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Second workshop to strengthen intersectoral working on prevention of child maltreatment in the Nordic–Baltic subregion

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ABSTRACT

The WHO Regional Office for Europe, the Nordic Council of Ministers and the Government of Lithuania jointly organized the second Nordic–Baltic workshop on the prevention of violence against children. The aim of the meeting was to build institutional capacity by promoting the exchange of expertise in the intersectoral response and to discuss the implementation of INSPIRE: seven strategies for ending violence against children and to further develop the foundation for such collaboration across the Nordic–Baltic subregion. Specific objectives included discussing the role of the health, welfare, education and justice sectors in an intersectoral response to preventing violence against children and how this could apply to the Lithuanian context and other Baltic and Nordic countries, and encouraging the development of networks to strengthen child violence prevention in the Nordic–Baltic subregion.

Keywords

CHILD ABUSE – PREVENTION AND CONTROL
VIOLENCE – PREVENTION AND CONTROL
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Acronyms

ACE	adverse childhood experience
CBSS	Council of the Baltic Sea States
FNP	Family–Nurse Partnership
MapchiPP	Multi-disciplinary Assessment and Participation in Child Protection (training programme)
NCD	noncommunicable disease
NGOs	nongovernmental organizations
NKVTS	Norwegian Centre for Violence and Traumatic Stress Studies
OBPP	Olweus® Bullying Prevention Program
PLH	Parenting for Lifelong Health
RCT	randomized controlled trial
SDG	(United Nations) Sustainable Development Goal
SEEK™	Safe Environment for Every Kid (model)
SEEK-PQ	SEEK™ Parent Screening Questionnaire
TF-CBT	trauma-focused cognitive behavioural therapy
Triple P	Positive Parenting Programme
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children’s Fund

Scope and purpose

Child maltreatment is one of the hidden forms of violence. Evidence shows that prevalence is unacceptably high in the 53 countries of the WHO European Region. The *World report on violence and health* defines child maltreatment as physical, sexual or emotional abuse, and/or deprivation and neglect. Child abuse, if severe, can lead to homicide, and although these appear relatively low at about 850 deaths each year in children under 15 years of age, deaths are the tip of the iceberg. Reports suggest that the prevalence of child maltreatment is much higher. In the WHO European Region, the prevalence ranges from 9.6% for sexual abuse, 22.9% for physical abuse to 29.1% for mental abuse, suggesting that tens of millions of children are abused before the age of 18 years. Child maltreatment is one of the more serious forms of adverse childhood experiences (ACE),¹ though other adversity may also present itself.

The lack of safe and nurturing relationships in childhood are thought to adversely affect neurodevelopmental change and, in turn, the emotional, cognitive and behavioural development of a child. ACEs are linked both to a propensity for increased violence later in life and health harming behaviours, such as alcohol and drug misuse, physical inactivity, depression and self-harm, and lead to poor health outcomes, including those due to increased noncommunicable diseases (NCDs) and psychiatric disorders. The scale, risks, consequences and evidence base for preventive action and policy options are summarized in the *European report on preventing child maltreatment*.

In view of concern about the scale and consequences of child maltreatment, all 53 Member States of the WHO Regional Committee for Europe gave their unanimous support to resolution RC64/R6, *Investing in children: the European child and adolescent health strategy 2015–2020* and the *European child maltreatment prevention action plan 2015–2020*. These calls on leadership by the health sector in coordinating an intersectoral prevention response focusing on improved surveillance, developing a comprehensive national action plan for prevention, and more widespread implementation of prevention programmes. There is a requirement to report back on progress in Member States to the WHO Regional Committee for Europe in September 2018 and countries are preparing for this by taking part in a survey. Each ministry of health of the 53 countries in Europe has also appointed a focal point for violence prevention to facilitate the implementation of WHO-related policies, such as the action plan.

The United Nations Convention on the Rights of the Child (UNCRC) requires all Member States to offer effective child protection, giving paramount importance to the rights and best interests of children under the age of 18. The United Nations Sustainable Development Goal (SDG) target 16.2 calls for ending abuse, exploitation, trafficking and all forms of violence against, and torture of, children. In response, international agencies such as WHO and the United Nations Children's Fund (UNICEF) and governments have come together to form the Global Partnership to End Violence Against Children. In addition, the World Health Assembly adopted the *Global plan of action to strengthen the role of the health sector within a multisectoral response to address interpersonal violence, in particular against women and girls, and against children* in 2016. The Minsk Declaration on the Life-course Approach highlights the importance of investing in early

¹ Adverse childhood experiences (ACE) may be one or more of emotional, physical and or sexual abuse, physical and or emotional neglect, substance misuse and or mental illness amongst family members, violent treatment of mother, separation or divorce of parents, imprisonment of family member

childhood development and promoting safe, stable and nurturing relationships to prevent ACEs and maximize developmental potential to ensure better health and social outcomes as adults.

