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Exploring the feasibility of screening and preventive financial counselling for families with young children in Sweden

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Abstract
Johansson, N. 2025. Exploring the feasibility of screening and preventive financial counselling for families with young children in Sweden. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 2199. 84 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-513-2628-3.

There is an increasing need to address economic stability as a social determinant of health among families with young children in Sweden. The topic of this thesis is how the work of Swedish preventive welfare services can be carried out to support families with young children living in, or at risk of, economic hardship. The Healthier Wealthier Families (HWF) model is a working model in which child health service nurses screen parents with young children for economic hardship and offer a referral to financial counselling at the municipal budget and debt counselling service. The overall aim of this research was to explore the feasibility of this model.

Four complementary studies were conducted. Study I used qualitative semi-structured interviews to explore the perceptions and experiences of the HWF model in a Swedish context. Study II was a pilot randomised controlled trial of the HWF model. Through a web-based survey, Study III investigated whether preventive counselling is being enacted within Swedish budget and debt counselling services, with a focus on the counsellors' working conditions to carry out preventive counselling. Study IV derived data from four open-ended questions in the Study III web-based survey, and explored how the counsellors' conceptualisation of prevention aligns with national and local guiding documentation.

Study I emphasised the importance of how professionals view their roles. Study II concluded that a full-scale trial of the HWF model was unfeasible due to low conversion rates and fidelity, highlighting the need for a revised evaluation design that considers contextual factors. Study III found that counsellors in the BDC face significant challenges due to a lack of structure in implementing prevention policies. Study IV stressed the necessity for clearer, actionable guidance to ensure a unified approach to prevention. Overall, the findings depict the complex nature of preventing economic hardship within Swedish societal services, underscoring the role of financial stigma, implementation challenges, and the need for structural changes.

Keywords: healthier wealthier families, budget and debt counselling, child health services, parents, economic hardship, prevention, stigma, qualitative method, randomised controlled trial, survey

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Att äga dagen framför sig
utan att behöva använda den
till avbetalning
på gårdagens skulder
i skräck att allt är för sent
Att aldrig ängsligt fråga sig
vad ens har blivit
om icke om…[1]

[1] Att kunna möta morgonen, Ingegerd Granlund

List of Papers

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

I. **Johansson, N.**, Warner, G., Avogadri, N., & Sarkadi, A. (2024). Screening for economic hardship at Child Health Care Centres: A qualitative study of stakeholders' perceptions and experiences of the Healthier Wealthier Families model in Sweden. *Scandinavian Journal of Public Health.*

II. **Johansson, N.**, Sarkadi, A., Isaksson, D., Warner, G. Feasibility of a randomised controlled trial of Healthier Wealthier Families in Sweden: Results from the Ameliorating Child poverty through Connecting Economic Services with child health Services (ACCESS) pilot study. *Under review in BMC Health Service Research.*

III. **Johansson, N.**, Warner, G., Sarkadi, A., Isaksson, D. "We are only putting out fires" – Conditions to enact preventive financial counselling in Sweden. *Under review in PLOS One.*

IV. **Johansson, N.**, Hedkvist, I., Isaksson, D., Sarkadi, A., Warner, G. "The key issue is the definition of preventive counselling" – a multi-method study exploring how prevention is conceptualised within Swedish Budget and Debt Counselling. *Manuscript.*

In addition to the papers included in this thesis, the author has also written and contributed to the following paper:

Johansson, N., Sarkadi, A., Feldman, I. *et al.* Ameliorating Child poverty through Connecting Economic Services with child health Services (ACCESS): study protocol for a randomised controlled trial of the healthier wealthier families model in Sweden. *BMC Public Health* **22**, 2181 (2022). https://doi.org/10.1186/s12889-022-14424-x

Contents

Abbreviations

ADePT	A process for Decision-making after Pilot and feasibility Trials
BDC	Budget and Debt Counselling
CFH	Child and Family Health
CHS	Child Health Services
EU	European Union
GDPR	General Data Protection Regulation
HWC	Healthier Wealthier Children
HWF	Healthier Wealthier Families
MRC	Medical Research Council
MSD	Material and Social Deprivation
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
RCT	Randomised Controlled Trial
SCA	Swedish Consumer Agency
SILC	Statistics on Income and Living Conditions
WHO	World Health Organization

Populärvetenskaplig sammanfattning

Den här avhandlingen handlar om förebyggande arbete och ekonomiska svårigheter hos småbarnsfamiljer. Ekonomiska svårigheter kan betyda olika saker. I mitt arbete har jag valt att beskriva ekonomiska svårigheter hos barnfamiljer som en oro för att hushållets pengar kommer ta slut innan månaden gör det, att man inte kan köpa nödvändiga saker till sin familj, att man inte kan betala löpande utgifter såsom hyra och försäkringar, att det inte finns någon vuxen i hemmet som har en fast inkomst, och att inte kunna hantera en oväntad utgift på 20 000 kronor utan be om hjälp eller låna pengar. En annan risk för ekonomisk svårighet kan vara om den disponibla inkomsten, det vill säga den inkomst man har kvar för konsumtion efter att alla fasta utgifter är betalda, är under 60% av den svenska medianinkomsten. Det måttet kallas relativ fattigdom.

Tidigare forskning har visat att barn som växer upp i hushåll där pengarna inte räcker till att täcka vardagens nödvändiga utgifter, riskerar psykisk ohälsa, social exkludering och stigma gentemot sina jämngamla kamrater, samt att själva uppleva problem med sin ekonomi när de blir äldre. Detta är ett växande problem i Sverige idag, men det finns befintliga samhällstjänster som kan identifiera ekonomiska svårigheter och hjälpa barnfamiljer. Ett exempel är den svenska barnhälsovården, som via Barnavårdscentraler (BVC) följer barnets utveckling från nyfödd till 5 år. Det svenska barnhälsovårdsprogrammet fokuserar på barnets hälsa och utveckling men även på miljön kring barnet, de så kallade psykosociala faktorerna. Ekonomiska svårigheter är en psykosocial faktor, som hade kunnat inkluderats i barnhälsovårdens fokus. Ett annat exempel är Budget och Skuldrådgivning (BUS), en lagstadgad verksamhet som ska finnas tillgänglig i Sveriges alla kommuner. BUS är en kostnadsfri och frivillig verksamhet för personer som upplever svårigheter i att själva hantera sin ekonomi. Verksamheten erbjuder stöd till personer med problematisk skuldsättning, och i processen att ansöka om skuldsanering. Verksamhetens nationella riktlinjer uppmuntrar till förebyggande arbete mot skuldsättning och ekonomiska svårigheter. ’Healthier Wealthier Families’ (HWF) är en arbetsmodell som använts i Skottland och Australien för att fånga upp och stötta

barnfamiljer med risk för ekonomiska svårigheter genom att länka samman barnhälsovården och ekonomiska rådgivningstjänster.

Denna avhandling utfördes genom fyra studier. I studierna använder jag mig av både kvalitativa och kvantitativa metoder med analyser av data från intervjuer, fältanteckningar, enkäter samt vägledande dokumentationer och riktlinjer. Min första delstudie visar hur HWF modellen uppfattades av sjuksköterskor på BVC, rådgivare inom BUS samt småbarnsföräldrar med självrapporterad ekonomisk svårighet. Studieresultatet visade att ekonomi och familjers välmående är sammanlänkat, att ekonomiska svårigheter är nära knutet till känslan av osäkerhet och stigma, samt att det finns olika utmaningar för att utföra förebyggande rådgivning. Delstudie två undersökte genomförbarheten av HWF modellen. I vår randomiserad kontrollerade studie blev studiedeltagarna slumpmässigt indelad i två grupper, där en grupp tog del av interventionen direkt och kontrollgruppen fick vänta i tre månader. Resultatet visade att HWF modellen inte är genomförbar att utföra som en storskalig randomiserad kontrollerad studie. Genomförbarheten påverkades av faktorer kopplade till själva HWF modellen som intervention, men också kontexten som den genomfördes i.

I delstudie tre undersökte jag förebyggande rådgivning genom en anonym webbaserad enkät, som skickades ut till alla kommunala rådgivare i Sverige. Enkätsvaren visade att majoriteten av rådgivarna möter klienter i ett senare skede än de hade föredragit, med en problematik som behöver akut hjälp. Många ansåg att förebyggande rådgivning var viktigt, men att arbetet hindrades av bland annat för få resurser i form av tid och personal, bristande standardiserad vägledande dokumentation samt bristande organisatoriskt stöd. Delstudie fyra baserades på fritextsvar från delstudie tre, samt standardiserad vägledande dokumentation på nationell och lokal nivå. Resultatet visade att det fanns en samstämmighet gällande förebyggande arbete mellan rådgivarna och den vägledande dokumentationen, men att det fanns olikheter gällande på vilken nivå förebyggande bör fokuseras.

Sammanfattningsvis visar denna avhandling komplexiteten med att förebygga ekonomiska svårigheter i en kontext av stigma, begränsad tid och resurser hos både yrkesprofessionella och småbarnsföräldrar idag. Mina resultat visar på behovet att konceptualisera och standardisera förebyggande arbete, för att motverka ekonomiska svårigheter och dess negativa effekter på hälsa och välmående.

Introduction

När man ser på hur barnen växer upp och står i
Kan man undra om barnen nånsin får det som vi?
Om det finns jobb, om det finns mat
om det är drägligt där dem bor?
Finns de får och kor, och vatten och luft?[2]

On the front cover of this thesis, there are two children sleeping. By the bedside is their parent, crafting a patchwork quilt for them to sleep under, warm and safe. Yet, not all patchworks are the work of the parent. One patch consists of the 'Convention on the Rights of the Child', another one the 'Agenda 2030', and a third and fourth consist of Swedish regulations. Together, they symbolise the different actors and frameworks in place to secure the safety and stability for families with young children. It is a shared mission and responsibility. The lyrics above were written in 1970, with a humorous approach yet aiming to raise the question of the future of Swedish children. Will they enjoy the same possibilities and rights as the generation before them with available employment, food and adequate housing? The questions were raised in 1970, and are still relevant today, 55 years later.

I have always been interested in the concept of health, which first brought me to a bachelor in political science and later a master's degree in public health. When presented with the opportunity to work as a research assistant, and later the opportunity to undertake a PhD, within the Healthier Wealthier Families project, I could see my two educational backgrounds and public health interest coming together perfectly. This doctoral project has taken me across Sweden, from Härnösand in the north to Malmö in the south, allowing me to experience not only the geographical but also the structural differences of this country. In this thesis, I will present what I have learned from all my travels over this four-year-long journey. I will present the findings of my doctoral project exploring how to address and prevent economic hardship in families with young children.

[2] T. Danielsson & H. Andersson

Background

Social determinants of health

For a person to be in a good state of health, live long and prosper, it is not solely dependent on the choices made by that person (1). The conditions in which a person is born, where they live, work, age, and their access to power, economic stability, and resources are what the World Health Organization broadly defines as the social determinants of health. These factors are important to understand the health inequalities and inequities of today and to understand how they should be formed and sustained by societal policies, structure and values (1).

The idea of social conditions and economic means influencing health and life expectancy is not new. It was theorised during the 19th-century typhus outbreak (2) and the spread of diseases and high mortality rates due to lack of sanitation among the British labouring population (3, 4). Chadwick exemplified that the poor sanitary levels were beyond the control of the low-level labouring class to manage and improve. Following that, Chadwick highlighted the noticeable barriers faced by responsible actors with the power to manage and amend the conditions; there seemed to be no discernible benefits for the responsible actors that compensated for the expenses incurred (4).

Since the late 1970s, scholars have embarked on the mission to explain the aetiological factors of differences in public health and life expectancy (5-15). In 1978, the first Whitehall study conducted by Marmot et al. (13) on 17,530 British civil servants displayed an inverted relationship between employment and health. The scholars presented that the group of low-grade employees were shorter and heavier in relation to their height, had higher blood pressure, smoked more and self-reported a lower leisure-time associated physical activity. After adjusting for the influence on mortality of the mentioned factors, the inverted relationship between employment grade and coronary heart disease mortality remained strong. The authors therefore concluded that the mortality rate among low-grade employees could only in part be explained by coronary risk factors, and that continued aetiological research was needed (13).

Twenty years after the first Whitehall study, a follow-up study was made with a new cohort of civil servants (11). Despite two decades passing between the two studies, the results presented similar findings; self-reported health status was worse in the groups of lower-grade jobs. The authors did, yet again, call for more societal attention on social environments (11). Later publications build upon that, when identifying the need for awareness of the construction and responsibilities of national, regional and local policies (6). It is noted that governmental and other institutions should be understood as actors managing and promoting state policies regarding poverty.

A further analysis of the two Whitehall studies emerged in 'Social Determinants of Health' (10) and 'The Status Syndrome' (16). The research findings, in addition to presenting British statistics, showed that health follows a social gradient; a high social position often indicates better health. The authors also concluded that this is not isolated to those in deprivation and poverty. The social gradient of health spans across social classes, where a step down the social hierarchy ladder is also a step down in health standards. The living and working conditions of people, their position in the social hierarchy and their sense of control and justice have a strong psychosocial influence on population health (10).

