

Research Article

A Qualitative Study of Professionals' Experiences and Challenges in the Early Identification of Psychosocial Concerns in Children

E. Randell ¹, M. Olsson ², D. von Ahlefeld Nisser ², and J. Ericson ^{3,4}

¹Department of Social Work, Uppsala University, Uppsala, Sweden

²School of Teacher Education, Dalarna University, Falun, Sweden

³School of Health and Welfare, Dalarna University, Falun, Sweden

⁴Centre for Clinical Research Dalarna, Falun, Uppsala University, Sweden

Correspondence should be addressed to E. Randell; eva.randell@uu.se

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Aim. Early intervention and detecting early signs are often cited as a goal by professionals working with children, but detecting and describing early signs is not well explored. Thus, the study's aim was to explore professionals' experiences and challenges in the early identification of psychosocial concerns in children aged 0–16. *Materials and Methods.* Data were collected from semistructured interviews with 26 professionals (e.g., nurses, psychologists, social workers, teachers, principals, and managers) working with children. The participants engaged in a pilot cooperation model between pre-schools, schools, social services, and healthcare to reach out early to children in need of support. The interviews were analyzed using thematic network analysis. *Results.* Four organizing themes were created as follows: "The idea of promoting and preventing is the key to success," "Identifying the children who need support and intervention," "Identifying observable early signs," and "Occupied with children needing immediate support." The organizing themes were interpreted into one global theme as follows: "All want an early intervention but putting it into practice is challenging." *Conclusion.* The study shows that it is difficult to identify children in need of psychosocial support at an early stage because the early signs are difficult to detect. Thus, our results suggest that both preventive interventions targeting all children and specific interventions for those in need of support are needed to promote health and wellbeing.

1. Introduction

Identifying and supporting children in need of psychosocial support is a major task for all professionals who work with children. It is well known that children can show a host of physical, emotional, social, and intellectual symptoms, indicating psychosocial concerns. These difficulties can be linked to the individual child (e.g., neurodevelopmental disorders, loneliness, and mental and chronic diseases); the family situation (e.g., economic matters, adverse childhood experiences, parental substance abuse, mental illness, intimate partner violence, and criminal behavior); or environmental factors (e.g., school, cultural, social, and economic settings). Psychosocial problems may lead to

mental illness and diminished school productivity, deteriorated school performance, increased need for additional support at school, early dropout, and potentially reduced educational attainment [1–5]. Although early intervention is often mentioned as a goal, signs, and symptoms of psychosocial concerns in children can be complex and challenging for professionals to identify.

Intervention in the early childhood period is a key strategy in the prevention of adverse psychosocial outcomes and mental disorders [6]. Child healthcare programs, schools, and social services may be arenas for prevention. Schools have been shown to provide children with several resources to help prevent psychosocial problems and impact resilience among the most disadvantaged children, and

completed school education is a health-promoting and protective factor for adulthood and for future mental health [4, 7–10].

Universal screening instruments are seen as a prerequisite for early identification, but there is little innovation regarding how to improve the early identification of psychosocial concerns in children. There is also limited evidence about effective early intervention to promote health [11, 12].

Research concerning collaboration between social services and schools is also limited [13]. However, one attempt to support children is “Getting it right for every child” (GIRFEC), a policy and framework aiming to improve children’s wellbeing in Scotland. GIRFEC addresses inequalities and improves child outcomes through interventions and prevention. One key focus in GIRFEC is ensuring that every child and young person has equal access to opportunities and health improvements [14].

Although progress has been made in studies investigating, explaining, and promoting risk and protective factors, little is known about early detection of psychosocial concerns in children and cooperation between professionals around children at risk for psychosocial problems. A multidisciplinary approach involving social, health, and education sectors addressing adverse experiences in children and supporting their and their family’s needs was under implementation in one municipality in Sweden. Thus, there was an opportunity to explore how professionals in preschools and schools could identify early signs of psychosocial concerns in children. In this study, we focused on psychosocial concerns in children, i.e., emotional, behavioral, and social difficulties. Detecting early signs in children with psychosocial concerns is often mentioned as important by professionals working with children. However, detecting and describing early signs is not well explored. Specifically, the aim of this study was to explore professionals’ experiences and challenges in the early identification of psychosocial concerns in children aged 0–16.