Lithuania is one of the countries that has shown great commitment in the field of violence prevention, and in 2017 banned corporal punishment in all settings. Violence prevention has been indicated as one of the priorities for collaboration between the WHO Regional Office for Europe and the Ministry of Health of Lithuania. As part of this, a survey of ACEs among university students was undertaken in 2014, with a policy dialogue to debate results. Interest has been expressed by the ministers of health, labour and social security, and education in supporting a high-level policy dialogue on ending child violence.

The Nordic and Baltic countries have a long history of collaboration and sharing of experience in a number of areas. Among these, violence prevention was the focus two workshops in collaboration with WHO held in 2009 and 2017 to stimulate the expansion of good practices, networking and capacity-building in the Nordic and Baltic region. Both were held in Riga, Latvia, with an attendance of about 100 stakeholders at each meeting. All Nordic and Baltic countries are committed to ending violence against children and have taken part in the 2017 survey of the *European status report on preventing violence against children*.

There is a large evidence base that prevention of child maltreatment and violence is more cost-effective than dealing with serious and far-reaching health and social consequences. This evidence has been captured in *Implementing child maltreatment prevention programmes: what the experts say* and *INSPIRE: seven strategies to end violence against children*, produced by WHO and the Global Partnership to End Violence Against Children. Sweden and Estonia have expressed an interest as Pathfinding Countries in the Global Partnership to End Violence Against Children. Many centres in the Nordic Baltic subregion have fostered innovative approaches to end violence against children and have considerable expertise. The sharing of such experience would lead to an opportunity to profit from programmes that lead to more widespread health, welfare and social benefits.

In line with WHO European strategy, Health 2020, which highlights the importance of intersectoral work, the WHO Regional Office for Europe and the Ministry of Health of Lithuania organized the Nordic–Baltic workshop on the prevention of violence against children, with support and collaboration from the Nordic Council of Ministers and other Lithuanian ministries, such as labour and social security, and education. The aim of the meeting was to build institutional capacity by promoting the exchange of expertise in the intersectoral response to end violence against children and to further develop the foundation for such collaboration across the Nordic–Baltic subregion.

The specific objectives of the workshop were to:

- discuss the role of the health, welfare, education and justice sectors in an intersectoral response to preventing violence against children and how this could apply to the Lithuanian context and other Baltic and Nordic countries;
- deliberate the burden of child maltreatment, risk factors such as alcohol, poverty and social exclusion, and the benefits of investing in children and the life-course approach;
- receive the latest examples of good practice on the prevention of maltreatment and violence in childhood from Europe, with a focus on Nordic countries;
- exchange evidence-based experience on implementing prevention programmes;

- debate how policy and programming may be improved to tackle this leading cause of childhood burden; and
- encourage the development of networks to strengthen child violence prevention in the Nordic–Baltic subregion.

Day 1

Opening session

The workshop opened with brief introductions and welcomes from: **Professor Aurelijus Veryga, Minister of Health of Lithuania; Ms Vilma Augienė, Vice Minister of Social Security and Labour of Lithuania; Mr Grazvydas Kazakevicius, Vice Minister of Education and Sciences of Lithuania; Ms Helen Nilsson of the Nordic Council of Ministers; and Dr Dinesh Sethi, Programme Manager for Violence and Injury Prevention at the WHO Regional Office for Europe.**

The introductory speakers agreed that the workshop offered an opportunity for participants from different sectors and at different levels to exchange expertise. They stressed that child maltreatment requires a truly intersectoral approach that includes colleagues from sectors outside health and social care in collaborations. Lithuania, the host country for this year's workshop, has taken serious political steps to deal with the problem, recognizing the importance not only of specialist support, but also of engaging with civil society. Health workers, however, are very close to children, and are often the first professionals a maltreated child sees – that is why they need to be trained to spot the signs of maltreatment early and have access to means of dealing with it.

