tr>
<td>☐ Sjukgymnast</td>
<td></td>
</tr>
<tr>
<td>☐ Annat, nämligen: ______________________________</td>
<td></td>
</tr>
<tr>
<td>☐ Nej, ingen hjälp/stöd</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har barnet haft någon typ av kontinuerlig hjälp/stöd i hemmet eller utanför förskolan under det senaste året? (Flera kryss möjliga)</th>
<th>Antal timmar per år</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Logoped/talpedagog</td>
<td></td>
</tr>
<tr>
<td>☐ Kurator</td>
<td></td>
</tr>
<tr>
<td>☐ Sjukgymnast</td>
<td></td>
</tr>
<tr>
<td>☐ Psykolog</td>
<td></td>
</tr>
<tr>
<td>☐ Socialsekreterare</td>
<td></td>
</tr>
<tr>
<td>☐ Kontaktperson</td>
<td></td>
</tr>
<tr>
<td>☐ Annat, nämligen: ________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>☐ Nej, ingen hjälp/stöd</td>
<td>-</td>
</tr>
</tbody>
</table>

Barnets kön  ☐ Pojke  ☐ Flicka
Vad är du till detta barn? ☐ Mamma  ☐ Pappa  ☐ Annat: ____________________________
Frågor om förälder

Frågorna nedan handlar om dig som förälder. De används endast för forskning och BVC-sjuksköterskan tittar inte på dem.

Sätt kryss så här ☒. Svaren läses maskinellt.

<table>
<thead>
<tr>
<th>Ditt välbefinnande</th>
<th>Har du de senaste veckorna kunnat koncentrera dig på allt du gjort?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hur bedömer du ditt allmänna hälsotillstånd?</td>
<td>Bättre än vanligt</td>
</tr>
<tr>
<td>□ Mycket bra</td>
<td>□ Som vanligt</td>
</tr>
<tr>
<td>□ Bra</td>
<td>□ Sämre än vanligt</td>
</tr>
<tr>
<td>□ Någorlunda</td>
<td>□ Mycket sämre än vanligt</td>
</tr>
<tr>
<td>□ Dåligt</td>
<td></td>
</tr>
<tr>
<td>□ Mycket dåligt</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du under de senaste veckorna känt att du kunnat uppskatta det du gjort om dagarna?</th>
<th>Har du under de senaste veckorna haft svårt att sova på grund av oro?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Inte alls</td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td>□ Inte mer än vanligt</td>
</tr>
<tr>
<td>□ Mindre än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Mycket mindre än vanligt</td>
<td>□ Mycket mer än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du under de senaste veckorna kunnat ta itu med dina problem?</th>
<th>Upplever du att du gjort nytta de senaste veckorna?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bättre än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td>□ Som vanligt</td>
</tr>
<tr>
<td>□ Sämre än vanligt</td>
<td>□ Mindre än vanligt</td>
</tr>
<tr>
<td>□ Mycket sämre än vanligt</td>
<td>□ Mycket mindre än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du de senaste veckorna känt dig olycklig och nedstämd?</th>
<th>Har du de senaste veckorna kunnat fatta beslut i olika frågor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Inte alls</td>
<td>□ Bättre än vanligt</td>
</tr>
<tr>
<td>□ Inte mer än vanligt</td>
<td>□ Som vanligt</td>
</tr>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Sämre än vanligt</td>
</tr>
<tr>
<td>□ Mycket mer än vanligt</td>
<td>□ Mycket sämre än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du de senaste veckorna förlorat tron på dig själv?</th>
<th>Har du under de senaste veckorna känt dig spänd?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Inte alls</td>
<td>□ Inte alls</td>
</tr>
<tr>
<td>□ Inte mer än vanligt</td>
<td>□ Inte mer än vanligt</td>
</tr>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Mycket mer än vanligt</td>
<td>□ Mycket mer än vanligt</td>
</tr>
<tr>
<td>Fråga</td>
<td>Alternativ</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Har du tyckt att du varit värdelös de senaste veckorna?</td>
<td>Inte alls, Inte mer än vanligt, Mer än vanligt, Mycket mer än vanligt</td>
</tr>
<tr>
<td>Har du under de senaste veckorna känt att du inte orkat med dina egna problem?</td>
<td>Inte alls, Inte mer än vanligt, Mer än vanligt, Mycket mer än vanligt</td>
</tr>
<tr>
<td>Har du på det hela taget känt dig någorlunda lycklig de senaste veckorna?</td>
<td>Mer än vanligt, Som vanligt, Mindre än vanligt, Mycket mindre än vanligt</td>
</tr>
<tr>
<td>Har du och din partner gått i familjerådgivning eller parterapi under de senaste 6 månaderna?</td>
<td>Ja, uppskatta hur många gånger: Nej, Jag har ingen partner</td>
</tr>
<tr>
<td>Har du fått dvd-filmen &quot;Hitta språket&quot; på BVC?</td>
<td>Nej, Ja</td>
</tr>
<tr>
<td>Har du sett dvd-filmen &quot;Hitta språket&quot;?</td>
<td>Nej, Ja, på BVC, Ja, på Öppna förskolan, Ja, hemma</td>
</tr>
<tr>
<td>Om du sett filmen, har du provat något i dvd-filmen med ditt barn?</td>
<td>Nej, Ja</td>
</tr>
<tr>
<td>Ditt föräldraskap</td>
<td></td>
</tr>
<tr>
<td>I vilken utsträckning tycker du att du räcker till för att:</td>
<td>Mycket lite, Måttligt, Väldigt mycket</td>
</tr>
<tr>
<td>Tala med barnet om det som barnet visar intresse för</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Hjälpa barnet att uppmärksamma det som finns och händer omkring er</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Beskriva det som ni upplever tillsammans</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Förklara för barnet vad ni upplever tillsammans</td>
<td>☐ ☐ ☐</td>
</tr>
</tbody>
</table>

Hur många gånger i veckan brukar du eller någon annan i familjen läsa eller titta i en bok tillsammans med ditt barn?