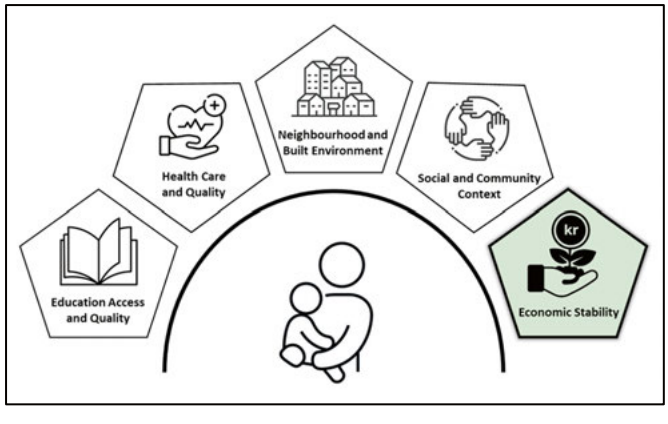

Figure 1. Economic stability as a social determinant of health

Economic stability is one of the core social determinants of health (see Figure 1); it can be understood based on three hypotheses: absolute income (17, 18), income inequality (9, 19) and relative income hypotheses (20). The three hypotheses span across different societal levels, where absolute income analyses present outcomes on an individual level, relative income on an individual level within a population and income inequality at a societal level. On the individual

level, the influence of absolute income on health can be displayed through higher income facilitating healthier life choices, providing safety and stability (21). On the individual level within groups, relative income unveils health disparities through the stress of comparison and low perceived status (22). At a societal level, income inequality has shown to impact public health outcome (19, 23).

In line with this, it is important to acknowledge that economic stability, like all social determinants of health, can be divided into the categories of structural and intermediary, see Figure 2 (24). The structural determinants of health are the social factors that can promote, and undermine, health on an individual and population level. These include governance, policies, culture and societal values, as well as factors that affect socioeconomic position, such as social class, gender, ethnicity, education, occupation, and income. Structural determinants come to terms in a series of intermediary social determinants of health i.e., individual-level influences, health-related behaviours and physiological factors. One prominent intermediate determinant is material circumstances. It is for this reason that an intersectional perspective (25) should be taken when considering economic stability as a social determinant of health. Interconnected social identities, such as race, gender, age, and class, create complex, overlapping experiences of disadvantage that can lead to economic hardship.

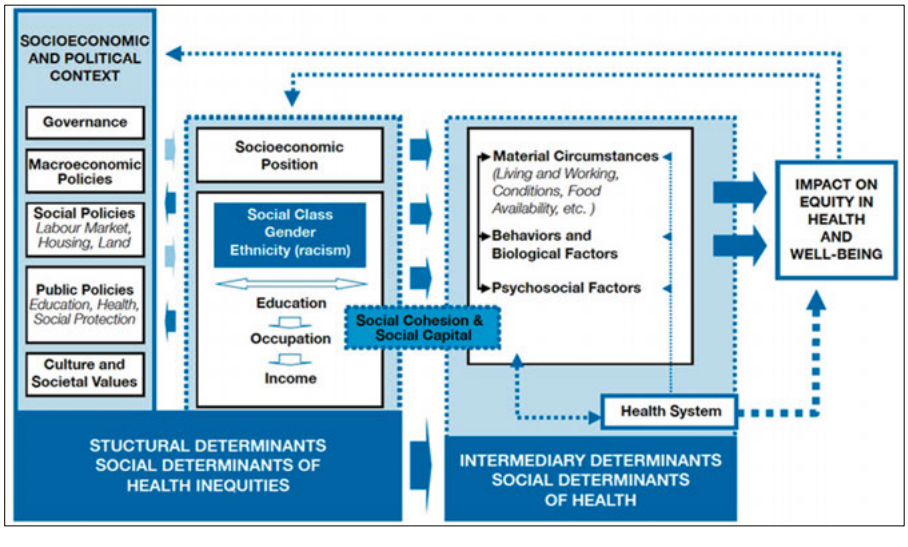

Figure 2. Structural and intermediary determinants of health. Reprinted under the WHO Open Access agreement (CC BY-NC-SA 3.0 IGO licence)

Economic stability as a social determinant of health in Sweden

Sweden's population enjoys relatively good health and high life expectancy compared to many other countries (26). It is a consolidated democracy with strong labour-market institutions and high levels of trust in public authorities (27). Historically, Sweden has been a model of the universal welfare state, associated with low levels of poverty and inequality (28, 29). However, the economic inequality of Sweden is increasing (30, 31). This can be noted through the Gini coefficient, which measures income distribution within a population, and to what extent the distribution deviates from perfect equality, 0, to full inequality, 1 (32). The Swedish Gini coefficient has increased from 0.263 in 2011 to 0.287 in 2023 (32), which is the highest among the Nordic countries (31, 33). Thus, while Sweden remains a relatively equal society by international standards, economic stability has become an important and growing concern.

Looking to the wider literature, we see that a lack of economic stability affects health outcomes in Sweden. Previous research exploring the effect of low income presents a clear impact on the risk of illness (34), and how low and downward income trajectories in family households increased the risk of children developing psychiatric disorders (35). Having financial means that do not cover the daily expenses or allow for managing unexpected expenses has been shown to increase the risk of poor mental health (36). Elevated risk of poor mental health outcomes has also been linked to self-reported economic hardship (37). Having financial means that are reliant on social assistance can, in the long-term, increase the risk of poor mental health, misuse of different substances and mortality (38).

One of many risk factors for economic hardship is gender inequality, a stubborn social issue evident in both developing and developed countries (39). In defiance of the development of women obtaining higher levels of education, they are still a minority in lucrative work fields (40). Women take the lead in the unpaid work of caregiving at home, with the result in a gendered stress gap and worsened well-being. Single parenthood is another important factor when considering risk of economic hardship, due to the hardship of managing costs on a single salary (41), the difficulty of managing the everyday-life with employment and child care responsibilities (42) and how available support services fail to support vulnerable single-parent groups (43). Ethnicity has been shown to constitute a risk factor for economic hardship due to its adverse effect on employment (44), and the lack of financial

resilience among migrant families in the event of a crisis (45). The negative effects on health do, however, depend on the country of origin (46). Elevated risk of hardship can be identified between different residential areas (47), housing forms (48), yet also depending on the accessibility of different housing forms in the country (49).

Income trends across social groups in Sweden

In Sweden, it is common to study the equivalised disposable income excluding capital gains. Equivalised disposable income consists of the sum of all taxable and non-taxable income, minus taxes and other negative transfers, adjusted for household size (50). Capital gains are, e.g., the sales profits of assets such as stocks, funds or real estate and by exclusion, the measures show a more stable measure of everyday living standards. Further on in this thesis, when writing about disposable income, it will refer to equivalised median disposable income excluding capital gains. In 2023, the Swedish median disposable income was 318,800 SEK (51). However, this number varies across socioeconomic groups. As seen in Figure 3, the median disposable income differentiates between Sweden-born and foreign-born, and if the household consists of children aged 0-19 years old. Statistics Sweden defines foreign-born as someone born in a country outside of Sweden, independent of the parents' country of birth or citizenship (52). Foreign-born population data from Statistics Sweden consists of individuals who are registered residents, meaning that, e.g., immigrants, foreign students and adopted individuals are accounted for as foreign-born.

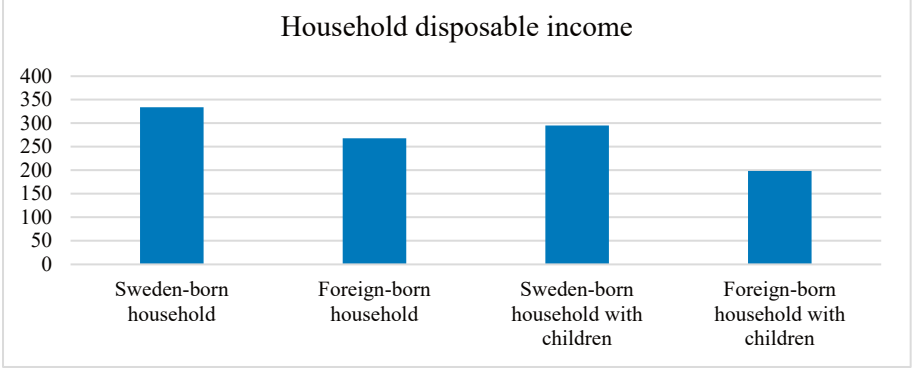

Figure 3. Disposable income in thousand SEK, Households according to country of birth and presence of children (0-19 years), 2023

When studying family households, there are notable differences across family compositions, see Figure 4 (53). The median disposable income was higher in households with two cohabiting adults than in households with a single mother.

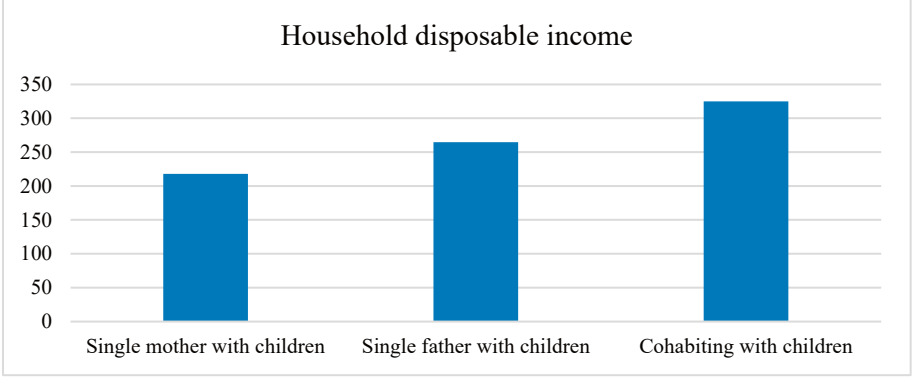

Figure 4. Disposable income in thousand SEK, Households with children (0-19 years) according to family composition, 2023

Relative poverty, also referred to as 'at-risk-of-poverty' in a statistical context, measures the proportion of households living with a disposable income below 60.0% of the country's median (54). The total proportion of households with children aged 0-19 years old living with a disposable income under 60.0% of the Swedish median has varied over the years 2011 to 2023, as seen in Figure 5.

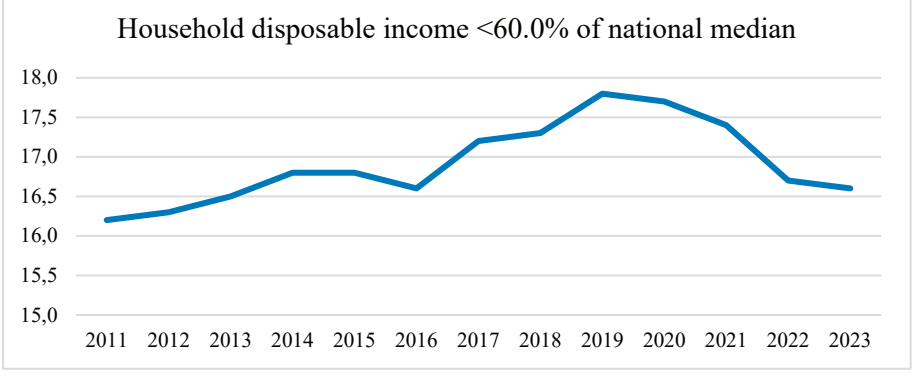

Figure 5. Rate in %, Relative poverty of households with children (0-19 years), 2011-2023

As seen in Figure 6, foreign-born households with children living in relative poverty are higher than the Swedish-born households with children. The rates in 2019, 13.9% for Swedish-born and 52.4% for foreign-born, had decreased to 13.7% and 44.9% in 2023, respectively (51).

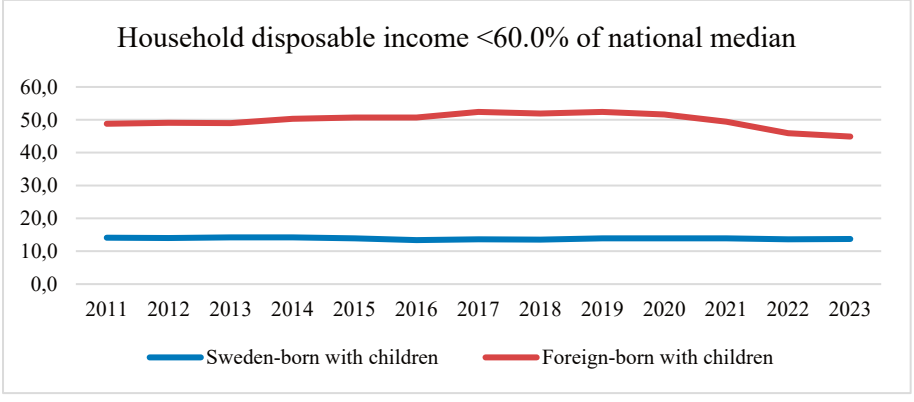

Figure 6. Rate in %, Relative poverty of households with children (0-19 years) according to country of birth, 2011-2023

When taking family composition into account, the proportion of households living with a disposable income below the national median has varied across the years and different households. As displayed in Figure 7, the relative poverty rate has remained stable for two-parent households, measuring 8.9% in 2023. Relative poverty among single mothers accounts for higher rates, yet has decreased from 34.1% in 2011 to 32.6% in 2023.

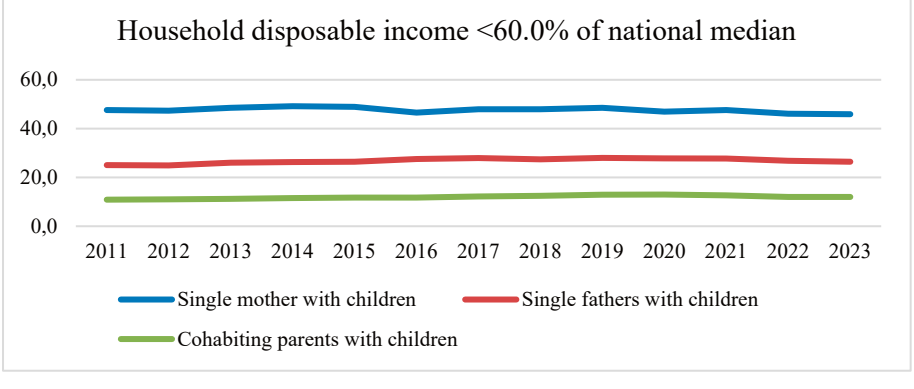

Figure 7. Rate in %, Relative poverty of households with children (0-19 years) according to family composition, 2011-2023

Deprivation and lack of resources

In addition to measuring the level of available income for households, the instrument Material and Social Deprivation (MSD) is used to measure the living conditions a household can afford (55). There are two versions of the MSD tool, one for adults and one for children (56). The Child MSD instrument consist of an 18-item list where 13 of the items were child-specific and 5 were

household-specific. In our work, we have opted to use the 13 child specific items, see Table 1.