Evidence of how the **Nordic Council of Ministers** has been promoting regional collaboration in many areas was presented, particularly in relation to health, human rights, welfare and social care, and gender equality. The Council contributes to efforts to create sustainable societies in which the rights and perspectives of children and young people are respected and contribute to the development of society. The current Council cross-sectoral strategy for children and young people in the Nordic–Baltic subregion emphasizes the importance of further collaboration and development of skills and best practices through knowledge-sharing.

The report on the European status report on preventing child maltreatment will be presented to the WHO Regional Committee for Europe in September 2018. One of the aims of the workshop was to allow countries to discuss the progresses and challenges in child maltreatment prevention as well as exchange good practices in the implementation of INSPIRE.



Plenaries

Countdown to 2020: European status report on preventing child maltreatment

Dr Dinesh Sethi, Programme Manager for Violence and Injury Prevention, WHO Regional Office for Europe

Of the estimated 55 million children in the WHO European Region who have experienced maltreatment over their lifetimes, only around 10% of it comes to the attention of protection agencies.

Childhood and adolescence are periods of vulnerability during which the brain is changing enormously and exposure to adversity during these times leads to mental trauma. Adverse events in childhood can lead to early death, NCDs, developmental and social problems, and increases in inequalities.

Child maltreatment will negatively affect the achievement of all of the SDGs – they cannot be achieved while child maltreatment is as common as it currently appears to be.

The aim of *Investing in children: European child maltreatment prevention action plan 2015–2020* is to reduce child maltreatment by 20% by 2020. It calls for child maltreatment to be made more visible, for national action plans to be developed, and for implementation of prevention programmes, in addition to targeted responses to existing maltreatment. Countries are to be thanked for completing the survey “Countdown to 2020: Implementing the European Child Maltreatment Prevention Action Plan” – the hope is that this will present a reasonable place to start the dialogue on what to do next.

Homicide rates in children aged 0–14 in Europe show the situation is improving, although the rates are higher in low-income countries, particularly in the Commonwealth of Independent States. The highest rate is eight times bigger than the lowest.

The WHO Regional Office for Europe has collaborated with countries on conducting ACE surveys among university students (aged 18–25). These show the rates of ACEs is high in many countries, and that young people affected by four or more ACEs are three times more likely to be a current smoker and to have had sex under 16 years, six times more likely to have used drugs, 10 times more likely to be problem drinkers, and 49 times more likely to have ever attempted suicide.

So far, only around 71% of countries have developed action plans for child maltreatment prevention. Of these:

- only one in three plans is fully funded
- only one in four has not been informed by a national survey
- only 19% have a quantifiable target.

In addition, more needs to be done to implement national action plans. Much progress has nevertheless been seen in banning corporal punishment in all settings, with measures in place in 66% of countries.

The essence of the workshop is looking at how evidence can be used to promote prevention. In the European Region (49 countries), countries are doing well with actions to prevent bullying, less well on parenting education, and well on home-visiting programmes. This now needs to be ramped up to meet the final goals. Countries have health and social service responses in place for child maltreatment, including actions in prenatal settings to detect intimate-partner violence and provision of medicolegal and child-protection services, but only 63% of countries have implemented mental health services for victims of violence on a large scale.

The cost and consequences of ACEs and how they can be avoided²

Professor Mark A. Bellis, Director, WHO Collaborating Centre for Investment in Health and Well-being, Public Health Wales

In the first two years, a baby's brain grows from 25% to 80% of the adult size. Critical restructuring continues through childhood and is crucial for developing children's ability to show empathy and trust, and take part in communities.

For most people who face a threat, they enter a period of heightened state of alert which subsides when the threat withdraws. With people who have been chronically exposed to ACEs, the heightened state of alert persists; people who have a continued heightened state of alert tend to wear out more quickly, with devastating impacts on their health. Affected children may interpret neutral cues as threatening and see threats in all kinds of situations, including school, where they may become anxious, suspicious and disengaged.

In the 13 countries in the Region that have surveyed samples of their university populations, 17.7% of students reported being physically abused as a child. Almost 13% had lived in a family with domestic violence and 16% with an alcohol problem. Forty-nine per cent had suffered at least one ACE and 6% four or more. A study in the United Kingdom (England and Wales) found similar figures.