- 1-2 gånger
- 3-5 gånger
- 6-9 gånger
- 10 gånger eller fler
- Aldrig

Bakgrundsinformation

Ditt födelseår: 

Är du född i Sverige?
- Ja
- Nej, i 

Hur länge har du bott i Sverige? 

Ditt civilstånd:
- Ensamstående
- Sambo
- Gift
- Särbo
- Annat:

Barnet bor:
- Med båda föräldrarna
- Växelvis hos föräldrarna, ungefär lika mycket hos båda
- Växelvis hos föräldrarna, mest hos mig
- Växelvis hos föräldrarna, mest hos den andra föräldern
- Enbart med mig
- Enbart med den andra föräldern
- Annat:

Hur många barn har du? 

När är det/de födda? 

När troligt är det att ni fortfarande bor i Uppsala län nästa år?

Din sysselsättning (flera kryss möjliga):
- Anställd
- Egen företagare
- Hemarbetar
- Föräldraledig
- Studerande
- Arbetslös/arbetssökande
- Sjukskriven
- Annat:

Din högsta avslutade utbildning:
- Ej avslutad grundskola
- Grundskola
- Gymnasium/yrkesskola
- Högskola/universitet (mindre än 3 år)
- Högskola/universitet (3 år eller mer)

När följande saker händer eller måste göras, hur ofta är det du som gör dem?

- Tar barnet till vårdcentralen, BVC eller annan vårdinrättning
- Går upp med barnet då han/hon vaknar på natten
- Hjälper barnet med bad/härvtätt
- Stannar hemma och tar hand om barnet då han/hon är sjuk
- Ordnar med papper till kommunen, förskolan, Försäkringskassan eller liknande

Frågor om ditt 3-åriga barn och dig som förälder

Dina svar ingår i en stor studie om barns och föräldrars hälsa. Svaren blir bara lästa av forskarna på Uppsala universitet.

• Fyll i enkäten.
• Kryssa i om du samtycker till att svaren används till forskning.
• Ta med den ifyllda enkäten till BVC.
Vill du delta i studien?


☐ Ja, jag samtycker till att delta eller vill fortsätta delta i studien.

Skriv tydligt med bläckpenna. Texten läses maskinellt. Sätt kryss så här ✗:

Underskrift ___________________________ Datum ____________ - ____________ - ____________

Namnförtydligande
☐ Mamma
☐ Pappa
☐ Annat ___________________________

Adress __________________________________________

Postnummer ________ ________ Ort _______________________

Barnets namn ____________________________

Barnets personnummer ____________ - ____________

Namn på barnets förskola/familjedaghem
☐ Har ingen barnomsorg

______________________________

Barnet hade samma förskola förra året
☐ Ja
☐ Nej, förskolans namn: ________________________________

Namn på barnets barnavårdscentral ________________________________
Frågor om ditt barn inför BVC-besöket

Var vänlig kryssa för det alternativ (Stämmer inte, Stämmer delvis eller Stämmer helt) som du tycker passar bäst. Det är värdefullt om du besvarar alla frågor, även om du inte är helt säker eller tycker att frågan verkar konstigt. Frågorna gäller barnets beteende de senaste 6 månaderna. OBS, svara på frågorna själv inte tillsammans med barnets andra förälder.

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<td>Ställer ofta upp och hjälper andra (föräldrar, lärare, andra barn)</td>
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<td></td>
</tr>
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<td>Kan stanna upp och tänka sig för innan han/hon gör olika saker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kan bete sig illa mot andra</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kommer bättre överens med vuxna än med andra barn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rädd för mycket, är lättskrämd</td>
<td></td>
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</tr>
<tr>
<td>Fullföljer uppgifter, bra koncentrationsförmåga</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sammantaget, tycker du att ditt barn har svårigheter på ett eller flera av följande områden: med känslor, koncentration, beteende eller med att komma överens och umgås med andra människor?

Nej □          Ja, små svårigheter □        Ja, klara svårigheter □    Ja, allvarliga svårigheter □
Om du svarade "Ja" på föregående fråga, var vänlig besvara de följande fyra frågorna:

1) Hur länge har svårigheterna funnits?
   - Mindre än 1 månad
   - 1-5 månader
   - 6-12 månader
   - Mer än 1 år

2) Oroas eller lider ditt barn av sina svårigheter?
   - Inte alls
   - Bara lite
   - Ganska mycket
   - Väldigt mycket

3) Stör svårigheterna barnets vardagsliv på något av följande områden?

<table>
<thead>
<tr>
<th></th>
<th>Inte alls</th>
<th>Bara lite</th>
<th>Ganska mycket</th>
<th>Väldigt mycket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemma/i familjen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med kamrater</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I inlärningssituationer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vid fritidsaktiviteter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) Blir svårigheterna en belastning för dig eller för familjen som helhet?
   - Inte alls
   - Bara lite
   - Ganska mycket
   - Väldigt mycket

Barnets kön
- Pojke
- Flicka

Vad är du till detta barn?
- Mamma
- Pappa
- Annat: ________________
Frågor om förälder

Frågorna nedan handlar om dig som förälder. De används endast för forskning och BVC-sjuksköterskan tittar inte på dem.

Sätt kryss så här ☒. Svaren läses maskinellt.