Table 1. Child Material and Social Deprivation

☐ Some new clothes
☐ Two pairs of shoes, including one pair of winter shoes
☐ Fresh fruits and vegetables daily
☐ Meat, chicken, fish or a vegetarian equivalent daily
☐ Age-appropriate books at home
☐ Outdoor leisure equipment and toys
☐ Indoor leisure equipment and toys
☐ Regular leisure activities that cost money
☐ Celebrations on special occasions
☐ Invitation of friends to play and eat from time to time
☐ Go on holiday for at least one week somewhere other than their hometown
☐ Participation in school trips and school events that cost money
☐ Suitable place to do homework

A household lacking two or fewer items from Table 1, for at least one child in the household, is classified as 'not experiencing deprivation', whereas a household lacking three or more items is classified as 'experiencing deprivation'. Notable increases can be detected in the Swedish household MSD over the last four years, see Figure 8 (57). In Swedish-born households, the MSD rate measured 4.6% in 2024. In foreign-born households, the MSD rate has increased by 4.7 percentage points since 2021, and numbered 15.4% in 2024 (57).

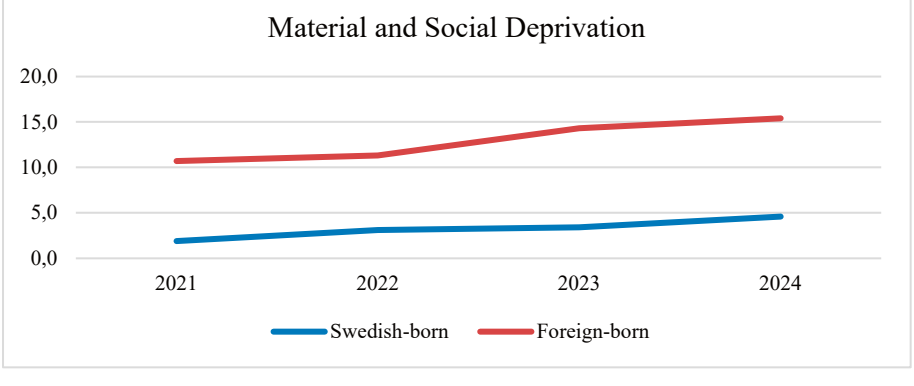

Figure 8. Rate in %, Material and Social Deprivation according to country of birth, 2021-2024

Across all household compositions, the MSD rate increased between 2021 and 2024 (57), see Figure 9. The highest rate detected was among single mothers in 2023, with a proportion of 16.8%.

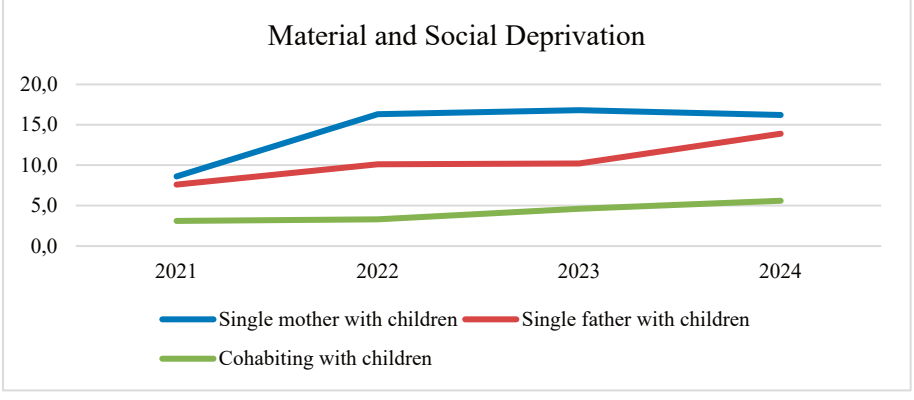

Figure 9. Rate in %, Material and Social Deprivation of households with children (0-24 years) according to family composition, 2021-2024

Economic strain

A more general term is 'Economic strain'. When presenting Statistics on Income and Living Conditions (SILC), 'Economic strain' encompasses several different measures, including being unable to face unexpected financial expenses of 14,000 SEK and experiencing difficulty or major difficulty in making ends meet (58).

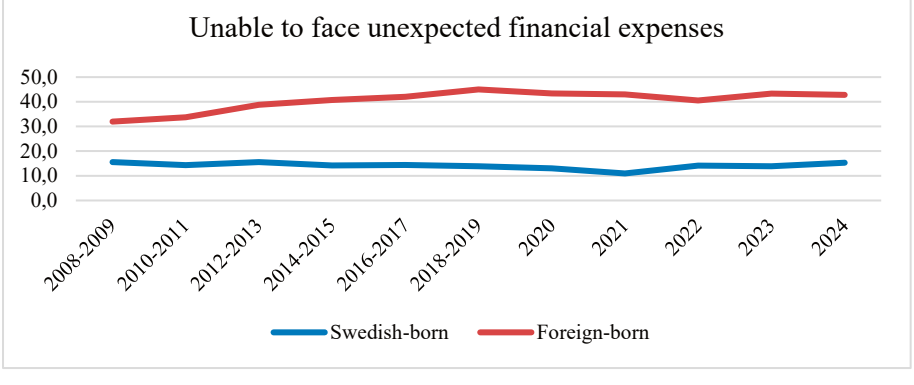

Figure 10. Rate in %, Economic strain of households according to country of birth, 2008-2024

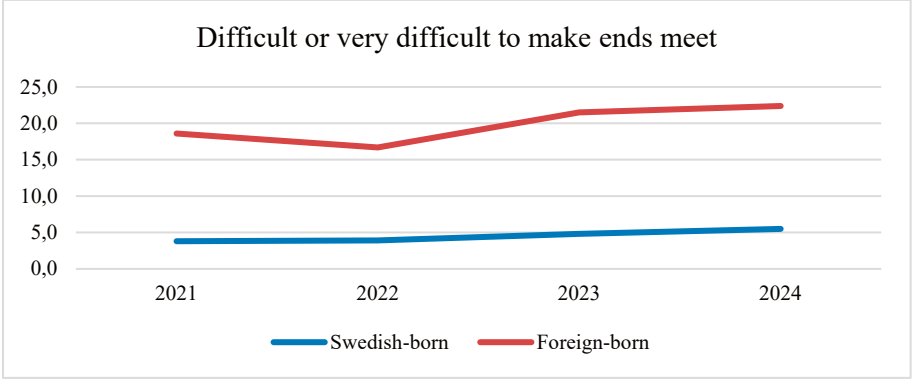

Figure 11. Rate in %, Economic strain of households according to country of birth, 2021-2024

Despite the increased proportion of Swedish-born households experiencing economic strain (58), there are substantial differences in comparison to foreign-born households as seen in Figures 10 and 11. The proportion of foreign-born households reporting inability to face unexpected costs measured over 40.0% between 2021 and 2024. In reports of difficulty in making ends meet, the rate among foreign-born households has increased to over 20.0% since 2024, while Swedish-born households have remained well below at 5.5% (58).

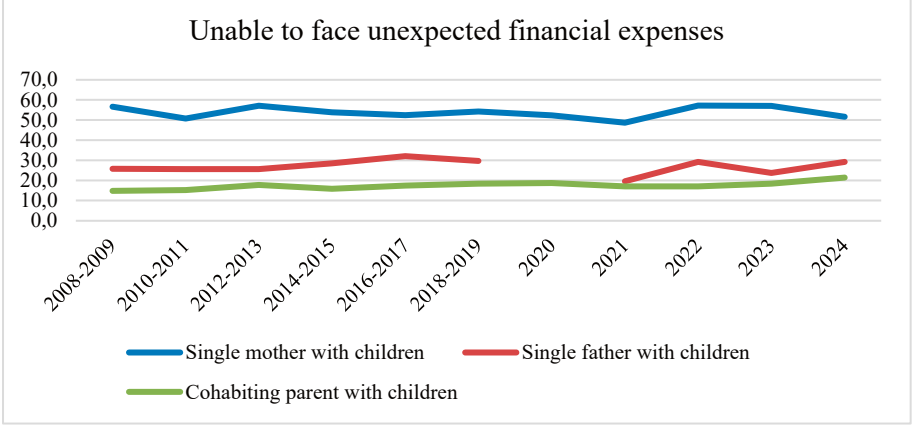

Figure 12. Rate in %, Economic strain of households with children (0-24 years) according to family composition, 2008-2024. Data missing for single fathers, 2019-2021

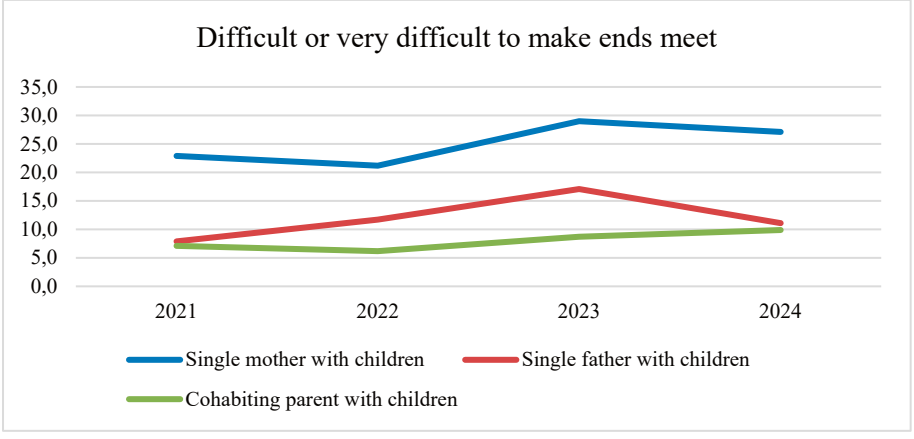

Figure 13. Rate in %. Economic strain of households with children (0-24 years) according to family composition, 2021-2024

As seen in Figures 12 and 13, across all the economic strain measures, single mothers reported the highest proportions, followed by single fathers (58). In Figure 12, the inability to meet unexpected costs was reported to be high across all groups, yet for single mothers, it was as high as 57.0% in 2023 compared with 21.4% for cohabiting parents. Regarding making ends meet, the highest rate among single mothers was 29.0% and single fathers was 17.1% in 2023.

Indebtedness

Indebtedness and over-indebtedness are growing challenges in the Swedish household economy (59-61). More than a decade ago, in 2010, the total amount of individual private debt amounted to 65 billion SEK, spread across 423,721 debtors (62). By 2024, the individual private debt had increased to 138 billion SEK, yet the number of debtors did not show a vast increase, being 436,996. A gendered aspect of Swedish indebtedness can be noted. In 2021, 34.0% females and 66.0% males had registered debts with the Swedish Enforcement Authority (63). This has remained stable, and for the following three years, the debt allocation was 33.0% females and 67.0% males (64-66). The proportion of children growing up in households where at least one parent is indebted is increasing, from 7.9% in 2022 to 8.8% in 2025 (67). A governmental report from 2013 explored the Swedish indebtedness (68), which showed that out of the registered indebted persons at the Swedish Enforcement Authority were 64.0% single-parents with children. When studying all single-parent households in Sweden, 12.0% had registered debts at the Swedish Enforcement Authority in 2013 (68).

The Family Stress Model

One aspect to consider when thinking about the impact of economic hardship on child health and well-being is the role of parental stress. The Family Stress Model of economic hardship aims to explain how socioeconomic status and related stress can influence parental behaviours, family relational health and child outcomes (69-71). The framework builds upon previous work on how stress caused by demographic characteristics can influence parental psychological function and behaviour (72-79). The model took the form of the Family Stress Model in 1994 (71), but was not referred by that name until 1999 (69). The model exemplified the mechanisms of how economic hardship (e.g., drastic loss of income) leads to economic pressure (e.g., not making ends meet), which in turn leads to psychological hardship in managing the day-to-day tasks, see Figure 14. In everyday life, these hardships can affect the contentment and solidity within romantic relationships, the quality of parent-child interrelations and various health and development outcomes among both children and adults (69).

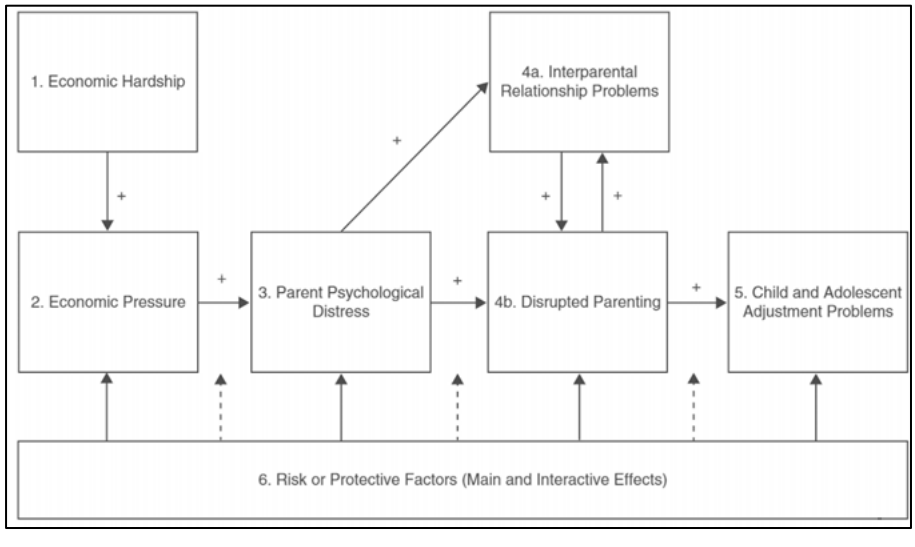

Figure 14. The Family Stress Model (Masarik & Conger 2017). Reprinted with the permission of Associate Professor April Masarik, Boise State University, US.