A collaborative global ACE analysis with WHO found that a wide range of health problems are more likely in those with four or more ACEs than people with none, ranging from negative effects on weight and height to low life satisfaction, poor self-rated health, and morbidities such as liver, digestive, heart and sexual disease, diabetes and cancer. It also showed that those with four or more ACEs are 10.2 times more like to misuse drugs, 8.1 times more likely to perpetrate violence, and 30.1 times more likely to attempt suicide.

ACEs are cyclical and intergenerational, which means that with the right interventions, they can be interrupted and prevented. Parenting programmes, for example, have been shown to have positive impacts on reducing child maltreatment, increasing school completion rates and reducing offences later in life. Better informed parents make better life-course choices.

Not all children with ACEs go on to have these kinds of problems as adults, however; resilience is a critical factor in protecting people and turning potentially toxic stress into tolerable stress. Central to developing resilience is the idea of a safe space where children can develop at a physiologically more normal level to stress and threats. Research shows that for children who have suffered four or more ACEs but who have always had a trusted adult to turn to, their levels

² Professor Bellis showed clips from a video on ACEs during his presentation. The full video can be accessed at: youtu.be/YiMjTzCnbNQ

of experiencing low mental well-being are half those of children with four or more ACEs who have no adult to go to.

Child welfare: change and cooperation in Lithuania

Ms Rūta Pabedinskienė, Adviser, the State Child Rights Protection and Adoption Service under the Ministry of Social Security and Labour, Lithuania

The basis of reform in Lithuania is the Law on Child Rights, adopted in September 2017. The law will be enacted from July 2018, and preparations are well underway. Systemic changes in child welfare include the Civil Code, the Law on Social Services, and other legislative changes.

Deinstitutionalization processes have been in place since 2014, with the focus now for children's services being on communities and families. Migration from institutional care to family and community services for disabled people and children without parental care is being coordinated through an action plan for 2014–2020. The goals are to:

- always serve the best interests of the child
- provide quick responses to child rights violations
- promote prevention
- avoid separation of children from parents whenever possible
- provide support to families
- interact with communities
- involve nongovernmental organizations (NGOs) and civil society
- create strategic partnerships.

The percentage of children receiving social care services in the community from the total number of children being cared for rose from 61.7% in 2012 to 73.2% in 2017. A coordinated system of early childhood and family support is in place at state and municipal levels

In Lithuania, it is not just the Ministry of Social Security and Labour that is responsible for child protection; a range of ministries cover rights, health, education and justice in cooperation. Centralized protection of children's rights means that departments on child rights throughout Lithuania are subordinate to the central institution – the State Children's Rights Protection and Adoption Service; this enables uniform practice to develop throughout the country and coordination between institutions to be maximized.

By law, the organization and provision of complex assistance to children and their representatives is provided by case managers, whose job is to enable the child's rights and legitimate interests to be independently guaranteed.

Mobile teams are groups of specialists who urgently provide and organize individual or group medical, psychological, social or legal aid for a child and family in crisis. They work intensively with the family (for up to 14 days) in cooperation with the case manager, providing intensive counselling and other assistance to create a safe living environment for the child.

Projects on preventing violence, including physical, psychological and sexual violence, and neglect, have been implemented in 54 municipalities. The child rights law writes into statute children's right to be protected from violence.

INSPIRE: seven strategies for ending violence against children

Dr Alexander Butchart, Coordinator, Violence Prevention, WHO headquarters, on behalf of the INSPIRE core agencies

INSPIRE is a technical package aimed at focusing diverse players' attention on a discrete group of evidence-based strategies and interventions. The name is an acronym for the seven strategies it presents:

- implementation and enforcement of laws
- norms and values
- safe environments
- parental and caregiver support
- income and economic strengthening
- responsive services
- education and life skills.

It consists of a core document, a handbook that describes how to implement the strategies in the core document (published 12 July 2018), and a set of indicators by which to measure the prevalence of violence to children and the extent to which interventions are reaching those who need to benefit from them (to be published soon). When the handbook is published, it will include an invitation for proposals for small grants of US\$ 5000–30 000 to, for instance, disseminate the package or hold training workshops.

The INSPIRE vision is of a learning cycle: the core document sets out what needs to be done, the handbook leads to action at country level, and outcomes are measured by the indicators. INSPIRE is then updated in 3–4 years to reflect what has been learned.