<table>
<thead>
<tr>
<th>Ditt välbefinnande</th>
<th>Har du de senaste veckorna kunnat koncentrera dig på allt du gjort?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hur bedömer du ditt allmänna hälsotillstånd?</td>
<td>□ Mycket bra</td>
</tr>
<tr>
<td></td>
<td>□ Bra</td>
</tr>
<tr>
<td></td>
<td>□ Någorlunda</td>
</tr>
<tr>
<td></td>
<td>□ Dåligt</td>
</tr>
<tr>
<td></td>
<td>□ Mycket dåligt</td>
</tr>
<tr>
<td>□ Bättre än vanligt</td>
<td></td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td></td>
</tr>
<tr>
<td>□ Sämre än vanligt</td>
<td></td>
</tr>
<tr>
<td>□ Mycket sämre än vanligt</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du under de senaste veckorna känt att du kunnat uppskatta det du gjort om dagarna?</th>
<th>Har du under de senaste veckorna haft svårt att sova på grund av oro?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Inte alls</td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td>□ Inte mer än vanligt</td>
</tr>
<tr>
<td>□ Mindre än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Mycket mindre än vanligt</td>
<td>□ Mycket mer än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du under de senaste veckorna kunnat ta itu med dina problem?</th>
<th>Upplever du att du gjort nytta de senaste veckorna?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bättre än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td>□ Som vanligt</td>
</tr>
<tr>
<td>□ Sämre än vanligt</td>
<td>□ Mindre än vanligt</td>
</tr>
<tr>
<td>□ Mycket sämre än vanligt</td>
<td>□ Mycket mindre än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du de senaste veckorna känt dig olycklig och nedstämd?</th>
<th>Har du de senaste veckorna kunnat fatta beslut i olika frågor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Inte alls</td>
<td>□ Bättre än vanligt</td>
</tr>
<tr>
<td>□ Inte mer än vanligt</td>
<td>□ Som vanligt</td>
</tr>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Sämre än vanligt</td>
</tr>
<tr>
<td>□ Mycket mer än vanligt</td>
<td>□ Mycket sämre än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du de senaste veckorna förlorat tron på dig själv?</th>
<th>Har du under de senaste veckorna känt dig spänd?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Inte alls</td>
<td>□ Inte alls</td>
</tr>
<tr>
<td>□ Inte mer än vanligt</td>
<td>□ Inte mer än vanligt</td>
</tr>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Mycket mer än vanligt</td>
<td>□ Mycket mer än vanligt</td>
</tr>
<tr>
<td>Har du tyckt att du varit värdelös de senaste veckorna?</td>
<td>Har du under de senaste veckorna känt att du inte orkat med dina egna problem?</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>□ Inte alls</td>
<td>□ Inte alls</td>
</tr>
<tr>
<td>□ Inte mer än vanligt</td>
<td>□ Inte mer än vanligt</td>
</tr>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Mer än vanligt</td>
</tr>
<tr>
<td>□ Mycket mer än vanligt</td>
<td>□ Mycket mer än vanligt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du på det hela taget känt dig någorlunda lycklig de senaste veckorna?</th>
<th>Har du för egen del fått någon behandling för psykologiska besvär under de senaste 6 månaderna?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Mer än vanligt</td>
<td>□ Ja, uppskatta hur många gånger:_________</td>
</tr>
<tr>
<td>□ Som vanligt</td>
<td>□ Nej</td>
</tr>
<tr>
<td>□ Mindre än vanligt</td>
<td></td>
</tr>
<tr>
<td>□ Mycket mindre än vanligt</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du och din partner gått i familjerådgivning eller parterapi under de senaste 6 månaderna?</th>
<th>Har du gått en föräldrakurs det senaste året?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ja, uppskatta hur många gånger:_________</td>
<td>□ Nej</td>
</tr>
<tr>
<td>□ Nej</td>
<td>□ Ja, COPE</td>
</tr>
<tr>
<td>□ Jag har ingen partner</td>
<td>□ Ja, Triple P</td>
</tr>
<tr>
<td></td>
<td>□ Ja, Marte Meo</td>
</tr>
<tr>
<td></td>
<td>□ Ja, annan:_______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Har du fått dvd-filmen &quot;Hitta språket&quot; på BVC?</th>
<th>Har du sett dvd-filmen &quot;Hitta språket&quot;?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Nej</td>
<td>□ Nej</td>
</tr>
<tr>
<td>□ Ja</td>
<td>□ Ja, på BVC</td>
</tr>
<tr>
<td></td>
<td>□ Ja, på Öppna förskolan</td>
</tr>
<tr>
<td></td>
<td>□ Ja, hemma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Om du sett filmen, har du provat något i dvd-filmen med ditt barn?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ja</td>
</tr>
<tr>
<td>□ Nej</td>
</tr>
</tbody>
</table>

**Ditt föräldraskap**

<table>
<thead>
<tr>
<th>I vilken utsträckning tycker du att du räcker till för att:</th>
<th>Mycket lite</th>
<th>Måttligt</th>
<th>Väldigt mycket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tala med barnet om det som barnet visar intresse för</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hjälpa barnet att uppmärksammar det som finns och händer omkring er</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beskriva det som ni upplever tillsammans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Förklara för barnet vad ni upplever tillsammans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>När följande saker händer eller måste göras, hur ofta är det du som gör dem?</td>
<td>Alltid</td>
<td>Ofta</td>
<td>Ibland</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>Tar barnet till vårdcentralen, BVC eller annan vårdinrättning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Går upp med barnet då han/hon vaknar på natten</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hjälper barnet med bad/hårtvätt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stannar hemma och tar hand om barnet då han/hon är sjuk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordnar med papper till kommunen, förskolan, Försäkringskassan eller liknande</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hur många gånger i veckan brukar du eller någon annan i familjen läsa eller titta i en bok tillsammans med ditt barn?