Since its introduction has the model provided a theoretical perspective on the relationship between economic hardship, family relational processes and family health and well-being. In recent research, the model has been used when studying economic hardship and stress, for example, in exploring the negative family stress of the COVID-19 pandemic (80, 81), how the model can be

applied to food insecurity (82) and the dual risk of children with negative emotionality and exposure to negative family relational processes due to economic hardship (83).

Prevention

The idea of prevention is central in the welfare state, often an established goal of social policy and public health (84). Prevention has been described as a combination of prediction and intervention, the goal to foresee an upcoming problem and act in advance. Previous research has shown that not all determinants of health are static, indicating modifiable factors relevant for different approaches and levels of prevention.

The levels of prevention

There are a variety of theories and frameworks describing prevention, often targeting different risk groups or different population levels. The approach of tiered prevention, with its three categorisations, is central to this doctoral thesis, see Figure 15 (85, 86). The first level, universal prevention, aims to reinforce protective factors of the general population to reduce the risk of negative outcomes. Selective prevention addresses populations with identified characteristics and factors that constitute certain risks, and offers support before problems arise. Indicated prevention offers early interventions to target groups with early signs of problems, to prevent negative escalation.

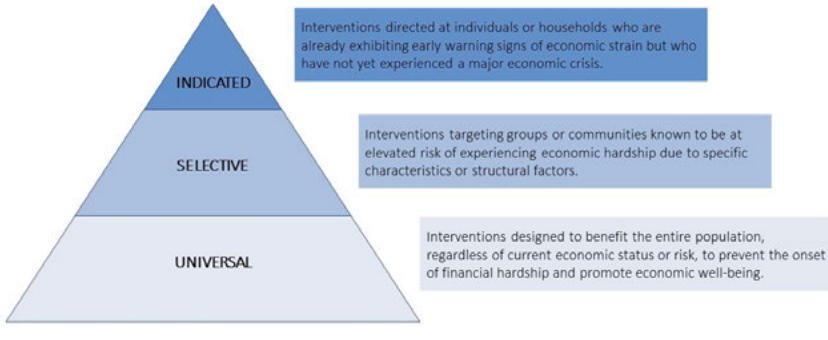

Figure 15. Levels of prevention based on (85, 86), with examples of preventive financial counselling

The Swedish setting

Sweden, with its 410,000 km^2 land area and 10.5 million inhabitants, is a large country with low population density (87). Sweden is geographically and politically divided into 21 regions and 290 municipalities, with certain levels of autonomy and mandate to control taxation (88). The regions have the main responsibility for the health care management, while the municipalities have the main responsibility for the social services (89). In this doctoral project, I have used the term 'site' when referring to an area within a municipality that holds a Child Health Care Centre within the public Child Health Service (CHS) and a financial counselling service called Budget and Debt Counselling (BDC).

Child Health Services

Responsibility of the Swedish health care services is shared between the state, the regional government and the municipal government (88, 90, 91). The Swedish Riksdag, the Government and the national authorities rule on statutes and legislations that set the legal framework of the health care (90, 92, 93), decide upon budgets and targeted subsidies, and set the direction for the future health care services (94). National authorities such as the National Board of Health and Welfare, the Public Health Agency of Sweden, the Health and Social Care Inspectorate and the Dental and Pharmaceutical Benefits Agency all have different obligations in the Swedish Health Care System. Exemplified, the authorities provide knowledge support and statistics for the state and other interest-holders, as well as performing evaluations and licensing procedures of the services. The regions have the main responsibility for the health care within their region by treating illness and injuries, as well as working with health promotion and prevention. The municipalities are responsible for the health care provided for special needs citizens, e.g., those granted specified forms of accommodation, daily care and rehabilitation (94).

CHS are a core part of the primary health care in Sweden. In 1937, the government agreed upon a freely available, voluntary and universal maternal and child care (95). Over the years, Swedish health care has shifted from control and monitoring to a more partnership-based approach between health care personnel and parents, to promote and support the health of the children and their families (95). The current national guidance and national child health program that guides the health services was implemented in 2014 (96). The guidance constructs the framework for the CHS, while the national child health program presents concrete directions on how to conduct the work.

The national CHS program offers free health visits to children under the age of six years (96). The program is delivered by specialist trained nurses and consists of different levels of intervention. The universal intervention includes approximately 16 visits, where the first 12 visits take place during the child's first 12 months. Through both clinical and home visits, CHS monitors children's growth and development and performs vaccinations. In addition, the services provide health promotional interventions for child safety, dietary habits, physical activity, and support the parent-child bonding and interaction. Attending the CHS program is voluntary, and the individual parent is free to choose their health care service unit (96). In 2020, there were approximately 950 CHS centres in Sweden, not including branches (97). A CHS centre can be part of a joint centre, called Family Centres. A Family Centre refers to the co-location of maternal health care, child health care, open preschools, and social services with preventive services. Other community actors could also be included.

Budget and Debt Counselling

Sweden's municipalities are legally bound, by the Ministry of Health and Social Affairs' legislation, the Social Service Act (98), to offer BDC to their citizens (98). By the legislation, guidance and support should be offered to those in need of finding long-term solutions to their economic hardship and to those with an approved debt restructuring program, until the program is terminated. BDC is a freely available service where the counsellors are sworn to professional secrecy, and it is up to every individual to decide upon the work of the counselling sessions. Responsibility for the service is today shared between the local government and the Swedish Consumer Agency (SCA). The SCA was founded in 1973 and is an authority responsible for issues related to purchases of goods and services, aiming to contribute to a securer market with available information for both consumers and businesses (99). The SCA has been responsible for the BDC services since 2007 (100, 101). Due to the certain level of municipal autonomy (91), it is up to the individual municipality to decide upon any local guidelines for their BDC service (102).

The Social Service Act (98), the Debt Relief Act (103), the SCA general recommendations (101), the Professional Association for Budget and Debt Counselling in Municipal Service (104) and any local guidelines (102) are what dictate the BDC services. As a result, the offered financial counselling may differ between municipalities, and between different counsellors (105). Since the BDC service in itself is not an exercise of public authority, it does not involve formal, legally binding decisions.

Commissioned by the Swedish Government, the Swedish Agency for Public Management explored and evaluated the work of the BDC services (105). The report revealed that prevention within the BDC services is a disputed topic. The municipalities and counsellors expressed varied viewpoints on preventive financial counselling; on the one hand, a grand part of the counsellors acknowledged the relevance of prevention, while on the other hand, there were expressions of ambiguity on which specific preventive measures to implement. In addition, there was also a perceived lack of support (105). In 2016 and 2017, the SCA issued general guidance and recommendations (106, 107), where preventive financial counselling was encouraged yet not explicitly described. In 2024, the SCA revised and reduced its national support to a set of recommendations, solely referring to prevention in terms of preventing problematic indebtedness (101). However, in 2025 an updated version of the Swedish Social Service Act was released, with an increased focus on prevention (98)

Research on the topic of Swedish BDC is a growing field (61, 100, 105, 108-120). In a Swedish interview study from early 2000 with counsellors from seven BDC services in a mid-Sweden region, the findings reported that a vast majority of the interviewed counsellors perceived a lack of support from the municipal work management team and vastly different levels of dedicated resources for the service across the sample (119). Local variations and a lack of national standards in the services were a prevalent issue, but the scholars noted work efforts being done to improve the field (112). The same year, a governmental report brought forward the ambiguities regarding the responsibility of the BDC services between the SCA, the National Board of Health and the Swedish Enforcement Authority (114). The auditors requested a more overarching responsibility from the SCA, a request that was echoed 24 years later in the report authored by the Swedish Agency for Public Management (105).

Mirrored research findings between the early 2000 and today are the identification of the different work traditions and perceptions of the role within the BDC field (116, 119). The authors of the papers argued that, as a result of the shared authority and responsibility, Swedish BDC generally consisted of two traditions: aligned with the scope of the SCA, educating in household finances and consumer behaviour; and aligned with the scope of the National Board of Health, the social service work of preventing problematic indebtedness (119). A more recent research report on the counsellors construction of guiding principles, and action drivers, found similar results; the counsellors themselves either argued that the BDC role was to aim for cliental agency, focusing on

promoting autonomy and self-determination regarding personal finances or; the counselling role was said to be guided by solely practical support and counsel on financial change (116).

Preventive financial counselling

To address economic stability as a determinant of health, financial counselling plays an important role (121) in terms of education (122). increasing knowledge and literacy (123-125) and to improve financial health and well-being (126). By applying the tiered prevention model to Swedish BDC (see Figure 15), universal prevention can take the form of interventions promoting economic well-being and financial knowledge, aimed at the whole population. Selective prevention within Swedish BDC can be identified in interventions towards identified risk groups of experiencing economic hardship, while indicated prevention can be defined as the work targeting groups that display hardship with a notable risk of worsening.

The Healthier Wealthier Families model

This doctoral project focuses on Healthier Wealthier Families (HWF), a preventive working model that implements routine screening for economic hardship at primary health care settings and, if hardship is indicated, the screening professional offers a referral to freely available counselling services.

The HWF model has previously been implemented in Scotland (127) and Australia (128). In Sweden, the routine screening for economic hardship takes place at CHS centres, by nurses and/or other health personnel working at the service. If the parent(s) agrees to the screening, five questions are posed:

I. During the last 12 months, have you been worried that your family will run out of money at the end of the month?
II. During the last 12 months, have you been able to pay current expenses, such as rent, bills, insurance?
III. During the last 12 months, have you been able to buy necessary items, such as clothes and food for yourself and your children?
IV. Is there at least one person in your household who currently has a paid job?
V. Would you be able to handle an unexpected expense of 20,000 SEK without asking for help or borrowing money?

The respondent is considered to have a risk factor for economic hardship if they answer 'yes' to question one and/or 'no' to questions two to five. Only one risk factor is required to process a referral. If any risk factors are indicated, the CHS personnel pose a sixth question:

> VI. Have you used a financial counselling service within the last month? (By that we mean if you have had a scheduled meeting with a financial counsellor to get help with your economy)

The screening questions were based on the form used by the Australian HWF team (128) but adapted together with an Advisory Panel to better fit the Swedish context. Further details on the Advisory Panel and their role in the project can be found in the 'Interest-holder engagement in the research process' section of the thesis. The adaptation of the questions largely entailed consideration of Swedish phrasings. CHS nurses on the Advisory Panel conveyed insecurities regarding introducing the topic of finances in a health care setting, and anticipated stigma among parents regarding economic hardship. So, a brief introductory text was also drafted together with the Advisory Panel, and shared with CHS personnel to inform the parent(s) about the screening:

> *"We are helping to conduct a new research study together with Uppsala University's research team CHAP, Child Health and Parenting. The study focuses on a working model for asking questions about finances to families who visit the centre, and offering financial counselling to families in need of support. The model is called "Healthier Wealthier Families".*
>
> *We know that family life can be expensive. As a parent, it can sometimes be difficult to afford the various things your family needs. Healthier Wealthier Families is a model that provides parents with support in planning their finances for the early years and beyond. Would you like to answer five questions about your family's finances?"*

The Advisory Panel noted several routine CHS visits during which the screening questions could be integrated, but advised that CHS personnel should be given some freedom in selecting when they introduce them. The personnel should be encouraged to reflect on this at the start of implementing the model. Another piece of preparatory work considered important by the Advisory Panel was for all involved professionals – from the CHS and BDC - to meet and for there to be a discussion about how economic hardship can happen to anyone, and that stigma might hinder families from expressing hardship and seeking help.

For the purpose of the research project, the screening process involved CHS personnel sharing contact details for parents who indicated risk of economic hardship with me, as the researcher managing data collection. Then, once the necessary research processes had taken place, I passed the details on to the local BDC service. This referral pathway varied across sites, depending on the preferences of the local teams, and could include scheduled telephone check-ins, either every week or every other week, and/or online forms.

Once a parent has been referred to the BDC service, a counsellor then makes contact with the parent at their earliest convenience, but not longer than within four weeks. Counsellors at BDC can be of assistance in various economic matters, ranging from budgeting, managing money, applying for benefits, to managing debts. To support the standardisation of the financial counselling received by parents, the BDC personnel involved in HWF in Sweden were provided with a 'topic guide'. The guide outlined the following subjects that should be covered during the counselling, ideally across three sessions:

I. *Why has the client sought counselling?*
II. *What is their goal(s)?*
III. *Managing money*
IV. *Income sources*
V. *Economic plan*

As outlined in the HWF logic model (Figure 16), the anticipated outputs from initiating the model were that families with young children, in areas with high proportions of relative poverty, are routinely screened for economic hardship. If hardship is identified and the parent(s) are interested in support, a referral to financial counselling is performed. The families attend the BDC service, and the BDC counsellors perform preventive financial counselling according to the topic guide provided. These outputs were considered fundamental to the HWF model achieving the theorised outcomes.