Evidence for the impact of INSPIRE in countries includes:

- laws: 4500 lives, many of them adolescent, have been saved in South Africa over five years following implementation of the Firearm Control Act;
- norms and values: 64% fewer children witnessing intimate-partner violence in Uganda due to a community mobilization programme;
- safe environments: in United Kingdom (Wales), 37% fewer violence-rated injuries have been seen in emergency departments;
- parent and caregiver support: a reduction of 48% in cases of child maltreatment following implementation of the Nurse Family Partnership programme over a 15-year period;
- income and economic strengthening: 50% reduction in children witnessing intimate-partner violence in South Africa following a programme that combined income generation with norms change;
- response and support services: reductions in trauma symptoms and functional impairment across 11 trauma-informed cognitive behavioural therapy trials; and
- education and life skills: reductions in aggressive and disruptive behaviour in school settings across 249 life-skills and socioemotional training programmes.

These are huge prevention gains from which we can all benefit and use in our own countries. Central to these gains is preparing national and local action plans.

The INSPIRE implementation handbook describes how interventions can be taken forward. It aims to provide a comprehensive guide that countries can use in implementation, supporting them to choose interventions that are appropriate to their context.

The INSPIRE indicators come with instructions for use and relate to each of the strategies and the crosscutting components. Wherever possible, questions in the indicators are drawn from well-evaluated instruments.

Trends in child maltreatment – the Swedish experience

Professor Staffan Jansson, Professor Emeritus, Karlstad University and Örebro University, Sweden

Development in Sweden has followed two lines: increased knowledge of child development; and child rights. Both have been considerations for over 100 years. There were a number of law changes during the last century, notably in 1979 with the ban on corporal punishment and any other humiliating treatment, accompanied by advice for parents. It was grounded in a vision and view that children are not parental property, but instead are independent individuals with a right to full respect for their integrity.

The aim was to emphasize that children have a right to be brought up without violence by changing attitudes, not by criminalizing parental behaviour. This was supported by a wide information campaign.

Serial surveys of parents since 1980 on attitudes to corporal punishment and its practice have shown remarkable changes over the decades, from 95% positive attitudes to corporal punishment and 55% actively practising it with their children in the 1960s, to 2% and 1% respectively in 2018. School surveys carried out between 1995 and 2016 also show decreases in rates of any lifetime child maltreatment.

These surveys confirm that physical child maltreatment in Sweden decreased substantially between the 1960s and 2000s and have been low thereafter. Severe physical maltreatment has not, however, decreased during the last 10–15 years and remains at around 3–4%. It seems that a small group of families remain problematic; they are not being reached and need to be engaged in other ways.

Overall, the Swedish experience indicates that attitudes and behaviour can be influenced and changed when there is:

- increased societal awareness of children as bearers of human rights;
- political consensus on successive changes to laws, combined with effective mass information campaigns (as in 1979);
- equality is placed on assaults on children and assaults on adults;
- universal prevention is in place, especially through midwives raising family violence at pregnancy check-ups;
- family support through the welfare state (with parental leave and provision of preschools); and
- a more profound understanding of the imminent and future risks of child maltreatment.

Successes and challenges in child rights protection in Lithuania

Dr Aušra Kurienė, Children Support Centre, Lithuania

After many years spent in convincing people that child maltreatment existed, amendments to the law banning all forms of violence and abuse against children, including corporal punishment, were adopted in Lithuania on 14 February 2017. This happened because society demanded it; one month before the amendments were passed, parliament had voted against the changes. Then, a child was killed by his mother and stepfather: this moved society to demand change. Reorganization of the entire child welfare system will commence in July 2018.

The amendments were required because many abusive and harmful practices still exist in Lithuania. Too many parents believed corporal punishment was a useful method of disciplining children; a survey conducted in 2010 found that the number of parents believing in corporal punishment had increased from 2002. The child protection system had merits, but was nevertheless ineffective: professionals lacked skills and training in modern methods of interventions, had over-heavy workloads and there was a lack of community-based services, particularly for parents with teenagers. Finally, there were many helpless and passive witnesses, even among professionals, some of whom chose not to report suspected abuse because they had little confidence that anything would happen.

Challenges were faced in bringing the amendments to statute because of the country's inherited culture of violence, and the public's mistrust of authorities. Even now, there are stories of social workers trying to approach families with offers of help, but the families flee in distrust and fear that their children will be removed.

After the death of the little boy in January 2017, many peaceful public demonstrations took place, expressing people's horror and desire for change. This heralded a month of exemplary collaboration between government, NGOs, the media and citizens to create the conditions for change, culminating in the amendments being passed unanimously in parliament in February.