2. Material and Methods

2.1. Setting. Sweden has well-developed welfare systems and child wellbeing policies in general through universal public health services and free education, i.e., education funded through government spending. There are several laws and regulations within the Swedish legislation regarding children such as the social services act, the education act, and the health care act, each with their confidentiality obligations, hindering cooperation without the consent of the agencies in question [15].

Inspired by the model (GIRFEC) in Scotland, a pilot model (“together for every child”) was developed in some school districts in the municipality. The study was performed among professionals (nurses, psychologists, social workers, teachers, principals, and managers) working with children in a medium-sized municipality with 55,000 inhabitants located in the central region of Sweden. The average educational level in this municipality corresponds broadly to that of the general population [16]. The Swedish model consists of cooperation between preschools, compulsory schools, social services, and

healthcare intended to reach out at an early stage for children under 16 years old to detect signs and respond promptly to prevent ill health and improve health outcomes for children. The pilot model was designed to identify, assess, and support children in need of emotional, behavioral, and social support at an early stage, not to work with children in great need. In the pilot model, a color-coded grading system was used to classify the difficulty level of children in the model during the first year. Children were divided into the following three groups based on the severity of their life situation: green for children with no difficulties, yellow for children in need of extra attention, which was the target group in the current pilot model, and red for children in great need of immediate support. Professionals in child healthcare services, preschools, schools, and social services within the pilot area were trained to use the approach of the color grading system but not in what specific signs to look for. In the pilot model, early signs did not refer to any specific symptoms but literally the phrase “early signs.”

In the pilot model, a family team was created consisting of people from different professions to work with children needing support. The professionals responsible for addressing children at risk were termed security persons, e.g., the principals or the child healthcare managers. In Scotland, they used the term “named person,” but in Sweden, the term “security person” was used in the pilot model. In addition, a development group and a steering group consisting of leading personnel were created to oversee and direct the pilot model. However, after approximately one year, the family team dissolved, and expanded student health teams and child health teams were established instead, one each for the preschools and the schools.

In the present study, early interventions of the professionals working around children detecting emotional and behavioral difficulties were the focus. Implementation of the model, the model’s origins and its development are not discussed further in this paper. This study reports the findings from the first 18 months after the implementation of the pilot model. Informed and written consent was obtained from all participants, and the study was approved by the Regional Ethical Review Board, Uppsala (Dnr: 2019-02115).

We have provided a flowchart describing the work process in the pilot project “Together for every child” in Figure 1.

2.2. Participants. The participants in the study worked within social services, health care, preschools, and schools. They had different professions, such as nurses, psychologists, social workers, teachers, school principals, and managers within social services, schools, and healthcare. The inclusion criterion in this study was that the participants were working according to the pilot model and discussed early signs in the interviews. No demographic data were collected on the participants.

In the first data collection in 2019, all 35 eligible participants were invited and agreed to be interviewed. In the second data collection, approximately 18 months after the