- [ ] 10 gånger eller fler
- [ ] 6-9 gånger
- [ ] 3-5 gånger
- [ ] 1-2 gånger
- [ ] Aldrig

**Bakgrundsinformation**

**Ditt födelseår:**

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

**Är du född i Sverige?**

- [ ] Ja
- [ ] Nej, i ___________________________

Hur länge har du bott i Sverige? [ ] år

**Ditt civilstånd:**

- [ ] Ensamstående
- [ ] Sambo
- [ ] Gift
- [ ] Särbo
- [ ] Annat: ___________________________

**Vad är du till detta barn?**

- [ ] Mamma
- [ ] Pappa
- [ ] Annat: ___________________________

**Barnet bor:**

- [ ] Med båda föräldrarna
- [ ] Växelvis hos föräldrarna, ungefär lika mycket hos båda
- [ ] Växelvis hos föräldrarna, mest hos mig
- [ ] Växelvis hos föräldrarna, mest hos den andra föräldern
- [ ] Enbart med mig
- [ ] Enbart med den andra föräldern
- [ ] Annat: ___________________________

**Din sysselsättning** (flera kryss möjliga):

- [ ] Anställd
- [ ] Egen företagare
- [ ] Hemarbetar
- [ ] Föräldraledig
- [ ] Studerande
- [ ] Arbetslös/arbetssökande
- [ ] Sjukskriven
- [ ] Annat: ___________________________

**Din högsta avslutade utbildning:**

- [ ] Ej avslutad grundskola
- [ ] Grundskola
- [ ] Gymnasium/yrkesskola
- [ ] Högskola/universitet (mindre än 3 år)
- [ ] Högskola/universitet (3 år eller mer)

**Hur många barn har du? ________****

När är det/de födda? ______________________

**Hur troligt är det att ni fortfarande bor i Uppsala län nästa år?**

- [ ] Mycket troligt
- [ ] Inte alls troligt

1 2 3 4 5 6 7

Frågor till förskolan

Detta barn deltar i Fokus barn och föräldrar – en studie om 3–5-åringar i Uppsala län.

Studien genomförs för att det saknas kunskap om små barns hälsa i Sverige.

För mer information om studien och förskolans medverkan läs på nästa sida.

Barnets BVC-besök är planerat till den:

---

Samtycket nedan fylls i av vårdnadshavare:

Jag/vi samtycker till att uppgifterna i enkäten lämnas vidare till BVC och till Uppsala universitet för att användas till forskning.

Datum:          Datum:

Vårdnadshavare 1          Vårdnadshavare 2

Vårdnadshavare har: ☐ Gemensam vårdnad
☐ Enskild vårdnad

Barnets namn:         Barnets personnummer:  

Förskolans namn:

---

Appendix I

Denna enkät och svarskuvert lämnas till förskolan
Information till barnets förskola/familjedaghem

Detta barn deltar i Fokus barn och föräldrar – en studie om 3–5-åringar i Uppsala län. Studien är ett samarbete mellan Uppsala kommun, Landstinget i Uppsala län och Uppsala universitet och genomförs för att det saknas kunskap om små barns hälsa i Sverige. Förskolans deltagande innebär att förskolans ledning har godkänt att förskolepersonal svarar på frågorna i enkäten och sänder den ifyllt till BVC.

Svaren kommer BVC-sjuksköterskan att gå igenom med föräldrarna. När barnets vårdnadshavare har godkänt att barnet deltar i studien ber vi dig att fylla i denna enkät om barnet och posta den till BVC. Enkäten ska inte sparas på förskolan. I studien kommer svaren att sammanställas så att ingen får reda på hur just du har svarat eller vilket barn det handlar om.

Till dig på förskolan som fyller i enkäten

- Du/ni som fyller i enkäten ska känna barnet väl.
- Frågorna gäller de senaste 6 månaderna.
- Tänk på barnets beteende snarare än personlighet/karakter.
- Efter att du har fyllt i enkäten skickar du den till BVC med bifogat kuvert.

Tack för din medverkan!

För mer information om studien se: www.kbh.uu.se/bvc-enkaterna

Hör gärna av dig om du har några frågor om studien eller enkäten.

Kontaktperson: Helena Fabian
leg. sjuksköterska, forskare. 018-611 59 63
helena.fabian@kbh.uu.se

Forskningsansvarig: Anna Sarkadi
leg. läkare, docent. 018-611 59 65
anna.sarkadi@kbh.uu.se
Fylls i av förskolan

Var vänlig kryssa för det alternativ (Stämmer inte, Stämmer delvis eller Stämmer helt) som du tycker passar bäst. Det är värdefullt om du besvarar alla frågor, även om du inte är helt säker eller tycker att frågan verkar konstig. Frågorna gäller barnets beteende de senaste 6 månaderna.

<table>
<thead>
<tr>
<th>Sätt kryss så här ☑</th>
<th>Svaren läses maskinellt.</th>
<th>Stämmer inte</th>
<th>Stämmer delvis</th>
<th>Stämmer helt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omtänksam, tar hänsyn till andra människors känslor</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rastlös, överaktiv, kan inte vara stilla länge</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Klager ofta över huvudvärk, ont i magen eller illamående</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delar gärna med sig till andra barn (t ex godis, leksaker, pennor)</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har ofta raseriutbrott eller häftigt humör</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ganska ensam, leker eller håller sig ofta för sig själv</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Följer vanligtvis vuxnas uppmaningar</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oroar sig över mycket, verkar ofta bekymrad</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hjälpsam om någon är ledsen, upprörd eller känner sig dålig</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Svårt att sitta stilla, rör och vrider jämt på sig</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Har minst en god vän (kamrat)</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Släss/bräkar ofta med andra barn eller mobbar dem</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ofta ledsen, nedstämd eller tårögd</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vanligtvis omytckt av andra barn</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lättstörd, tappa lätt koncentrationen</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervös eller klängig i nya situationer, blir lätt otrygg</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Omtänksam mot yngre barn</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Säger ofta emot vuxna</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blir retad eller mobbad av andra barn</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ställer ofta upp och hjälper andra (föräldrar, lärare, andra barn)</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kan stanna upp och tänka sig för innan han/hon gör olika saker</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kan bete sig illa mot andra</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kommer bättre överens med vuxna än med andra barn</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rädd för mycket, är lättkrämd</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fullföljer uppgifter, bra koncentrationsförmåga</td>
<td>☐ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sammantaget, tycker du att detta barn har svårigheter på ett eller flera av följande områden: med känslor, koncentration, beteende eller med att komma överens och umgås med andra människor?