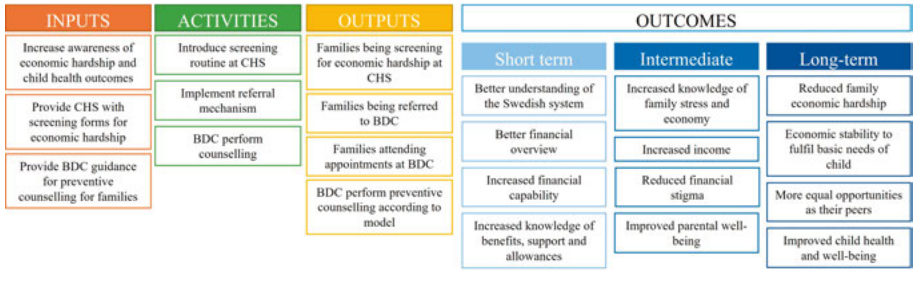

Figure 16. The Healthier Wealthier Families Sweden logic model

The logic model presents the linkages of the resources, activities, outputs and outcomes in the HWF model in Sweden. It shows how and why the HWF model theoretically addresses the issue of economic hardship among families with young children, and how the chosen measurements and evaluations will assess the work (129). As seen in Figure 16, the anticipated short-term outcomes, the beneficial effects being most closely related to the HWF model output, included a better understanding of the Swedish system, a better financial overview, strengthened financial capability, and increased knowledge of benefits, supports and allowances. To understand the Swedish system entails all participants, where the aim was for CHS nurses to gain awareness of the work being carried out by the BDC (105), and for the BDC to get a better understanding of how psychosocial factors are included within CHS (95). Meeting with a financial counsellor can help participants enhance their knowledge of the Swedish system. This includes gaining knowledge about available benefits and monetary aid, as well as exploring their eligibility for these resources. Individuals facing hardship have found this process challenging (130), making such meetings valuable. Increased financial capability among parents through knowledge and control can be derived from simply taking the first step of admitting to hardship, getting informed about available help and accepting support. By the testaments of financial counsellors, this is often a difficult but important hurdle for clients to overcome (100). That the counsellors and participants meet and, together, draw up a budget can support the participant to gain a better overview of their financial situation and lay out practical positive strategies going forward (131).

The anticipated outcomes on an intermediate time horizon, the outcomes that derive from applying the short-term outcomes (129), focus on increased knowledge, monetary gains, reduced stigma and improved parental well-being. Predicted results from the application of the HWF model within CHS and BDC were to increase the knowledge of the relationship between economic pressure and family stress (69). The foreseen outcome of parents meeting with a counsellor and receiving guidance on how to manage their finances was to reduce the sense of internal stigma (132), often being linked to economic hardship among families with children (133). The gain of knowledge regarding the Swedish system and the possibility of obtaining financial benefits and support could increase the income and reduce the perception of external stigma (132). By addressing economic hardship, the economic pressure in the household can be reduced, which in turn can improve parental well-being (71).

It was predicted that the long-term outcomes, following the positive changes of the intermediate results (129), would be economic stability and improved outcomes for the child. An increased income would be able to secure a sense of economic stability within the family, and to fulfil the basic needs of the child. This can be expected to have a significant impact on children's environment and on their development (134), improving alignment with 'non-poor' peers (28). Moreover, the reduced economic pressure and improved parental well-being would translate to improved child health and well-being in the long term (71).

Previous international research on the model

The first introduction of the model was the Healthier Wealthier Children (HWC) project, in the National Health Service (NHS) of Greater Glasgow and Clyde, Scotland, in 2010 (127). The aim was to develop a partnership between primary care services and money/welfare counselling services, to provide help to pre-birth parents and families with young children at risk of, or living in, poverty. Early years staff, such as midwives and health visitors, posed financial enquiries to visiting parents. The referral criteria focused on geographical setting, family composition, screening outcome and special needs. A family was eligible if they were pregnant or had children under five years old, had an annual household income below £40,000 (460,373 SEK), and were a family with extra support needs for their children up to the age of 19 years. Eligible and consented participants were referred to the money/welfare counselling service by NHS staff. The local counselling service established contact and offered counselling, which could include support in applying for benefits such as working tax credits or child-related benefits, as well as matters regarding debt, including reducing payments, shifting to social tariffs or the possibility of having the debts written off. The counsellors could also provide help in applying for one-time payments, such as Social Fund awards (127).

How the project impacted the participating workforce was surveyed in a random sample of 230 midwives and 170 health visitors within the NHS (135). Unfortunately, the survey response rate was low at 36.0%. The findings showed that the majority, 80.0%, had awareness of the ongoing HWC project. When asked to rank objectives in order of importance in everyday work, breastfeeding (56.0%) and parenting (62.0%) were the top priorities. Income inequalities and financial poverty were included as priorities, where 23.0% of the health visitors ranked income inequality as the same priority level as child weight, and at a higher priority level than child oral health. When asked if they routinely had financial conversations with parents, 87.0% reported that they

did. The reports showed that the HWC referrals changed attitudes regarding including financial inquiries in their day-to-day work for 48.0% of the health visitors and 35.0% of the midwives. It was argued by the respondents that the HWC project enabled the introduction, and/or extension, of financial inquiries and discussions with patients (135).

Over the project period, from late 2010 to early 2012, 2,516 referrals to HWC advice services were conducted. The most common professions to make referrals were health visitors (51.0%) and midwives (29.0%) (127). Out of the 2,516 referrals, 54.0% of parents accessed the advice service in some form. Of the persons accessing advice, 77.0% were categorised as low-income groups and 59,0% were single-parents. Almost half of the people seeking advice were entitled to financial gains, and among the participants entitled to gains, one in five families would receive disability allowance payments. The total amount of participant financial gain amounted to £2,2 million (25.9 million SEK), with an average client gain of £3,404 (39,179 SEK). Other than financial gain, the advice service supported clients with childcare and housing, applications for charity, finding cheaper consumption alternatives and increasing the uptake of health vouchers. Further referral from the advice service was made for 8.0% of the clients, most commonly in the matter of financial aid, immigration, social work and voluntary organisations. In follow-up interviews, participants who had accessed the advice service reported a sense of reduced stress, increased well-being, strengthened self-worth and a feeling of safety. Some also noted improved family relations (127).

An Australian adaptation of the HWC model, named Healthier Wealthier Families (HWF), was introduced in 2020 (128). Despite economic hardship being acknowledged as an adverse experience in the early family years, there was an identified lack of routine screening and active handling of identified cases. The Australian HWF project aimed to create a referral pathway between two freely available universal community-based services to ameliorate childhood adversities caused by poverty. The pathway was set up between the universal Child and Family Health (CFH) services and the financial counselling services. The Australian CFH services work towards families with children below five years old, and the financial counselling is a service provided for low-income citizens and offers guidance in income maximisation, debt management and budgeting. The feasibility of implementing and evaluating the Australian HWF model was tested through a pilot randomised controlled trial (RCT), which ran from March 2020 to November 2021 across four sites in Australia (128).

The pilot RCT used a five-item screening form for economic hardship at CFH services to identify eligible parents (133). The intervention group was offered a referral pathway to financial counselling, while the control group was offered information available online at a governmental website. The pilot study coincided with the COVID-19 pandemic and faced several challenges and limitations, one being poor recruitment rates, which resulted in a small sample size. The results showed that 355 (81.8%) of 434 approached parents completed the screening. Out of the 355 parents completing the screening, 79 (22.2%) reported a hardship. The number of eligible parents who enrolled in the study was low at 13, with one site only recruiting one person to the study. As a result, a study limitation was the lack of a viable control group (133). Due to the hindered study progress, qualitative interviews were conducted with the participating professionals to identify trial obstacles. The interviews revealed several reasons for the challenges. Besides the implications of the COVID-19 pandemic, stigma, limited knowledge of financial counselling, lack of financial literacy, and research burden were all raised as potential issues.

In 2024, a London-based team received funding to conduct an evaluation of the HWF model in the English context. At the time of writing this thesis, the project was underway, but with no published findings to report.

Evaluating complex interventions

As presented above, the implementation of complex interventions like the HWF model can present obstacles connected to some, or several, of the intervention components. The Medical Research Council (MRC) developed guidance in 2000, revised in 2006 and in 2021, to support researchers in developing and evaluating complex interventions (136-138). The guidance aimed to function as a framework to guide researchers to not solely try to answer the question of whether the intervention works as planned, yet also take the broader questions into account. The framework encourages researchers to identify, consider and refine the core elements of an intervention: the context, the programme theory, the engagement of interest-holders, potential uncertainties and the usage of financial resources (138).

Rationale for this thesis

Historically, Sweden has been a frontrunner in terms of equity, equality and a universal welfare service that supports citizens in need. Yet over the last decades, the development has shifted, and today there is an increasing need to address economic stability as a social determinant of health among families with young children. Universal welfare services, freely available to all citizens, are in a position to identify and prevent economic hardship. However, there are challenges and obstacles. Swedish CHS services have a long tradition of working towards all families, and reach almost all families with children aged 0-5 years. But despite handling a lot of difficult questions affecting health, economic hardship is not one of them. The BDC service is legislated to be available to all clients in debt, in all 290 municipalities. Though, the service has little governmental guidance on how to structure the work, and by what measures to evaluate and review the work. This results in a service that differs a lot between areas, and it is unclear to what extent preventive financial counselling is taking place, and what preventive counselling entails. HWF is a working model that has the potential to address these shortcomings; it provides an opportunity to introduce screening for economic hardship at CHS services and standardise preventive financial counselling for parents of young children. However, when introducing a complex intervention, such as the HWF model, feasibility needs to be assessed.

Aims

Overall aim

The overall aim of this thesis was to explore the feasibility of screening and preventive financial counselling for families with young children in Sweden.

Specific aims

The specific aims of the included studies were:

I. To explore interest-holders' perceptions and experiences of the HWF model in Sweden
II. To assess the feasibility of conducting an RCT of the HWF model
III. To investigate if preventive counselling is being enacted in Swedish BDC services, and the counsellors' working conditions to do so
IV. To explore how prevention is conceptualised within the Swedish BDC services, with a focus on how counsellor perceptions align with guidance documentation

Study design and methodology

Overview of studies

The starting point of this doctoral project was the HWF model, and the importance of assessing the feasibility of screening and financial counselling to support families with young children living in or at risk of economic hardship in Sweden. As outlined in the MRC framework for developing and evaluating complex interventions (138), assessing feasibility is an important phase in complex intervention research. To explore this, Study I assessed interest-holders' perceptions and experiences of the HWF model, after some adaptations for the Swedish context. The work process and research findings of Study I informed Study II, a pilot RCT of the HWF model. Specifically, Study I highlighted the importance of addressing preconceptions within working roles and operating with an awareness of financial stigma and parental stress related to financial matters. When scaling the HWF model to further sites in Study II, it became apparent that the structure and organisation of the BDC services could vary across municipalities and, by that, the allocation of time and resources would also differ. How prevention was defined and carried out also appeared to be differentiated across the participating sites in Studies I and II. In line with the MRC framework, this informed the need for further investigations of the context in which the HWF model operates (138). Study III was developed as a survey study, distributed to all counsellors within Swedish BDC services, to explore the everyday BDC service and the working conditions to enact preventive financial counselling. The findings presented a service being carried out primarily to clients in acute need of support, and that the counsellors wished to have met with the client in an earlier stage. The responses of prevention being important were common, yet several obstacles to this happening were laid out. A Study III finding that evoked a curiosity for further research was the relatively low number of counsellors reporting awareness of local guidelines. It was unclear whether this was due to low awareness or due to low prevalence of local guidelines, which came to inform the work of Study IV. Another key finding that informed Study IV was that prioritising preventive work was mainly up to the individual counsellor or counsellors' office, and that the lack of an adequate regulatory framework was hindering the work. To understand more about preventive financial counselling within Swedish

BDC services, Study IV aimed to explore how prevention is conceptualised within the services, with a focus on how counsellor perceptions align with national and local guidance documentation.

Table 2. Overview of included studies.

	Study I	Study II	Study III	Study IV
Aim	To explore interest holders' perceptions and experiences of the HWF model in Sweden	To assess the feasibility of conducting an RCT of the HWF model	To investigate if preventive counselling is being enacted in Swedish BDC services, and the counsellors' working conditions to do so	To explore how prevention is conceptualised within the Swedish BDC services, with a focus on how counsellor perceptions align with guidance documentation
Sample	19 parents of children 0-5 years 7 CHS nurses 5 counsellors in BDC	20 parents of children 0-5 years	316 counsellors in BDC	124 counsellors in BDC (Derived from the same sample as Study II)
Design	Qualitative interview study	Pilot RCT	Survey study	Multi-method study
Data	Transcripts from semi-structured interviews	Screening survey Trial management records Fidelity checklists	Survey	Survey Guidance documents
Analysis	Thematic analysis	Explanatory and descriptive analysis Inductive content analysis	Descriptive analysis and deductive content analysis	Deductive content analysis

Study I

Aim

The aim of Study I was to explore interest-holders' perceptions and experiences of the HWF model in Sweden

Methods

In this study, 31 qualitative semi-structured interviews were conducted with three interest-holder groups to explore the perceptions and experiences of the HWF model in Sweden. The development of the interview guide was guided by the model of Steckler and Linnan (139), for process evaluation of public health interventions and research.

The first interest-holder group consisted of seven CHS nurses, partaking in the study by screening families for economic hardship and referring eligible parents to financial counselling at BDC. The second group was counsellors at BDC, receiving referrals of eligible parents from CHS and performing counselling. The third group was 19 eligible parents, i.e., parents with at least one child under the age of five and at least one screened risk factor for economic hardship. Out of the 19 parents, nine accepted the referral and received financial counselling, while ten declined financial counselling.

The interviews were conducted through telephone and video-teleconference calls from April to September 2021. They were recorded digitally, transcribed verbatim and had a duration of 15-60 minutes. While the majority of the interviews were conducted in Swedish, seven of the parental interviews were conducted through interpreters in Arabic and Tigrinya. A quality check of the translations was conducted for a sample of the interview transcripts.

An iterative, inductive and reflexive thematic analysis was performed (140). The analysis process commenced with familiarising with the material, generating codes and searching for themes. In the following steps, the themes were reviewed and defined.

Results

Three main themes, with three to four sub-themes, emerged from the analysis. See Table 3.