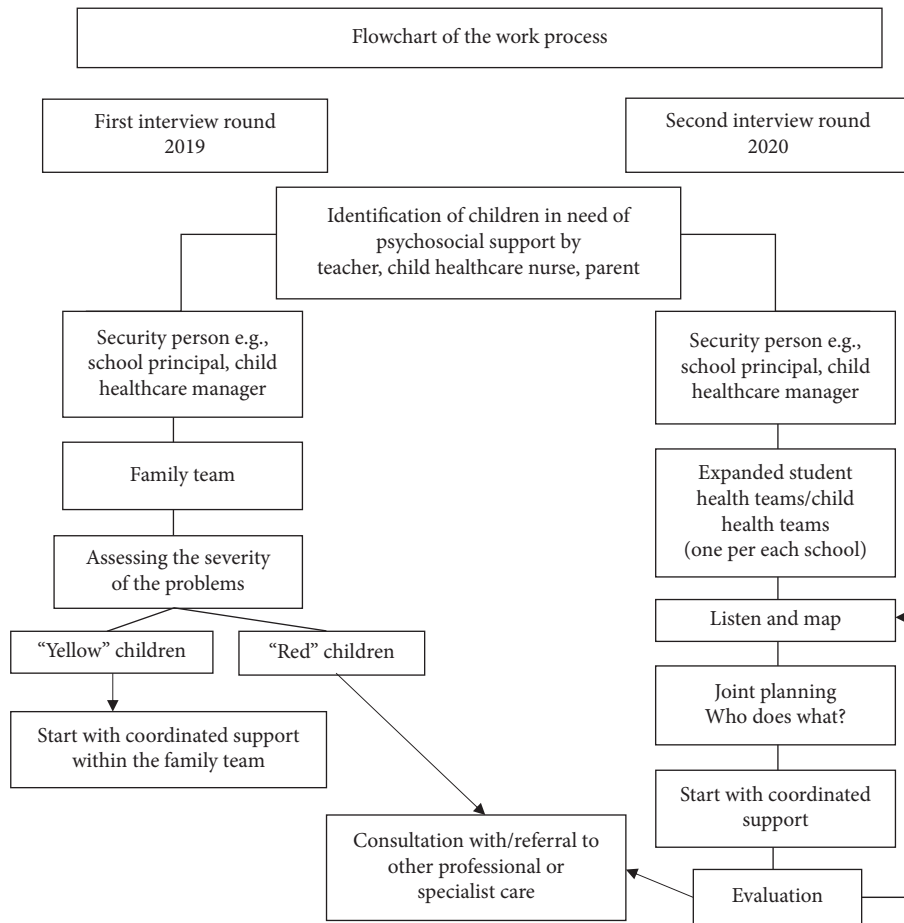


FIGURE 1: Flowchart of the work process in the pilot project “Together for every child.”

first data collection, a selection of professionals was made based on a strategic sample, in which every professional group was represented. In the second data collection, 23 participants were asked and agreed to be interviewed.

2.3. Data Collection. The interviews were conducted following the same semistructured interview guide. The first interviews were performed in spring 2019, and the second interviews were performed in summer/autumn 2020. The interviews, lasting 30–90 minutes, were conducted in quiet rooms in either the participants’ workplace, by telephone, or online. The interviews were audio-recorded with the participants’ permission and transcribed verbatim.

The interview guide comprised questions about signals perceived regarding the children’s situation, identifying the child, the participants’ role in the pilot model, cooperation, contacts with the family team/expanded student health team, and the model’s purpose and aim.

2.4. Data Analysis. All interviews were analyzed using thematic network analysis, a method for conducting thematic analysis by creating global, organizing, and basic themes of qualitative material [17].

In the first step of the analysis, all transcripts were read several times to obtain an understanding of the content. In the next step, all text regarding identifying early signs of children at risk was highlighted. In the first data collection, early signs were mentioned in 16 of the 35 interviews. In the second data collection, early signs were mentioned in 10 of the 23 interviews. In total, data from 26 interviews were analyzed in this study. Thereafter, the differences and similarities in the participants’ descriptions of early signs of problems in children were determined. After re-reading and coding all highlighted text from the interviews, codes were clustered into basic themes, which in turn generated four organizing themes according to Attride-Stirling [17]. Finally, the organizing themes were clustered into one global theme, representing the overarching subject matter of the text. No software was used for data management. Quotes from the interviews were used to support the interpretation of the content of the interviews and labeled according to the professional group to which the participant belonged, for example, security person, person from the family team/expanded student health team and person from the development and steering groups. No names of participants were used to ensure the participants’ confidentiality.

3. Results

The thematic network was based on several interconnected basic themes grouped and formed into four organizing themes. Four organizing themes were created as follows: “The idea of promoting and preventing is the key to success,” “Identifying the children who need support and intervention,” “Identifying observable early signs,” and “Occupied with children needing immediate support.” The organizing themes were interpreted into one global theme as follows: “All want an early intervention but putting it into practice is challenging.” All those who worked with children wanted an early intervention but translating the idea into practice was demanding, which encapsulated the main points of the interviews. The organizing themes and the global theme are illustrated in Figure 2.