The biggest challenges to progress remain the need to change societal attitudes and to convince parents that children have rights. Competent child protection workers are still required. Ensuring the availability of local services for families and foster families remains a big challenge, as does providing effective parent education (current access to parenting courses does not meet need) and specialized services for parents and children on areas such as addiction and trauma. Finally, collaborative networks among institutions and professionals need to be strengthened.

National and international programmes

Implementation of The Incredible Years in Norway

Mr Bjørn Brunborg, The Incredible Years, Norway

The Incredible Years in Norway has grown greatly since its inception. It now comprises eight programmes provided across Norway, ranging from the teacher classroom management programme through child treatment and prevention programmes for those aged 3–8, to a range of programmes for parents of children aged 0–12 years.

The programmes can be categorized as those that target treatment (for children with a diagnosed disorder that is above the clinical cut-off), programmes for indicated/targeted prevention (for

those with symptoms of disorders or who have identified risk factors), and programmes for universal prevention (for those with no known symptoms or risk factors).

Eight randomized control trials (RCTs) of the treatment programmes have been carried out by the developer of The Incredible Years and six by independent investigators. These have shown:

- increases in positive parenting, including child-directed play, coaching and praise, and reduced use of criticism and negative commands;
- increases in parents' use of effective limit-setting by replacing spanking/hitting and harsh discipline with proactive discipline techniques and increased monitoring;
- reductions in parental depression and increases in parental self-confidence;
- increases in positive family communication and problem-solving; and
- reductions in conduct problems in children's interactions with parents and increases in children's positive affect and compliance with parental commands.

Evidence has also been gathered on the effectiveness of the prevention programmes. Four RCTs by the developer and six by independent investigators of the parenting series with high-risk populations indicated significant improvements in:

- positive parenting interactions
- reductions in harsh discipline with children
- reductions in aggressive behaviour problems
- increases in child social competence.

The Incredible Years in Norway celebrates its 20th anniversary in 2019. From 2004–2017, around 1900 people were trained, mostly on parenting programmes. The aim is to ensure the people who undergo the training go on to take on parent groups themselves.

The Norwegian Directorate of Health supports implementation by funding the three regional Incredible Years centres. This means that organizations can acquire training, access to programme manuals and ongoing supervision for free, helping municipalities to implement the programme. The government has also cited The Incredible Years in national guidelines and strategic documents, raising awareness throughout the country that the government is behind the programme.

Challenges to implementation include:

- group leaders having insufficient time and resources to deliver the programme with fidelity;
- group leaders having to attend for consultations/supervision;
- changes in leadership and turnover;
- translation of material to non-English language;
- professional resistance to programmes, particularly in schools; and
- concerns about predictable financing over time.

There are now European and international networks for The Incredible years that are instrumental in supporting implementation and ensuring fidelity and sustainability. The European network now has 11 member countries (including the four regions of the United Kingdom).

Parenting for Lifelong Health

Dr Yulia Shenderovich, University of Cambridge, United Kingdom

There is much evidence to support the effectiveness of parenting programmes in preventing child maltreatment, most of which relates to children of 0–9 years, with less on adolescents of 10–17. Economic studies, mostly into The Incredible Years programme, suggest cost–effectiveness, with benefits outweighing costs. Research suggests parenting programmes have greater effects for socially disadvantaged families and ethnic minorities, so have an impact on reducing inequalities. Outcomes include improved parenting skills with reduced child behaviour problems, reduced child abuse and risk of abuse, and lower levels of maternal depression and stress.

A global systematic review found that programmes transport successfully even to very different cultures with surface-level adaptations, and a related review of 129 randomized trials revealed that effect sizes were similar for so-called transported and homegrown evidence-based programmes. Many well-researched programmes involve high licensing costs and the availability of highly trained professionals, however, which can inhibit uptake.

Parenting for Lifelong Health (PLH) is a group including researchers, implementing partners and policy organizations that is developing and evaluating a suite of parenting programmes. It has been piloted in South Africa and studies currently are underway in the Philippines and Thailand, and in three eastern European countries (the Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia).

PLH programmes are designed to be delivered by nonprofessional staff through home visits, group sessions or a combination of the two, with minimal materials required. Target ages for children in the four PLH programmes range from newborns to adolescents. Programme manuals have been licensed through Creative Commons, so are freely available.