Table 3. Themes and sub-themes

Main themes	Sub-themes
'Talking about finances is so taboo!' Or is it?	The anticipated obstacle of the topic The personal relationship – to cherish and build upon The norm and the façade – friend or foe
Financial well-being is family well-being	How to work a wicked problem Being a parent in society today Economic hardship and the child focus
The how, who and why of working preventively	Who is it really for? Constraints of time and resources Experiencing financial counselling Expectations and conditions – to lead or to get in the way

The results brought forward the sense of stigma associated with economic hardship, and the identified obstacles it creates, together with possible facilitators to overcome stigma. The second theme was related to the well-being aspect of economic hardship, focusing on the different aspects of a family. The third theme focused on the obstacles and facilitators of prevention.

Conclusion

Economic hardship can have negative effects on the health and well-being of families. It can be complex to address these issues through societal services such as CHS and BDC. Working models like HWF need to address the preconceptions within working roles, the prevalence of financial stigma, and the parental stress related to financial matters.

Study II

Aim

The aim of Study II was to assess the feasibility of conducting an RCT of the HWF model, with the objectives to determine the screening and conversion rates, observe the implementation of BDC, assess the feasibility of the outcome measures and assess the feasibility of the randomisation process.

Method

This study was a two-arm randomised waitlist-control superiority trial with a one-to-one allocation ratio. The randomisation process was performed through the web-based software application 'sealedenvelope', where separate lists were set up for the seven participating CHS services. As in Study I, the target population was parents with at least one child aged from newborn to five years, with a screened risk factor for economic hardship. The intervention arm was referred to BDC counselling after randomisation, while the waitlist-control arm was referred 3 months later. Assessments were conducted at two time points: pre-intervention (T1) and post-intervention (T2; 3 months post-randomisation).

Data collection of the trial outcomes was conducted through an online survey, available in Swedish, English, Arabic, Tigrinya, Dari or Somali. Data analysis was descriptive and explanatory due to the small sample size. Assessment of the pilot study outcomes, such as the site recruitment process, was done through field notes. Screening and conversion rates were collected through trial management records. Parents who actively declined study participation at the CHS, were asked to motivated their answers, which was noted in the trial management records.

To make recommendations for future trials, the framework 'A process for Decision-making after Pilot and feasibility Trials' (ADePT) was used (141). The ADePT framework categorises potential issues into three types: types A, B and C. Type A issues are expected problems for a trial, type B are problems

both for a trial and the real-world, and type C issues pose problems only for the real-world. The motivations for declining were analysed using inductive content analysis (142)

Results

Site recruitment

The feasibility of site recruitment was low. Out of 18 approached regions, 8 expressed initial interest in participation. Within those 8 regions, CHS and BDC services were approached across 40 municipalities. The field notes of the recruitment process showed a difficulty in aligning interest across the different services, in addition to the varied levels of capacity and resources to take on a research trial commitment. In the end, 7 sites across 5 regions participated in the study.

Participant recruitment

The number of parents that were approached about screening for economic hardship was 388, out of which 94.8% consented. The screening and conversion rates are displayed in Figure 17.

The ADePT framework

The ADePT framework identified five feasibility issues, two ‘type A’ problems, related to the trial, and three ‘type B’ problems, related to the context. The first ‘type A’ problem focused on the issue of setting up agreements to share data between the study sites and the research team, displaying different interpretations of the GDPR regulation. The second 'type A' problem identified the challenge of measuring economic outcomes. The identified ‘type B’ problems showed issues aligning service engagement, a low number of individuals being screened and a low participant recruitment.

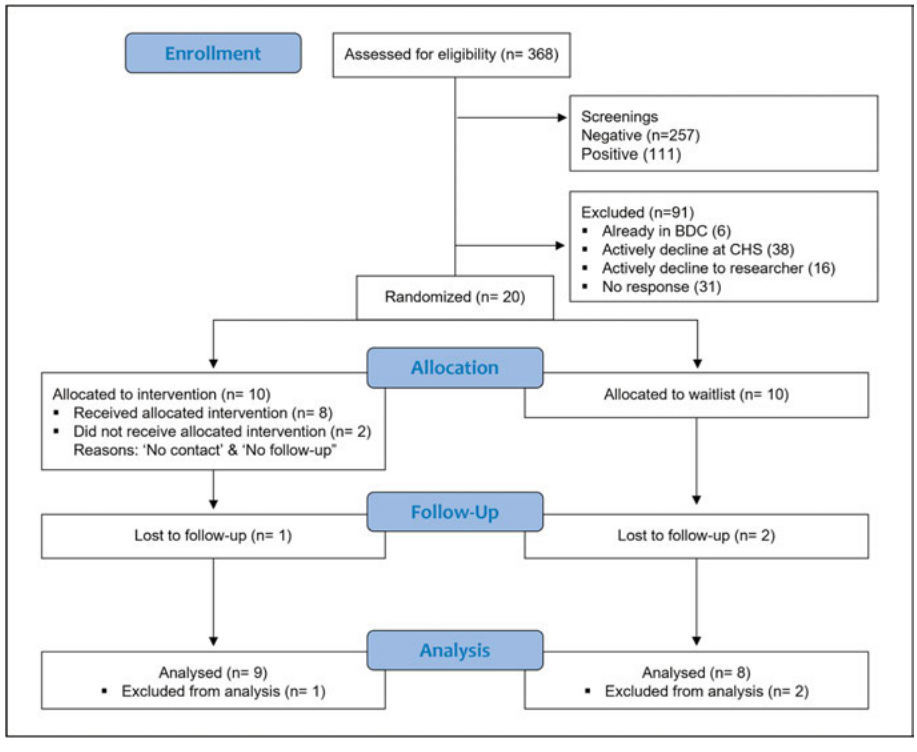

Figure 17. Consort flow diagram

A majority (92.1%) of the 38 parents who actively declined participation at CHS presented a reason for their decision, see Table 4.

Table 4. Reasons given for declining participation in the study

Theme	Category	Sub-category	Stated examples
Thank you, but no thank you	External factors	A network to fall back on	The person has no need or interest. The eldest son has a job and helps out when needed.
		Just worrying times	We're not really that worried, just a bit concerned right now, but nothing serious.
		Know-how is not the problem	Parents consider themselves to be financially literate and able to manage the situation.
	Internal factors	Mind your own business	The father was annoyed: 'That's our business'.
		Too much stuff, too little time	Being a single mother of four, while studying. There is no time.

Conclusions

The findings presented strengths and limitations in the trial design and in the intervention setting, yet it was considered that a large-scale RCT was not feasible. The pilot trial findings presented a strength in that the screening outcome was as anticipated, yet limitations in conversion rates. The BDC adherence to the fidelity protocol could be improved, and additional implementation support was identified as potentially beneficial. The primary outcome showed a floor effect, indicating a need to reconsider which outcome measurement should be used in future evaluations.

Study III

Aim

The aim of Study III was to investigate if preventive counselling is being enacted in Swedish BDC services, and the counsellors' working conditions to do so.

Method

A web-based survey was distributed to all counsellors within the Swedish BDC. The survey consisted of closed questions and four open-ended questions, to allow the respondents to elaborate on their thoughts. The quantitative findings were summarised using descriptive statistics, and the answers to the open-ended questions were qualitatively analysed through deductive content analysis (143) using Lipsky's theory of Street Level Bureaucracy (144, 145).

Results

Quantitative findings

The respondents' awareness of existing guiding documentation was high, where 92.6% and 94.7% reported awareness of the SCA guidance and the SCA recommendations, respectively. However, the awareness of any local guidelines was lower at 47.2%. Of the respondents who knew of existing guidelines, a moderate proportion reported a high level of focus on prevention. In the questions of day-to-day work, a majority of the respondents reported meeting clients with acute support needs, in a later stage than the counsellors would have wished for. There was also a high rate of respondents stating that preventive counselling is considered important, yet the enactment of preventive work was often hindered by obstacles in everyday working-life, where time, staff capacity and leadership were the three most commonly stated obstacles.

Qualitative findings

By applying Lipsky's four categories of Street Level Bureaucracy to the BDC working conditions, the findings presented problems of resources, exemplified in the quote:

> "We want to [work preventively], we know how to do it, but we have no resources. We are only putting out fires!"

In Lipsky's second category, Goals and Performance Measures, the findings can be exemplified in the quote:

> "There is an urgent need for knowledge review and method development that builds a basis for training for BDC. Some municipalities have come further than others, while some work according to the same model from 1994! It is scattered, to say the least."

The Street Level Bureaucracy in the client-counsellor relationship was identified in the findings through quotes like:

> "I wish I didn't belong to the Social Work Office, and it would be better for the residents if the visiting room was not situated there. It is a tense environment, exposed to threats at times."

The fourth and final category of Lipsky's theory focuses on the advocacy within the counselling role:

> "I want to work more with a focus on finances and not on the other social difficulties clients often have and which are difficult to find help for."

> "I would like to see more prevention. For example, how can they [the clients] change their lifestyles to improve their finances and at the same time perhaps promote well-being."

Conclusions

This study concluded that the working conditions of BDC counsellors align with the theorisation of Street Level Bureaucracy. The findings showed challenges in applying the national policies and mission. From the basis of our findings, we saw that prioritising preventive work was often an individual task for the counsellors.

Study IV

Aim

Study IV aimed to explore how prevention is conceptualised within the Swedish BDC services, with a focus on how counsellor perceptions align with guidance documentation.

Method

This study had a convergent, qualitative multi-method design. Using content analysis, we examined two sources of data: open-ended survey responses derived from the survey data of Study III, and guidance documentation derived from national and local authorities and actors. Out of the sample of 316 respondents answering the full survey, 124 provided an answer to at least one of the four open-ended questions. The theoretical framework used in the analysis was the tiered model of prevention (85, 86), ranging from universal to selective to indicated approaches. The guidance documentation used in this study came from the responsible authority SCA, the professional BDC organisation and a sample of municipalities. The deductive content analysis (143), and the alignment between the counsellors' responses and the guidance documentation.

Results

The 124 open-ended responses were analysed together with 56 local guidance documents and six national guidance documents. The integrated findings displayed a common understanding of the concept of prevention, exemplified in Table 5. Yet, the findings showed differing emphasis on the various levels.

Table 5. Joint display of survey and document analysis, organised by the deductive categories of universal, selective and indicated prevention and inductive sub-categories

	Survey	Documents
Universal	Promote service visibility Hold lectures Collaborate to reach out	Promote service visibility Hold lectures Increase knowledge and resilience
Selective	Target at-risk groups Collaborate to reach at-risk populations	Target at-risk groups Collaborate to reach at-risk populations Budget counselling for various life situations
Indicated	Avoid worsening	Avoid worsening

Conclusions

The conclusions from Study IV highlight the need for clear and practical guidance in both universal and selective prevention within the Swedish BDC. The findings indicate that professionals require support in translating policy into actionable steps within their services.

Methodological considerations

Reflections on the study designs

Different methods have been used in this doctoral project to study the feasibility of screening and preventive financial counselling to support families with young children exposed to economic hardship. The different methods, both qualitative and quantitative, have allowed the project to explore the challenges of addressing economic hardship in a Swedish context. I consider the different methods and approaches of this project as a strength, yet there are several methodological considerations to take into account.

Trustworthiness of the qualitative components of the research

All four studies contained elements of a qualitative study design. The data collection of Study I consisted of semi-structured interviews, analysed through inductive thematic analysis (140). In Study II, the possibility to share the reasons for declining participation was offered to all participants, and the responses were analysed through inductive content analysis (142). Similar to Study II, the primary data collection of Study III was quantitative, but with an opportunity for the respondents to answer open-ended questions to elaborate on their thoughts. These findings were analysed using deductive content analysis (143). Study IV entailed a qualitative multi-method study with deductive content analysis (143). All four studies, and their findings, raise the question of the trustworthiness of qualitative methodology (146, 147). When discussing the trustworthiness of qualitative research, it is important to acknowledge the belief that reality can be constructed and is multifaceted and bound by contextual factors (147).

To elevate the level of trustworthy findings, the qualitative analysis process has included components of credibility, dependability, confirmability and transferability. One example of strategies for credibility within this doctoral project is the usage of different methods, as stated above, and the employment of several data sources. Study I included interviews with three interest holder

groups, to understand the perceptions and experiences of the HWF model from different perspectives. In Study II, the data sources consisted of screening surveys, including an open-ended question on the reason for decline, trial management records, and fidelity checklists. This provided information on different aspects of the feasibility of conducting an RCT of the HWF model. In Study III, while only survey data were utilised to understand if preventive counselling was being enacted in Swedish BDC services, and the counsellors' working conditions to do so, this included both open and closed questions. In Study IV, the data collection consisted of responses to four open-ended survey questions and the collation of guidance documentation from both the national and local levels. By triangulating the methods and data sources, my co-authors and I tried to corroborate the acquired information and strengthen the credibility of the findings.

In relation to transferability, I am aware of the contextual factors of the studies, and thoroughly reported sampling strategies to enable others to assess the transferability of the findings (146). The work was conducted in a Swedish setting, which we have acknowledged can differ across the 21 regions and 290 municipalities. The site recruitment process of Studies I and II entailed a criterion of a relative poverty level above 19.7% (148). Given the limitation of the measurement not taking into account geographical differences between the Swedish municipalities and areas, in addition to our knowledge of the differences across the Swedish setting (105), every site was approached with the official statistics and asked if they recognised this as an issue within their area. By discussing the issue of relative poverty together with the sites, the team aimed to elaborate on whether our interpretation of the context aligned with the perception of the professionals. The sample included in Studies I and II, was sites with high levels of relative poverty and a joint agreement that economic hardship is an issue for the families they encounter on a day-to-day basis. To achieve a comprehensive understanding of the perceptions of the HWF model, and promote transferability of the findings from Study I, parents who did not take part in the intervention were sampled as well as those who did. Given that Study I was limited to one geographical area in Sweden, it was considered important to recruit more geographically diverse sites for Study II. In turn, this meant that the qualitative findings of parents motivating their decline to participate would have better transferability and support our understanding of whether the HWF model was considered acceptable in different settings across Sweden. It can be argued that Study III had a high level of transferability on the basis that the findings included 316 respondents out of the, at the time estimated, 379 employed counsellors within Swedish BDC

(149). However, in Study IV, only 124 respondents provided at least one response to the four open-ended questions, presenting a limitation in the transferability of our results.