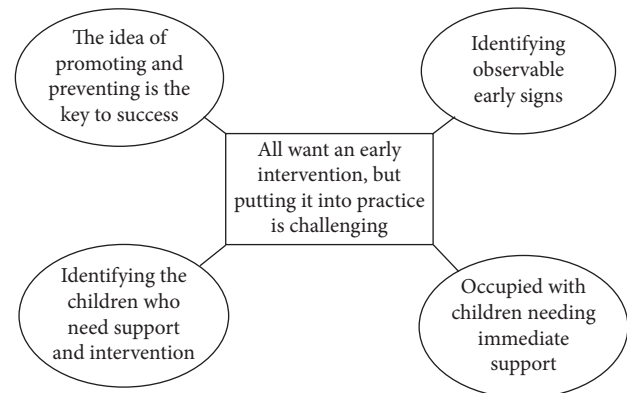


FIGURE 2: Organizing themes and global themes describing aspects in identifying early signs in children at risk of developing psychosocial problems.

3.1. All Want an Early Intervention, But Putting It into Practice Is Challenging. One global theme emerged that summarizes the main points of the interviews. All participants were positive and highlighted the importance of early intervention, but at the same time, they reported the difficulty of putting the interventions into practice. The participants were uncertain about the meaning of the early interventions, describing the challenges in identifying the “right” children, when to act and what should be done as a response to the child’s situation. Thus, it was difficult and demanding to put early intervention into practice.

3.2. The Idea of Promoting and Preventing Is the Key to Success. In this organizing theme, the participants expressed that if the needs of the children at risk were detected promptly, the problems would less likely develop into more serious issues. The idea of “the earlier the better” was emphasized. A security person at school explained, “We must start early. Even at an early age, so to speak, not just early efforts. When you notice that something starts to go wrong. Because then we have the chance.” (Security person).

All participants believed that through preventive interventions, the children’s needs should be easier to meet. It was a question of acknowledging the child’s life situation and family, taking the child’s whole situation into account.

Early intervention for the family, for the child, is such that the child makes the right choices. This is what the ideal image is—identify and intervene at earlier ages. (Security person).

Collaboration and consultation between professionals were described as important aspects in promoting wellbeing in children and preventing possible negative development in children at an early stage. When representatives of different professions shared each other’s concerns for the child, it contributed to a strengthened ability to act at an early stage.

Collaboration with the social services has not been very active and fruitful, but I already feel that it has improved. When I call the preschools and the preschool principal, it

feels like we have something in common, that we should work together, and absolutely, we should have a meeting. So, it already feels like we are all on board. (Child health care nurse).

3.3. Identifying the Children Who Need Support and Intervention. In this organizing theme, the participants noted that the children in need of support were hard to detect early because the early signs were difficult to identify. The participants did not think it was obvious what help the children needed. They were also uncertain about finding the appropriate level for when to act. Uncertainty concerning which children should be the target group was also mentioned.

We only see the red one [children in need of immediate support], and the principals and security persons are so uncertain who these kids are. When are they red and when are they green and on their way to yellow? Yes, quite simply, what are the early signs and what should I do when I see an early sign? (Manager/member of the steering group).

A security person said, “We need to find the boundary when to act, and teachers must learn to discover and ask [relevant questions].” Some feared that the participants were not able to identify the children. For instance, one member of the steering group explained, “They have a hard time finding these kids with early signs. They find them who already...where it has already gone so far, or they already clearly have a diagnosis.” (Manager/member of the steering group) However, some participants believed that the professionals already knew the children in need of support: “We must get in early, we already know who these children are. We must put in efforts earlier.” (Family team member).

The participants also expressed that identifying children in need of early support was often time-consuming and difficult. They further stated the desire for more education concerning identifying the children and assessing their needs. Some participants talked about the “tool of wellbeing indicators” to detect the children, a tool comprising questions about development and learning, health, social

relations, self-confidence, and self-esteem developed in the pilot model but not yet fully implemented. Using the device was seen as necessary for the teachers to ask questions they normally did not ask.

That is the strength of the wellbeing indicators. You must ask these uncomfortable questions. (Manager/member of the development and steering group).

3.4. Identifying Observable Early Signs. In the organizing theme “identifying observable early signs,” some of the participants in the schools mentioned several observable and concrete early signs. These were often behavioral changes or challenging external or internal behavior noted; however, the child’s potentially bad home situation and the parents’ circumstances were also cited as potential early signs for children at risk. Concrete early signs included behavioral changes (e.g., withdrawal and school absence) and changes in mood (e.g., anger, aggression, depression, and tiredness). Moreover, pain, e.g., stomachache, headache, and neck pain, was more common in girls than in boys.