Nej ☐  Ja, små svårigheter ☐  Ja, klara svårigheter ☐  Ja, allvarliga svårigheter ☐

Fler frågor finns på nästa sida
Sätt kryss så här ☒. Svaren läses maskinellt.

<table>
<thead>
<tr>
<th>Barnet:</th>
<th>Stämmer inte</th>
<th>Stämmer delvis</th>
<th>Stämmer helt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tycker om att titta i en bok tillsammans med en vuxen.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Förstår en uppmaning utan att du samtidigt visar, t.ex. &quot;Hämta skeden på bänken i köket&quot;!</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kan hålla sig till ämnet i ett kortare samtal.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Deltar aktivt i låtsaslekar (spade blir flygplan, saftkalas osv.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Har svårt för ändrade rutiner.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Ifyllt av:  
☐ Förskollärare  
☐ Barnskötare  
☐ Annan (var vänlig precisera): ________________________________

Förskolans namn: ________________________________

Övriga kommentarer:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Tack så mycket för hjälp!

- Kontrollera att båda vårdnadshavarna gett samtycke till att svaren kan användas för studien (första sidan).

- Skicka svaren till BVC i bifogat kuvert så snart som möjligt.
**Ditt föräldraskap**

Till och från uppför sig alla barn illa eller gör saker som skulle kunna vara skadliga, som är "fel" eller som föräldrar inte tycker om. Några exempel är att slå någon, att gnälla, att kasta mat, att få ett utbrott eller att vägra gå och lägga sig. Föräldrar har många olika sätt eller stilar för att hantera dessa typer av problem.

Nedan presenteras några exempel på olika föräldraskapsstilar. Kryssa för varje exempel i det nummer som bäst beskriver din föräldraskapsstil under de senaste två månaderna med ditt barn.

<table>
<thead>
<tr>
<th>Så här är du ofta:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>inte mer än vanligt</th>
</tr>
</thead>
<tbody>
<tr>
<td>När jag är upprörd eller stressad är jag petig och tjatar på mitt barn...</td>
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<tr>
<td>När mitt barn uppför sig illa brukar jag...</td>
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<tr>
<td>Jag hotar att göra saker som jag vet att jag...</td>
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<tr>
<td>Jag är den typen av förälder som, när det gäller vad mitt barn får göra...</td>
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<tr>
<td>När mitt barn uppför sig illa är mina utläggningar...</td>
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<tr>
<td>När jag vill att mitt barn ska sluta göra något brukar jag...</td>
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<tr>
<td>Efter att det har uppstått ett problem med mitt barn brukar...</td>
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<tr>
<td>När vi inte är hemma behandlar jag mitt barn...</td>
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</tbody>
</table>

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**The parenting scale**

(*Arnold et al. 1993, **Salari et al. 2012*)

<table>
<thead>
<tr>
<th>Så här är du ofta:</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>inte mer än vanligt</th>
</tr>
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<tr>
<td>Efter att det har uppstått ett problem med mitt barn brukar...</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>När vi inte är hemma behandlar jag mitt barn...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
När mitt barn gör något som jag inte tycker om brukar jag...  
gör något åt det  1  2  3  4  5  6  7  ofta låta det passera  
varje gång  □  □  □  □  □  □  □  

När det uppstår ett problem med mitt barn...  
gör jag saker  1  2  3  4  5  6  7  spårar situationen  
som jag inte  □  □  □  □  □  □  □  
mener  □  □  □  □  □  □  □  

När mitt barn uppför sig illa händer det att jag grabbar tag i barnet eller ruskar om det...  
aldrig  1  2  3  4  5  6  7  för det mesta  
□  □  □  □  □  □  □  

När mitt barn uppför sig illa händer det att jag slår till barnet eller ger det smisk...  
aldrig  1  2  3  4  5  6  7  oftast  
□  □  □  □  □  □  □  

När mitt barn inte gör det jag ber om...  
lätter jag det ofta  1  2  3  4  5  6  7  vidtar jag någon  
vara eller gör det  □  □  □  □  □  □  □  
själv  □  □  □  □  □  □  □  

När jag ger ett rättvist hot eller varning brukar jag...  
ofta inte  1  2  3  4  5  6  7  alltid göra som jag  
genomföra det  □  □  □  □  □  □  □  
sagt  □  □  □  □  □  □  □  

Om det inte fungerar att säga "nej" brukar jag...  
vidta en annan  1  2  3  4  5  6  7  erbjuda barnet något  
åtgärd  □  □  □  □  □  □  □  
trevligt för att  □  □  □  □  □  □  □  
uppföra sig  □  □  □  □  □  □  □  

När mitt barn uppför sig illa blir jag själv...  
inte upprörd  1  2  3  4  5  6  7  så upprörd att  
□  □  □  □  □  □  □  
barnet kan se det  □  □  □  □  □  □  □  

Om mitt barn uppför sig illa och sedan uppträder ångerfyllt hanterar jag situationen...  
som jag brukar  1  2  3  4  5  6  7  låter problemet  
□  □  □  □  □  □  □  
passera  □  □  □  □  □  □  □  

När mitt barn uppför sig illa använder jag...  
sällan skällsord  1  2  3  4  5  6  7  nästan alltid  
□  □  □  □  □  □  □  
skällsord  □  □  □  □  □  □  □  

När jag säger att mitt barn inte får göra något...  
lätter jag ofta  1  2  3  4  5  6  7  håller jag fast vid  
barnet göra det  □  □  □  □  □  □  □  
ändå  □  □  □  □  □  □  □  

När mitt barn gör något jag inte tycker om förolämpar jag mitt barn, säger elaka saker eller är oförskämd mot barnet...

aldrig □ □ □ □ □ □ □ för det mesta

Om mitt barn blir upprört när jag säger "nej" brukar jag...

backa och ge med mig □ □ □ □ □ □ □ hålla fast vid det jag sagt


To legal guardian 1:
Before your 3-year-old’s visit
to the Child Health Centre

Here is a form containing questions about your child that you should fill out before your child’s visit to the Child Health Centre. The nurse will go through the answers with you during your visit.