The Methodological Documentation and Audit Trails in this doctoral project have been a strategy for achieving dependability (146). The qualitative work process for all four studies has been thoroughly documented, with the development and different versions saved, to enable backtracking the interpretation of findings. In Study I, the six phases of reflexive thematic analysis (140) were documented. Code books were kept with the themes and categories exemplified with quotes. For the Study II content analysis (142) of why parents declined to take part, the methodological documentation included a paper trail of themes and categories, exemplified with quotes and motivations. Similarly, the deductive content analysis (143) based on the Street Level Bureaucracy theory (144, 145) in Study III was documented in code books. The qualitative content analysis work of Study IV (143) based on the tiered model of prevention (85, 86), was also documented in code books. The analysis process of Studies III and IV both followed the phases of preparation, organisation and reporting. All code books were made using Excel version 2018.

To strengthen the confirmability within this project, peer debriefing was a cornerstone of the analysis work (146). In addition to seeking input from the Advisory Panel, on several occasions throughout the PhD project, I presented emerging findings at seminars and conferences to gather feedback.

Randomised controlled trials as a method

In research methodology, RCTs are considered to be 'the gold standard' of certain fields (150). In Study II of this doctoral project, the pilot RCT concluded that a full-scale trial of HWF was not feasible, which brings forward some interesting discussion points. When the ADePT framework (141) was applied to identify and classify possible problems, it became evident that some were due to the trial design, discussed here in the Methodological Considerations section, and some were related to the challenges of implementing a complex intervention, discussed later in the Discussion of findings.

The trial timing

One important finding of Study II was the difficulty in timing the site recruitment (150). Resembling the research findings of previous HWF trials (133),

our trial coincided with the aftermath of the COVID-19 pandemic. As the start-up of the study took place at the beginning of 2020, my supervisors and I were aware of potential obstacles related to the pandemic. Yet, we were also considering the economic impact the pandemic had on households with children, and the possible upside to offer families support. Through the field notes from the study period, this reasoning could also be noted among the services. The approached services had different incentives to engage in a new way of work. On the one hand, some of the contacted BDC services identified a need for increased visibility for households in need of support in their household finances. Parallel with this, other BDC services experienced an overwhelming increase in clients seeking help. Similar trends could be seen among the CHS, where some identified a need to focus interest and resources to support families in hardship, while others expressed a wish and need to focus on their main mission of child health.

The trial design affecting the working model

The HWF working model would typically involve a direct contact between nurses at CHS and counsellors at BDC. However, due to the trial element of assessment between T1 and T2, and the process of randomisation, I, in the role of the researcher managing data collection, was placed in the middle. I was the person receiving the referrals from the CHS nurses, where I would provide more detailed information about the study to the potential participants and collect informed consent. I would then do the distribution and collection of the surveys and the randomisation. In the final step, I communicated the randomisation results to the participants and shared the contact information with the counsellors at BDC, who would then make contact with the parent.

When reflecting upon this process, it was beneficial from the point of view of managing and controlling the trial. Yet, in terms of building a relationship for collaboration between the two services, this process may have had a negative effect. The start-up procedure in both Study I and Study II was to schedule an on-site meeting including myself, the CHS and the BDC. That joint meeting aimed to initiate a working relationship, to go over the study material, and to address any upcoming questions. The goal was for the services to have knowledge of each other to enable collaboration after the trial ended. However, the field notes of Study II present the professionals' perception of not having a working relationship with each other, but with me in my role as responsible research contact person. The field notes showed an increased knowledge of each other. For example, some CHS nurses reported after the trial finished that they were now more likely to recommend the BDC service

to a family in distress. However, the number of nurses saying that they would assist a family in the referral process was lower. Standardising complex interventions, as was done for the referral process in this case, may not be helpful for the longer-term implementation process, and instead mechanisms should be allowed to take on different forms according to local context (151).

As also identified in earlier international HWF work in Australia (133), there were indications of the research burden being too heavy. In the field notes from Study II, some professionals argued that the assisted implementation was time efficient. As the participating professionals knew the trial was to be conducted over a limited period of time and they solely had to manage contact with me, which was arranged in a flexible manner to adhere to their schedule, the work process ran smoothly. However, for the potential trial participants, this trial design led to more persons being in contact with and several steps to go through before reaching the financial counselling support. We have seen in previous research that a high level of participant burden can affect trial processes, particularly the recruitment rate (152), which is likely to have been the case in this trial.

Waitlist-control and follow-up assessment time period

As the trial targeted families with young children in areas with high rates of relative poverty, the ethical perspective was essential when developing the trial design. The design for the control group and the follow-up timeline was discussed among the RCT Advisory Panel, where we reached an agreement on a waitlist-control design, so that all participants would eventually receive support from the BDC. While a longer follow-up period would have been beneficial from a scientific point of view, it was decided for ethical reasons that the control arm should not have to wait too long. It was reasoned that 3 months should be enough time to see a change in the outcome measures and was not too long for participants to wait. It was also suggested that all parents should be offered the financial guidance book 'Your Child & Your Money' (153). The book was considered to contain information about how to self-manage a situation of economic hardship, as well as providing information on where to turn for support and help. In case of the nurses screening someone in an acute need of support with their economic situation, it was agreed that it would be unethical to proceed with the trial process. It was therefore decided that these parents would get information on how to directly access the BDC. Lastly, it was also discussed that the BDC is a freely available public welfare service, and it was made clear that an earlier consent to the research trial would not hinder someone from accessing the service themselves.

Primary outcome measure

When considering the primary outcome measure for the pilot RCT, the Child MSD instrument was chosen by the RCT Advisory Panel due to its benefits of identifying hardship beyond current income level (55), the child-specific adaptation (56) and the possibility of comparing trial results to other EU countries thanks to the EU-SILC evaluations (154). The Study II findings did, however, show a floor effect, defined as a participant response cluster at the lowest score of a scale (155), which led to the decision that the primary outcome measure should be changed. The floor effect could be due to several possible explanations. Despite the trial targeting areas with high proportions of child households living in relative poverty, the parents screened eligible might not have experienced that level of deprivation. The Study II participant screening for economic hardship included, in addition to managing running costs, questions on financial worry, cash margin and paid employment. Although being risk factors of economic hardship, they might not have been severe enough to also experience material and social deprivation. Another possible factor is that some participants would experience deprivation, yet the prevalence of stigma prevented them from reporting this truthfully. This potential issue is supported by previous evaluations of the Swedish BDC (100, 106), which reported stigma as an issue among clients. A third possible factor could be the age of the children within the sample. The majority of the nurses opted for performing the screening process at the 8-month visit, which could indicate that the Child MSD questionnaire did not adhere to the living situation of the included parents, with several of the items referring to factors relevant to older children, e.g., invitation of friends to play and eat from time to time, participation in school trips and school events that cost money, and suitable place to do homework.

Trial contamination

A potential risk in RCT trial design was the waitlist-control arm being exposed to the intervention, known as trial contamination (156). In Study II, the nature of the BDC service, being a freely available welfare service, was identified as a risk. The risk of contamination could be that the waitlist-control arm sought counselling on their own, not awaiting the referral after 3 months. This was monitored, with a question in the T2 assessment stating: “Have you met with a counsellor with BDC within the last month?”. In retrospect, this should have asked if the participant had met with a counsellor in the last 3 months. However, the potential for contamination was also monitored at the time point for the waitlist-control arm participant to be referred to counselling. The BDC

service used the participants' social security numbers to check whether they had accessed the service previously. No contamination was identified.

Anonymous web surveys as a method

Studies III and IV used an anonymous web survey as the primary data collection method. As the target population was, at the time, all 379 BDC counsellors (149) across Sweden's 290 municipalities, the research method of web-survey was chosen to elevate the accessibility of the survey, as well as facilitate a time-efficient data collection (157). Given that the target population commonly worked in settings of solely one or two counsellors per municipality, the anonymous aspect was also chosen to encourage open and honest responses. The survey was presented at an in-person BDC event to increase the visibility of the research, availability of the researcher in case of any arising questions and to enhance the familiarity of the research and researcher (158). Through familiarisation, the goal was to overcome the risk of the survey email invitation being perceived as unfamiliar and, by that, dismissed as potential spam or not important, as has been reported in previous research.

Anonymous web-based surveys could also present some methodological limitations. The anonymous aspect presented the risk of not being able to control for respondents submitting more than one answered survey. The data collection process included four email reminders, which may have elevated the risk of participants interpreting it as a new survey to respond to. My co-authors and I identified this as an issue upon receiving emails from participants, sharing their mistake and asking us to disregard their last response. On account of them stating their employment municipality, we could then identify and correct that error. It does, however, raise the question of how many other respondents made the same mistake. The anonymous aspect and stating home municipalities presented another limitation. The survey aimed to be anonymous and stated in the introduction that: "*The results of the study will be presented at group level. It will therefore* ***not be possible*** *to identify individual persons or municipalities in the published study results*". However, when considering that 34.1% of the respondents reported that they were the sole counsellors within the service, enabling a possible identification, the 55.7% response rate regarding the stating of employment municipality could be explained.

A further limitation of survey studies is that they do not capture the voice of the respondents. To thoroughly explore the counsellor's definition and perceptions of prevention within their services, in-depth interviews or focus

groups could have strengthened the research findings. Yet, by including open-ended questions, we encouraged the respondents to elaborate on their answers for richer responses.

Interest-holder engagement in the research process

In this doctoral thesis, I have chosen to use the term 'interest-holder' as an alternative to 'stakeholder', due to its negative colonial connotation (159). I have defined 'interest-holders' as individuals with recognised interest in, and experience of, the researched issues.

In this doctoral project, intrinsic and instrumental imperatives motivated interest-holder engagement (160). Our primary motivation was intrinsic, justified on ethical and moral grounds. It was agreed that interest-holders had a right to be engaged in the work. Therefore, guiding principles in our work were autonomy, equity and inclusive partnership. Our perception is that this was achieved, presented in the internal communication within the group. However, several instrumental benefits, i.e., the engagement of interest-holders perceived as having improved the research process, were noted. From our experience, the interest-holder engagement elevated the level of relevance, transparency, and usefulness of the findings. We derive this from the positive responses being shared after conducting public presentations.

In the preparatory phase of Study I, the process of adapting the HWF model was led by me and two of my supervisors, Georgina Warner and Anna Sarkadi, together with interest-holders from the local setting, who were collectively referred to as an Advisory Panel. The panel included another researcher as well as representatives from the regional health care services and the local social service, one local CHS and the local BDC service. A mother with lived experience of economic hardship, recommended by one of the CHS nurses, was also included. Altogether, the Advisory Panel consisted of one researcher and 14 local representatives. The adaptation process spanned across four months, from September 2020 to February 2021, both through in-person and online meetings. In addition to improving the adaptation of the HWF model to the Swedish setting, working with the panel functioned as a form of prolonged engagement, allowing the researchers to become familiarised with the study site and build relationships, arguably enabling a deeper understanding and richer insights into their experiences, behaviours, and beliefs expressed in the subsequent qualitative study (147).

The original Advisory Panel were invited to stay on in the development of an RCT Advisory Panel for Study II. The CHS and BDC service chose representatives who would stay and represent the views of the team. The representatives from the social services and the regional health care accepted the invitation, as well as the mother with lived experience. Additional members were added to the panel, including a BDC counsellor from another municipality, two mothers with lived experiences of economic hardship and a public health service representative. Additional researchers were also added to the panel, including senior researchers engaged in relevant research in Australia (128), the UK (161) and Sweden (162, 163). Altogether, the RCT Advisory Panel consisted of four researchers and nine local representatives. RCT planning took place between September 2021 and August 2022. The co-authored RCT protocol paper can be viewed as the main output of this collaborative process (164). The groundwork of the protocol paper entailed online meetings to discuss different aspects of the trial. Many aspects were discussed as a group but, in some cases, the representatives had different roles depending on their expertise. For example, the mothers with lived experience were asked to bring forward opinions regarding the study information material and survey, to better understand the reality of parents with young children living in exposure to economic hardship and ensure the material and questionnaires were both understandable and relatable. To give another example, the BDC representatives were directly consulted about questionnaires related to finances, i.e., 'income sources', 'financial knowledge' and 'financial control' to ensure they were relevant to individuals seeking help from the BDC and the financial counselling that takes place. RCT Advisory Panel meetings continued throughout the pilot trial period, with arising issues, such as slower than anticipated recruitment, discussed with the group.

Despite expanding the membership of the panel, it was acknowledged that several of the advisory panellists were from the same local context. To obtain better levels of transferability of the work being done, some materials were discussed with representatives outside of the RCT Advisory Panel. For example, the structure and content of the BDC topic guide, used in Study II to ensure a standardised counselling across the different sites, was workshopped together with a team of BDC counsellors from different municipalities. Similarly, a broader group of BDC representatives and the national BDC organisation were engaged in the development of the survey for Study III and Study IV. The representatives were invited to workshop the survey content, as well as take part in *Think Aloud* sessions between March and April 2023 (165) in which they completed the survey while on a video teleconference call,

expressing their thoughts as they did so. Through observing the immediate reactions and reflections of the sessions, valuable information about the survey content emerged. Changes were made to make the survey more user-friendly and to adjust the language to better adhere to the target population.