We have talked a lot about this concept of early signs. When we pay attention to something, it can be that quite suddenly a pupil is very depressed and school absence has increased dramatically. It can be a concrete example. (Security person).

Other signs mentioned by participants in school were linked to the family situation, such as divorce, a tragic event, or poor socioeconomic status. It could also be that the parents asked the professionals for help or support regarding their children.

“Yes, early signs again. Because it may be that something happens in the family, a tragedy in grade eight” (Security person).

The participants emphasized the importance of asking the child about the circumstances concerning the child’s life and determining whether they noticed whether the child became introverted and closed. They mostly underscored how important it was to pay attention to small changes in the children’s behavior, e.g., becoming withdrawn, not performing, or not attending classes.

“Is there a pattern or something? But we have talked about this before, and we have said that now we must follow up on the absence because that is a sign that something is not right.” (Security person).

The preschool professionals mentioned having daily contact with parents and knowing the child’s home situation. According to the professionals, the children themselves told the staff their situations at home and school. The professionals also explained that they tried to draw attention to troubled preschool children. The child healthcare service nurses followed an established schedule at the child health services, evaluating the child’s development, behavior, and

skills. Special attention was given to the child’s developmental level, language ability, sight and hearing, skills, and communication. The child was followed up on in the event of abnormal findings, such as developmental deviations or delays. If the parents agreed, the preschool could be contacted. Of note, the child was often reported to have the same problems in preschool.

3.5. Occupied with Children Needing Immediate Support. In this organizing theme, the participants articulated that the children termed “red children” prioritized themselves and that their tremendous needs dominated when support was offered. The participants underlined that much of their time was spent with children needing immediate support. The pilot model together for every child focused on prevention, which conflicted with how the preschools and schools had to manage difficult and demanding (red) children.

You divide the children into green, yellow, and red groups. Green children are the easy ones, and the yellow ones are the ones on the border in need of support. The red ones are the ones I work with the most. I have not spent my time doing anything preventive for those children when you start to see these difficulties. (Security person).

Many participants found it difficult to summon the strength and motivation to work with those less needy pupils and not work further with the more demanding children in this model. The more demanding children were not meant to be referred to the family team, whose primary task was to work with early signs in children at risk, which created a conflicting view. Several participants underscored the importance of working with all children, regardless of their health challenges. They could not abandon the children in need of strong support, and some emphasized that they should work with children who have different levels of needs. *“The red kids occupy a lot of time from the principals and preschool staff. We are having a discussion: How can we help the red children, too?”* (Family team).

After initiating the extended healthcare teams at schools, the family social workers who participated in the meetings could quickly begin working with the families after consent. However, they were still heavily occupied with children at the highest risk levels. A participant emphasized a need for a specialist level outside the model. *“We need to retain the specialist level and a school that can manage red children”* (Manager/member of the steering group).

4. Discussion

This study describes professionals’ views regarding early signs and how they tried to identify early signs of psychosocial concerns in children in a pilot model of cooperation to detect, assess, and support these children during the first 18 months after the implementation of the model. This study showed that professionals had to address several issues when trying to identify needs in children who were at risk of developing psychosocial problems.

The main goal of the pilot model was to prevent, promote, and be aware of early warning signs in children rather than working with already troubled children. There was a notion at the start of the pilot model that it would be easy to find early signs of children at risk, but it turned out to be difficult. The main finding was that it was very challenging and difficult to identify children at risk but not yet showing signs of psychosocial problems. Thus, it was an ambition shared by the participants that was difficult to attain. However, prevention was valued by all participants regardless of their profession, and the participants described various views and beliefs about the early signs of children needing support. The definitions of the early signs of children in need of early support were not clearly defined in this pilot model. To our knowledge, there was no written material communicated to the staff containing definitions of the early signs of risk, which may have affected the professionals' ability to detect and help the children and families who needed support. During the 18 months the pilot researchers followed the implementation, few children and families received help. After the extended healthcare teams were established, the flow of children increased; however, it was still at a low level. We speculate that the lack of defined early signs and unclear target groups made it difficult for the professionals to know which children needed support and identify the most appropriate time to act.