You are also invited to participate in a survey about child and parental health. If you choose to participate in the survey, please hand in the form with questions about your child to the child’s preschool/home day care centre and also answer the questions about your own health and parenting. The questions concerning you personally will only be used for research purposes and will not be discussed at the Child Health Centre. You will find more information about the survey on the following page.

Instructions:

- Fill out the form Questions about your child in preparation for your visit to the Child Health Centre (p. 4-6).
- Fill out the form Invitation to participate in the survey (p. 3).
- Bring the completed forms with you to the Child Health Centre. The nurse will go through your answers about the child.

If you wish to take part in the survey:

- Hand the form Frågor till förskolan (Question for the preschool) along with the prepaid envelope to the child’s preschool. Register your approval on the last page. The preschool will post the answers to the Child Health Centre directly and then you will go through them together with the nurse.
- Fill out the form Questions about parent (p. 8-12). Bring the form with you to the Child Health Centre. The questions about you will only be collected for research purposes.

Continue on the next page!
Invitation to participate in Children and Parents in Focus – a study on children aged 3 to 5 in Uppsala County

Would you like to participate in a survey about children and parents in Uppsala county? It is a collaborative project between Uppsala University, Child Health Care Services and Uppsala Municipality and is intended to redress the lack of knowledge about the health of small children in Sweden.

Information about the survey

About the survey
The health of preschool children is a priority field of research in Sweden. Uppsala University has therefore launched a survey to investigate the health and well-being of children and parents, and whether their health can be improved with different forms of municipal parental support and child health care services. The survey is scheduled to continue until 2017.

Participation
Participation in the survey entails that the form you fill out before your child’s visit to the Child Health Centre (for children aged 3, 4 or 5) will be used in the research. You will also need to hand in a form to the preschool/home day care centre for them to fill out about your child. This form will also be reviewed jointly with you at the health centre before being collected for the research.

To follow the progress of the children throughout the survey we will monitor them during school time. Using the child’s national registration number, we can do so through the registers of national school tests (grades 3, 6 and 9), health care diagnoses, health and medical care treatments and other public services. The information that we, the researchers, extract from the register is a coded list with the national registration numbers removed.

You will also answer some questions about your own health and parenting as well as your participation in parenting courses (if any). The questions about you are only compiled by the Child Health Centre, and will not be viewed or discussed when you visit the health centre.

Confidentiality and your rights
Uppsala University is the accountable authority and data controller for the survey. According to the Swedish Personal Data Act you once a year, free of charge, have the right to access all the information about you that is being processed, and, if necessary, make corrections.

All details are handled in a manner that prevents unauthorised parties gaining access to them. The information is condensed so that no individuals can be identified in any of the reports.

Your participation is entirely voluntary and you can stop participating at any time. The service you receive from the Child Health Centre will not be affected should you decide not to participate in the survey.

When the survey is completed, you will be given the possibility of reading the reports and results prepared by Uppsala University.

Accept or decline participation in the survey on the next page
Every single answer is equally important and we hope you do participate!

Contact person: Helena Fabian
Registered nurse, researcher, 018-611 59 63, helena.fabian@kbh.uu.se

Senior researcher: Anna Sarkadi
MD, associate professor, 018-611 59 65, anna.sarkadi@kbh.uu.se
**Invitation to participate in the survey**

Would you like to participate in the Children and Parents in Focus survey?
Say YES or NO below

- **Yes**, I have read the information about the survey and accept the conditions of participation.
- **No**, I do not wish to participate in the survey.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name in block capitals</td>
<td>☐ Mother ☐ Father ☐ Other:</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Postal code</td>
<td>City</td>
</tr>
<tr>
<td>Telephone number</td>
<td>E-mail</td>
</tr>
<tr>
<td>Child’s name</td>
<td></td>
</tr>
<tr>
<td>Child’s national registration number</td>
<td>-</td>
</tr>
<tr>
<td>Name of child’s preschool/family day care centre</td>
<td>☐ Receives no child care</td>
</tr>
<tr>
<td>Name of child’s Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

Fill out the form and hand it to the nurse at the Child Health Centre.

**Contact person:** Helena Fabian  
Registered nurse, researcher, 018-611 59 63, helena.fabian@kbh.uu.se  

**Senior researcher:** Anna Sarkadi  
MD, associate professor, 018-611 59 65, anna.sarkadi@kbh.uu.se
Questions about your child in preparation for your visit to the Child Health Centre

How would you describe your child’s health in general?
☐ Excellent  ☐ Good  ☐ OK  ☐ Poor  ☐ Very poor

Does the child have any disabilities or long-term illnesses?
☐ No  ☐ Yes. If so, please specify______________________________

Have you seen a doctor for the child on occasions other than regular visits to the Child Health Centre in the last 12 months?
☐ No  ☐ Yes  If Yes, number of times_____________

What was your reason for seeing the doctor? You can choose more than one alternative.
☐ For infectious disease, e.g. ear infection, a temperature, diarrhoea
☐ For accidents/injuries
☐ Other reason. Please specify_______________________________________

Has the child been admitted to hospital in the last 12 months?
☐ No  ☐ Yes

Has a doctor diagnosed the child as having any of the following illnesses? Mark all the alternatives that apply
☐ Asthma  ☐ Gluten intolerance  ☐ Lactose intolerance
☐ Hay fever  ☐ Allergy to pollen, animals, dust mites
☐ Allergic eye complaint  ☐ Food allergy or oversensitivity

Can your child with some assistance repeat something that you have read to him/her or something he/she has experienced?
☐ Yes  ☐ No

Can your child complete common nursery rhymes when you read them?
☐ Yes  ☐ No

Your child:

<table>
<thead>
<tr>
<th></th>
<th>Not true</th>
<th>Partly true</th>
<th>Very true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes active part in pretend games, e.g. ‘shovel becomes airplane’, ‘tea party’.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Keeps to the subject in a short conversation.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has problems adjusting to new routines.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months. Answer the questions yourself, not together with the child’s other parent.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not true</th>
<th>Somewhat true</th>
<th>Certainly true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerate of other people's feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often complains of headaches, stomach-aches or sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares readily with other children (treats, toys, pencils etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often has temper tantrums or hot tempers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rather solitary, tends to play alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally obedient, usually does what adults request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many worries, often seems worried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpful if someone is hurt, upset or feeling ill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constantly fidgeting or squirming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has at least one good friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often fights with other children or bullies them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often unhappy, down-hearted or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally liked by other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily distracted, concentration wanders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous or clingy in new situations, easily loses confidence</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kind to younger children</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Often argumentative with adults</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Picked on or bullied by other children</td>
<td></td>
<td></td>
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<tr>
<td>Often volunteers to help others (parents, teachers, other children)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Can stop and think things out before acting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can be spiteful to others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets on better with adults than with other children</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Many fears, easily scared</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sees tasks through to the end, good attention span</td>
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</tr>
</tbody>
</table>

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No ☐  Yes - minor difficulties ☐  Yes - definite difficulties ☐  Yes - severe difficulties ☐
If you have answered “Yes” to the previous question, please answer the following questions about these difficulties:

**How long have these difficulties been present?**

- □ Less than a month  □ 1-5 months  □ 6-12 months  □ Over a year

**Do the difficulties upset or distress your child?**

- □ Not at all  □ Only a little  □ Quite a lot  □ A great deal

**Do the difficulties interfere with your child’s everyday life in the following areas?**

<table>
<thead>
<tr>
<th>Area</th>
<th>Not at all</th>
<th>Only a little</th>
<th>Quite a lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure activities</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Do the difficulties put a burden on you or the family as a whole?**

- □ Not at all  □ Only a little  □ Quite a lot  □ A great deal

---

**Does the child receive any kind of continuous assistance/support in preschool?**

- □ No  
- □ Yes, since the child was _______ years old

**If Yes, what kind of support?**
(You can choose more than one alternative)

- □ Special needs teacher  □ Physiotherapist
- □ Counsellor  □ Other, specify: ________________
- □ Psychologist  □ Assistant

---

**Does the child receive any kind of continuous assistance/support at home or outside preschool?**

- □ No  
- □ Yes, since the child was ________ years old

**If Yes, what kind of support?**
(You can choose more than one alternative)

- □ Speech therapist  □ Child welfare officer
- □ Counsellor  □ Contact person
- □ Physiotherapist  □ Other, specify: ________________
- □ Psychologist  □ Other, specify: ________________

**What is your relationship to this child?**

- □ Mother  □ Father  □ Other: ________________
Questions about parent

The following questions concern you as the parent and are only collected by the Child Health Centre for research purposes.

You will not be asked about them when you visit the child health centre.

If you wish to discuss your parental situation at the Child Health Centre, that will be OK.

The questions begin on the next page
Questions about parent

<table>
<thead>
<tr>
<th>Your well-being</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you summarize your state of health at present?</td>
<td></td>
</tr>
<tr>
<td>very good</td>
<td>X</td>
</tr>
<tr>
<td>good</td>
<td></td>
</tr>
<tr>
<td>neither good nor bad</td>
<td></td>
</tr>
<tr>
<td>bad</td>
<td></td>
</tr>
<tr>
<td>very bad</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you recently:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>been able to concentrate on what you’re doing?</td>
<td>been able to face up to your problems?</td>
</tr>
<tr>
<td>better than usual</td>
<td>more so than usual</td>
</tr>
<tr>
<td>same as usual</td>
<td>same as usual</td>
</tr>
<tr>
<td>less than usual</td>
<td>less than usual</td>
</tr>
<tr>
<td>much less than usual</td>
<td>much less than usual</td>
</tr>
<tr>
<td>lost much sleep over worry?</td>
<td>felt constantly under strain?</td>
</tr>
<tr>
<td>not at all</td>
<td>not at all</td>
</tr>
<tr>
<td>no more than usual</td>
<td>no more than usual</td>
</tr>
<tr>
<td>rather more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>much more than usual</td>
<td>much more than usual</td>
</tr>
<tr>
<td>felt you couldn’t overcome your difficulties?</td>
<td>been feeling unhappy or depressed?</td>
</tr>
<tr>
<td>not at all</td>
<td>not at all</td>
</tr>
<tr>
<td>no more than usual</td>
<td>no more than usual</td>
</tr>
<tr>
<td>rather more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>much more than usual</td>
<td>much more than usual</td>
</tr>
<tr>
<td>been losing confidence in yourself?</td>
<td>been thinking of yourself as a worthless person?</td>
</tr>
<tr>
<td>not at all</td>
<td>not at all</td>
</tr>
<tr>
<td>no more than usual</td>
<td>no more than usual</td>
</tr>
<tr>
<td>rather more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>much more than usual</td>
<td>much more than usual</td>
</tr>
<tr>
<td>felt that you are playing a useful part in things?</td>
<td>been able to enjoy your normal day to day activities?</td>
</tr>
<tr>
<td>more so than usual</td>
<td>more so than usual</td>
</tr>
<tr>
<td>same as usual</td>
<td>same as usual</td>
</tr>
<tr>
<td>less so than usual</td>
<td>less so than usual</td>
</tr>
<tr>
<td>much less than usual</td>
<td>much less than usual</td>
</tr>
</tbody>
</table>
been feeling reasonably happy, all things considered?

- more so than usual
- same as usual
- less so than usual
- much less than usual

felt capable of making decisions about things?

- more so than usual
- same as usual
- less than usual
- much less than usual

Have you personally received treatment for any psychological problems in the last 6 months?

- Yes, roughly how many times: ______
- No

Have you and your partner attended family guidance or couples counselling in the last 6 months?

- Yes, roughly how many times: _____
- No
- I have no partner

Have you taken a parenting course in the past year?