Discussion of findings

Stigma related to economic hardship

The relationship between stigma and economic hardship has been researched and modelled (132, 166, 167) as well as expressed in qualitative work (29, 168). Despite the measures being taken to ameliorate the consequences of stigma in this doctoral project, it was evident that it did play an inevitable role. Across the different perspectives being represented in the studies, it was discussed how to mediate stigma and insecurities regarding economic hardship. The voices of the CHS nurses in Study I showcased that the mere anticipation of stigma could create insecurity about bringing the topic up for discussion. The Study I parents had different views on financial stigma. Similar to the Australian HWF findings, some parents shared their experience of economic hardship being a topic they would not feel comfortable sharing with just anyone (133). Yet it was also presented as an inevitable subject, as finances are a natural part of life. The nurses' reports also aligned with the challenges of the Australian HWF research (133), where the CHS services approached in the site recruitment process of Study II expressed insecurity regarding their literacy of the topic 'economic hardship'. In addition, the nurses put words to a worry on behalf of the visiting parents, in regards to introducing economic hardship into the CHS model of care. This is supported by previous research exploring screening for psychosocial risk factors in the Swedish CHS setting (169), where attitudes and engagement play an important role

Stigma was also prevalent in Studies III and IV. This echoes from previous research questioning why individuals do not seek help in an earlier stage in matters of their developing indebtedness (170) and exploring how debt advisers could address the moral identity in conversations with stigmatised groups (171). This relates to the findings of Study III, where counsellors shared their experience of meeting clients in a later stage than they would have preferred, due to the client then being in an acute need of help. This was argued to be on account of stigma, where clients did not seek help until they could not see any other way forward. In accordance with the Lipsky's theory of 'Street Level Bureaucracy' (145), this was, in Study III, referred to as the 'involuntary client'. Stigma came into terms in Study IV in a similar way. The data sources

included content that inferred that individuals experiencing hardship can perceive seeking help and following through with that help as stigmatising and difficult, as seen in previous research (130).

The challenges of implementing a complex intervention

The main findings of this doctoral project revolve around the complexity of the HWF model. As described in the 'Overview of studies', in line with the MRC framework for the development and evaluation of complex interventions, there was a need for further investigation of the context in which the HWF model was operating (138). Various characteristics can contribute to the complexity of interventions, including the setting, the number of professional groups involved, whether human interaction is required to deliver the intervention, and the level of active participation required (172). Multiple settings are involved in the HWF model, which encompass different professional groups. This is further complicated by the geographical variation in these settings. Human interaction is an essential part of the HWF model, with relationships playing a key role. The model also requires active participation. While the screening and referral mechanisms are embedded into routine care, the parents who screen positive for financial hardship are expected to attend the BDC service and actively engage in the financial counselling process. Moreover, implementation of the HWF model required active participation from professionals; both the CHS nurses and the BDC counsellors were expected to change their working routines.

Geographical variation in services

As made reference to earlier, Sweden is a geographically large country with a political system that has divided the governing mandate between the state, the regions and the municipalities (88, 89). The regions and municipalities regulate the taxation and budgeting of the services, and by that the allocation of resources. Given that the work processes of Studies I and II included six different Swedish regions, across seven different municipalities, and eight residential areas, this presents interesting findings regarding both differences and similarities. In order to achieve standardised services, besides national legislations, there are national programs issued by the responsible authorities. The CHS services are guided by the national Child Health Program (173), issued to contribute to the development of standardised care. The BDC equivalent is issued by the Swedish Consumer Agency (SCA) to support a national standardised service. By the time of data collection for the four studies, the SCA

had two sets of documentation: general recommendations (107) and a guidance document (106). However, when conducting the document analysis for paper IV, revised SCA documentation was released, which was included in the data analysis (101). Our analysis revealed major changes between the two versions of the SCA guidance. In the newly released recommendations, more responsibility was put on the local governments to guide their BDC services to encourage a local responsibility for the services, on the basis of the local knowledge and expertise. This approach has since been critiqued (105). In line with this, the findings of this doctoral project exemplify the need for clearer and more actionable plans regarding guidance frameworks and BDC organisational set-up. In Study IV, when approaching registrars in municipalities requesting any existing local guidance framework, some would refer to their organisational set-up and stated no knowledge or no existing guidance framework, displaying the low awareness of guidance frameworks.

The importance of relationships

A joint finding across the studies was the importance of relationships. In Study I, this was articulated as the importance of the nurse-family relationship, where the nurses expressed their ambition to build good relationships with their families, while the parents emphasised the positive sentiments of having their nurse make them feel seen and valued. These findings are aligned with the original Scottish HWC model, where attention was drawn to the role of the nurse (135). Building on the Australian HWF findings of the financial counsellor-client relationship being empathetic and respectful (133), the findings of Study I presented parents being grateful for the reception they got from the BDC counsellors. Previous Swedish research indicates a challenge in sensemaking within the counsellor role, which serves as both an authority implementing policy and a source of interpersonal guidance, helping individuals navigate economic hardship to possible solutions (116). The importance of relationships was further highlighted in Study I, when reporting on the negative effects of transitioning from in-person meetings to telephone or video teleconferencing due to the COVID-19 restrictions. Losing the personal meeting created obstacles for some of the counsellors, not being able to connect with the person, as in-person meetings allow.

The burden of participation

Constraints of time and resources were a recurrent topic across all four studies presented in this doctoral thesis. There is an identified complexity in interventions that require active participation from participants (172). In the Study I

findings, this was highlighted when parents made reference to the tiring life puzzle of e.g., being a single-parent, being a student, and the difficulty in making their way to a financial counselling session together with a toddler. The field notes showed that even having peace and quiet to do a proper read through of the Study Participant Information and Informed Consent Form was sometimes difficult. In both Studies I and II, 'Not having the time and energy' was present in the findings. This was also argued in terms of the capacity of the professionals in Study I. The professionals would stand by prevention being important, yet also reporting stress when having to devote time and resources to matters that did not feel urgent. Study I highlighted that preventive work regarding economic hardship is important, but that changes need to be made in work routines for it to be feasible. In Study II, this concern was already apparent at the recruitment level. The organisations could identify the topic and the issue as important, but at the same time recognised their own limitations in terms of time and resources.

This continued to be a prevalent issue within Studies III and IV. The majority of the professionals reported that they wanted to work more preventively in Study III, and the document analysis in Study IV showed that the national guidance documentation (106, 107) up to the updated version in 2024 (101), encouraged preventive measures. The counsellors argued that prevention could make the service less reactive over time. This is supported by recent Swedish research on the negative consequences of over-indebtedness (174, 175), which is commonly the primary task of Swedish BDC (116). However, our findings showed that the BDC counsellors were so overburdened with reacting to crisis cases that they struggled to prioritise preventive work.

A need for action at the structural level

Reflecting on this doctoral project, there are considerations to be made regarding what models like HWF can change, and at what level. The HWF model functions as a downstream intervention, operating on an intermediary level close to the individual (24). Previous research on the model has presented changes on the individual level, primarily in the form of monetary gains (127, 133). The model does not set out to change the distribution system of resources, yet it aims to make available social support more accessible. Any potential upstream effect, creating changes on a more structural level, would be considered to be indirect.

In our work with Studies III and IV, we aimed to explore the perceptions and working conditions of BDC counsellors to enact preventive counselling. It can be argued that the counsellors within BDC are positioned between the intermediate and structural. They are mandated to carry out the governmental task of supporting individuals in debt, while directly meeting with people in crisis. This echoes earlier research findings where counsellors within Swedish BDC experienced being mandated to provide financial counselling to clients in economic hardship, while also being expected to guide individuals in difficult situations (116, 120). While Study IV showcased the various levels of preventive work BDC can do, the services have limited conditions to make changes on a structural level.

While the HWF model may have the potential to create positive change at the intermediary level (24), it must be recognised that economic hardship, like all social determinants of health, requires action at the structural level. The complex, overlapping experiences of disadvantage that can lead to economic hardship are unlikely to be resolved by BDC alone.

Ethical considerations

Ethical applications

The Swedish legislation on ethical review for research involving humans (SFS 2003:460) applies to research that involves processing sensitive personal data (176). I had a central and active role in writing up and submitting the ethical applications to the Swedish Ethical Review Board regarding Studies I and II. The applications were granted approval, case number (Dnr 2020-06738) and (Dnr 2022-01391-01). Studies III and IV targeted BDC counsellors within the scope of their professional role, focusing on their perception of their work tasks. Being an anonymous survey, the data collection did not entail any personal information; therefore, it did not require ethical approval from the Swedish Ethical Review Board (176). However, the ethical considerations being made in this doctoral project reached beyond the standard ethical applications.

Economy as a sensitive topic

One of the ambitions of my doctoral project was to explore how to address economic hardship in Swedish welfare services to support families with young children. Through substantial research evidence (132, 166-168, 177-180) and the interest-holder engagement work, we learned that economic hardship is a stigmatised topic, not restricted to vulnerable groups but in the general population. To ethically consider how to address economic hardship in Studies I and II was therefore essential. Through the interest-holder engagement work, we aimed to adapt the different components to better adhere to the prevalence of stigma. For example, an introductory script acknowledging that economic hardship can happen to anyone was developed together with the Advisory Group. Moreover, the screening was offered to everyone visiting the CHS, rather than targeting particular families. Yet, an obstacle outside of our control was the public opinion about the Swedish social service, which has worsened over the years (181, 182). The Swedish social service has experienced a disinformation campaign, claiming that the social service is ‘stealing kids’ from vulnerable families. Despite our four studies not including the particular social service unit at which the campaign has been directed, both the nurses and the counsellors expressed hesitation about public opinion. The parental reports in

Study I solely presented sentiments of safety and trust in nurses at the CHS. However, the nurses' responses in Study I and the field notes of Study II reported a feeling of parents withholding information. In Studies III and IV, the counsellors expressed discontent with being administratively linked to the social service. The counsellors would then feel guilty by association, anticipating that parents would be hesitant to share information about economic instability. We consider this to be an ethical consideration for future studies.

Interest-holder engagement

The interest-holder engagement in Studies I and II included individuals with lived experience of economic hardship. Ethical considerations were therefore essential when creating an environment of equity and autonomy for an inclusive partnership. Two former participants from Study I were invited to take on a role of interest-holder on the RCT Advisory panel, further elevating the importance of making a clear distinction between the research-participant relationship and the partnership that makes up the interest-holder engagement relation. Relevant literature (160) and collegial expertise (183) were consulted, yet the issue was also raised within the Advisory Panel to secure joint understanding and transparency.

Survey anonymity

The anonymous web-based survey for Studies III for IV was accessed through a direct link or a barcode, and distributed via a conference app and through email send-outs. The survey collected no personal information, such as name, e-mail address or other identifying information. It was also made clear that the presented results would not include any identifiable information. However, it was acknowledged that some of the demographic questions regarding employment municipality, the office composition and gender could reveal participant identity. Therefore, to further protect participant identity, the municipality identifier or other demographic information questions were not mandatory, as we anticipated that some municipalities might have very few practitioners/respondents, leading to a higher risk of identification.

The usage of OpenAI

The work of this doctoral thesis has been partially supported by the GPT-5, OpenAI's large language model (LLM). I have used the model as a tool in the work of statistical analysis coding in R Studio for Studies II and III. I

have also used the GPT-5 model as a supplementary search tool for information and literature. The model has not been used for text generation. In the work of translating between Swedish and English, the specialised LLM DeepL has been used. The tool has not been used to translate whole sections of text, but solely as an additional support in the writing process. For spelling and grammar check the AI writing assistance Grammarly desktop app for Windows has been used. I retain full responsibility for the content presented in this publication.

Conclusions

The overall aim of this thesis was to explore the feasibility of screening and preventive financial counselling for families with young children. To achieve this, the four studies specifically aimed to: explore interest holders' perceptions and experiences of the HWF model in Sweden; assess the feasibility of conducting an RCT of the HWF model; investigate if preventive counselling is being enacted in Swedish BDC services, and the counsellors' working conditions to do so; and to explore how prevention is conceptualised within the Swedish BDC services, with a focus on how counsellor perceptions align with guidance documentation.

Study I implied that working models like HWF, in the contextual setting of CHS and BDC, need to address the prevalence of financial stigma and the preconceptions of economic hardship within societal services, as well as how the professionals perceive their role and mandate. The Study II findings concluded that a full-scale trial of the HWF model was not feasible. The findings of low conversation rates, low fidelity to protocol within the BDC service and floor-effect of the primary outcome concluded the need for an adjusted evaluation design. Problems in aligning service engagement and the burden of research participation implied that contextual factors need to be considered in future research designs. The Study III findings showed that counsellors within the BDC face challenging working conditions to carry out the assigned policies. The main identified challenge was related to a lack of structure, revealing a service where it is up to the individual counsellor or BDC office to decide upon enactment of prevention. Study IV illustrated the need for clearer and actionable guidance, to create a joint understanding and conceptualisation of prevention, equipping professionals with the same tools to carry out prevention.

The studies in this thesis provide pieces to a complex puzzle of preventing economic hardship within Swedish societal services. Overall, the findings portray the role of financial stigma, the challenges of implementing complex interventions and a need for action at a structural level.

Future research

Future research could further investigate the HWF model in Sweden. As a large-scale RCT was not deemed feasible, a pre-post study evaluating the effectiveness of preventive financial counselling for parents of young children could be conducted. This would, in line with the MRC Framework (138), provide valuable information on one of the key components of the HWF model – the BDC service. The HWF model is based on the assumption that attending the BDC service can create positive change for parents of young children, but this has not yet been evidenced.

The Advisory Panel meetings conducted as part of this PhD project were observed by an external researcher, a member of my research group, but who had no involvement in the research project. The observations were conducted using the Active Involvement of Users in Research Observation Schedule, with the purpose of recording group dynamic characteristics and decision-making processes (184). The observations were passive, and the advisors and researchers were aware they were being observed. Future research could explore how the interest-holder engagement was conducted and the potential impact of the engagement on the study, using these observation notes.

Given the noted limitations of interventions targeting economic stability at the intermediary level, future research initiatives should also consider how changes can be made at the structural level.

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"To conserve energy and protect themselves from the cold, Emperor penguins adopt a behavioural strategy of huddling close together in groups. Huddling is considered key to their ability to live in such a cold place."
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