An ambition to identify children early was difficult to attain, which shows the difficulty of early detection of children at risk, especially school-aged children. Thus, a major concern is whether the problems and needs of children at risk are perceptible before the children express their risk situations and need for support more clearly. The participants said that changes could happen suddenly due to events in a child's or family's life situation and that such changes are not easy to predict. Only through concrete changes in the child's behavior or mood can participants observe early signs of trouble. Participants also stressed the importance of recognizing those children most in need of early support and developing multidisciplinary strategies to manage them. The question is whether it is the best strategy. Studies on the school environment indicate that long-term interventions involving changes in the school climate that include both context and individuals are likely to be more successful in increasing children's wellbeing and improving educational outcomes than short, class-based prevention programs [18–20]. Creating equal opportunities for all preschool and school-aged children can prevent unequal conditions such as socioeconomic and gender differences in mental health [21]. A review suggests that schools may have the greatest impact on resilience among the most disadvantaged children by providing the necessary resources to ensure that the children have a sound and secure foundation for their emotional development and physical and mental health [10]. School-based interdisciplinary interventions may promote child health and academic achievement [22].

Our results show that the participants used the color-coded grading system to categorize children. The color-coded system that was used during the first year may be linked to the tradition within compulsory schools to

categorize children based on how severe their problems are [23]. Grading children using a three-color coding scheme can lead to ethical dilemmas. Moreover, it can box professionals into a static way to look at the problem. When dividing children into groups, professionals may not see the individual child and his or her unique needs. Children can exhibit a complex pattern of needs, and it might be better to discuss their needs instead of grouping them into faceless segments. Some children may even need support throughout their entire school career.

Only one participant discussed the impact of the preschool and school environment on children's health and wellbeing. Most participants focused on the family's impact on the child's health. Participants may consider children and their families as the main source of the problem and not the challenges children face in school and in other environments. Thus, they proposed support for children and families rather than other possible explanations. The dominant discourse in many Western countries, including Sweden, is that children's health and future life are determined by parents' parenting behavior, i.e., that good parenting behavior can prevent psychological ill health [24, 25]. With that model of explanation, the psychosocial problems among school-aged children depend on the parents' abilities or the individual's characteristics [25, 26]. However, a child's psychological and psychosocial development is probably more complex, with many possibly connected components, such as genetics, personality, disabilities, family, school, and local community. Health and wellbeing have a contextual dimension, and a socioecological understanding also needs to focus on the child in different contexts, e.g., family and school settings, linking the individual and their surrounding environment [1, 2, 27].

Some aspects may be important to consider when implementing new ways of recognizing early signs in children to ensure that the child receives timely help and support. Our results show the importance of carefully defining the target group and core elements to those key individuals who will identify the children needing support. In addition, the importance of consensus and training everyone involved in the new way of working must be emphasized, especially when involving staff from diverse expertise areas.

4.1. Methodological Considerations. The credibility of the study is high because of the large sample that includes different groups of professionals working with children from different work areas, all of which contribute to detailed and rich descriptions. The current research group was interdisciplinary, which offered different perspectives on the analysis. The team consisted of a nurse, two social workers, and two pedagogues, all with experience in research and clinical work with children.

The model has not yet been evaluated, and because only part of the original model was adapted and implemented, differences in implementation make it difficult to compare with other similar projects. Furthermore, differences in social welfare and school systems impose special requirements complicating comparisons to other settings.

5. Conclusions

Participants expressed diversity in their views about early signs of children needing psychosocial support. In addition, there was a call for more education and support for health promotion. Much time and effort were expended for children in dire need of support; however, there was also a strong desire to identify the children at risk for psychosocial problems in good time. However, translating early intervention into practice proved challenging. Thus, our results suggest that both preventive interventions targeting all children and specific interventions for those in need of support are needed to promote health and wellbeing. Psychosocial support work should also focus on the aspects of an environment or situation that affects both the social and psychological wellbeing of children. Implication for practice is that professionals working with children need to apply a socioecological understanding that places the individual child's needs in a context that considers the school, family, and surrounding society.

Data Availability

The data that support the findings of this study are available from the corresponding author upon request. The data are not publicly available due to legal issues and the privacy of research participants.

Conflicts of Interest

The authors have declared that they have no conflicts of interest.

Authors' Contributions

All authors planned, designed, and performed the data collection. JE and ER performed the data analyses and wrote the manuscript. All authors reviewed and revised the manuscript and approved the final manuscript.

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