- No
- Yes, COPE
- Yes, Triple P
- Yes, Marte Meo
- Yes, other: ______

Your parenting style

At one time or another, all children misbehave or do things that could be harmful, that are “wrong”, or that parents don’t like. Examples include:

- hitting someone
- forgetting homework
- having a tantrum
- arguing back
- whining
- not picking up toys
- refusing to go to bed
- coming home late
- throwing food
- lying
- running into the street
- wanting a cookie before dinner

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, circle the number that best describes your style of parenting during the past two months with your child.

When I’m upset or under stress…

I am picky and on my child’s back. 1 2 3 4 5 6 7 I am no more picky than usual.

When my child misbehaves…

I usually get into a long argument with my child. 1 2 3 4 5 6 7 I don’t get into an argument.

I threaten to do things that…

I am sure I can carry out. 1 2 3 4 5 6 7 I know I won’t actually do it.
I am the kind of parent that...
sets limits on what my child is
allowed to do. 1 2 3 4 5 6 7 lets my child do whatever
he or she wants.

When my child misbehaves...
I give my child a long lecture. 1 2 3 4 5 6 7 I keep my talks short and to
the point.

When my child misbehaves...
I raise my voice or yell. 1 2 3 4 5 6 7 I speak to my child calmly.

When I want my child to stop doing something...
I firmly tell my child to stop. 1 2 3 4 5 6 7 I coax or beg my child to
stop.

After there's been a problem with my child...
I often hold a grudge. 1 2 3 4 5 6 7 things get back to normal
quickly.

When we're not at home...
I handle my child the way I do
at home. 1 2 3 4 5 6 7 I let my child get away with
a lot more.

When my child does something I don't like...
I do something about it every
time it happens. 1 2 3 4 5 6 7 I often let it go.

When there's a problem with my child...
things build up and I do things
I don't mean to do. 1 2 3 4 5 6 7 things don't get out of hand.

When my child misbehaves, I spank, slap, grab, or hit my child...
never or rarely. 1 2 3 4 5 6 7 most of the time.

When my child doesn't do what I ask...
I often let it go or end up doing
it myself. 1 2 3 4 5 6 7 I take some other action.

When I give a fair threat or warning...
I often don't carry it out. 1 2 3 4 5 6 7 I always do what I said.

If saying no doesn't work...
I take some other kind of
action. 1 2 3 4 5 6 7 I offer my child something
good so he/she will behave.

When my child misbehaves...
I handle it without getting
upset. 1 2 3 4 5 6 7 I get so frustrated or angry
that my child can see I'm
upset.

If my child misbehaves and then acts sorry...
I handle the problem like I
usually would. 1 2 3 4 5 6 7 I let it go that time.

When my child misbehaves...
I rarely use bad language or
curse. 1 2 3 4 5 6 7 I almost always use bad
terrible.
When I say my child can’t do something…

I let my child do it anyway. 1 2 3 4 5 6 7 I stick to what I said.

When my child does something I don’t like, I insult my child, say mean things, or call my child names…

never or rarely. 1 2 3 4 5 6 7 most of the time.

If my child gets upset when I say “No”…

I back down and give in to my child. 1 2 3 4 5 6 7 I stick to what I said.

<table>
<thead>
<tr>
<th>How capable do you think you are when it comes to:</th>
<th>Not very capable</th>
<th>Moderately capable</th>
<th>Very capable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking to the child about things that the child shows an interest in</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Helping the child to pay attention to his/her surroundings</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Describing things that you are experiencing together</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Explaining to the child what you are experiencing together</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

When the following things happen, or need to be done, how often are you the one who does them?

<table>
<thead>
<tr>
<th>Always</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take the child to the Child Health Centre or other care facility</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Get up with the child when he/she wakes up in the middle of the night</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Help the child bathe/wash his/her hair</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Stay at home and take care of the child when he/she is ill</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Take care of paperwork for municipality, preschool, Social Insurance Agency (Försäkringskassan) or similar</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

How many times a week do you or someone in your family read a book or browse through it with your child?

- [ ] 10 times or more
- [ ] 6-9 times
- [ ] 3-5 times
- [ ] 1-2 times
- [ ] Never
Background information

Your year of birth: _________

Were you born in Sweden? □ Yes □ No

Your civil status:

□ Single
□ Co-habiting with child’s other parent
□ Co-habiting with someone else
□ Married to child’s other parent
□ Married to someone else
□ Live-apart relationship
□ Other: ____________

Your occupation:

□ Employed
□ Self-employed
□ Working from home
□ On parental leave
□ Student
□ Unemployed/job seeking
□ On sick leave
□ Other: ____________

Your highest completed education level:

□ Have not completed elementary school
□ Elementary school
□ Upper-secondary school/vocational school
□ University/higher education (less than 3 years)
□ University/higher education (3 years or more)

What is your relationship to this child?

□ Mother □ Father □ Other: ____________

The child lives:

□ With both parents
□ Alternates between parents, roughly equal time with both
□ Alternates between parents, mostly with me
□ Alternates between parents, mostly with the other parent
□ With me exclusively
□ With other parent exclusively
□ Other: ____________

How many children do you have? ____________

When was he/she/they born? ____________

How likely is it that you will still be living in the Uppsala region next year?

Highly likely

Highly unlikely

1 2 3 4 5 6 7

Thank you for your help!

➢ Take the whole form with you to the Child Health Centre. The Child Health Centre will only process the questions about the child. The questions about you will be collected only.

➢ Please register your approval (last page) in the “Frågor till förskolan” (“Questions for preschool”) and hand the form to the child’s preschool with the prepaid envelope. The preschool will send the answers to the Child Health Centre by post and you will go through them there.
A doctoral dissertation from the Faculty of Medicine, Uppsala University, is usually a summary of a number of papers. A few copies of the complete dissertation are kept at major Swedish research libraries, while the summary alone is distributed internationally through the series Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine. (Prior to January, 2005, the series was published under the title “Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”.)