There are four PLH programmes, one each for babies, toddlers, young children and adolescents. All are based on principles common to effective interventions and draw on systematic reviews, qualitative research and other research interventions for preventing violence, and include parent–child attachment, cognitive stimulation and positive parenting techniques for non-violent discipline. The programmes have been evaluated in South Africa through RCTs and have shown improvements on multiple outcomes, including physical discipline and maltreatment. Currently the programmes are either being implemented or planned in 15 African countries and seven in the European Region. It is estimated that around 180 000 families have been involved.

It is recommended that organizations interested in PLH receive training and collect data to help build knowledge on programme implementation and effects. Issues to consider in implementation include:

- countries' political and cultural landscape, and policy context;
- service delivery and human resources, including facilitator training and support;
- participant recruitment and engagement: the average attendance in studies of parenting programmes is estimated to be around 70%; and
- the importance of involving fathers and other family members.

The Incredible Years in Finland

Ms Piia Karjalainen, The Incredible Years, Finland

The Incredible Years is delivered in a collaborative group format. Programmes aim to promote individual goal-setting and problem-solving, and feature videotaped vignettes, skills training and practices, group discussions, home assignments and weekly phone discussions with trained group leaders to see how they are managing their home assignments. The goal is to enhance age-appropriate positive management skills for misbehaviour, improve children's positive behaviour and adult–child interactions.

The Incredible Years was adopted by Finland because the Health Care Act stipulates that “the provision of health care shall be based on evidence and recognized treatment and operational practices”. The Incredible Years has a strong evidence base, and is transferrable, feasible and cost-effective.

The programme was introduced to Finland in 2005, when a Helsinki-based NGO received a grant to run two parent and teacher programmes for three years. More programmes followed, with 3–4-year funding available. Teams worked to translate materials, organize training and lead groups in the Helsinki area.

In 2014, the National Institute for Health and Welfare began to ask questions about the impact of The Incredible Years in Finland. A survey at that time found 239 people had been trained to be group leaders, but only 85 had gone on to lead groups. These 85 leaders were followed-up, and it was found that supportive factors included support from managers and co-workers, adequate planning time, supervision from coaches, and the understanding that the demands of the programme meant their normal workload had to be reduced. Ensuring fidelity was challenging, but was enhanced once they had grasped the full detail of the manuals. Issues that perhaps explained why only 85 had gone on to lead groups included the lack of permanent funding, no implementation strategy, low support at national level for training, lack of official guidelines and only partial translation of materials.

Following this, The Incredible Years has been cited in many national guidelines and documents, and an NGO has created an early intervention resource database that indicates how well rated some programmes are (The Incredible Years has a high rating). Child and family services are being reformed in Finland currently, and The Incredible Years is being included in the Evidence-based Early Support, Care and Parental Skills toolkit set up to enhance the use of evidence-based programmes.

Government funding ends at the close of 2018. Last year, the parliament gave 50 million in stocks to the NGO that set up the resource database; at the moment, it is not clear what the board of the NGO will choose to do with dividends from the stock, but The Incredible Years hopes it can continue to be part of the work.

A problem the team has encountered was the low number of referrals coming from social services. However, once parents had accessed the programme, there was no problem in keeping them engaged.

Lessons from implementation of Triple P – Positive Parenting Programme – in Sweden

Dr Raziye Salari, Uppsala University, Sweden

Many parenting programmes that aim to reduce child maltreatment target only those families who are at high risk. The problem with this approach is that it does not necessarily reduce child maltreatment rates at population level, so prevalence rates remain constant.

The most effective way to reduce rates at population level is to adopt a public health approach to parenting. Evidence-based parenting programmes should be available to everyone, not just those at high risk, offered in a variety of formats, and be capable of reaching a high proportion of parents – around 20–30% of the parent population.

Triple P is such a programme. It is evidence-based and reflects a public health approach to parenting through a multilevel system of parenting and family support interventions that offers parents a toolbox of parenting skills, including strategies to enhance parent–child relationships and promote self-regulation skills. Parents can find in it something that will suit their needs.

Triple P is a parental behaviour programme and works on the idea that if parents have good relationships with their children, the number of misbehaviours reduce significantly. Its main principles are:

1. ensuring a safe, engaging environment
2. promoting a positive learning environment
3. using assertive discipline
4. maintaining reasonable expectations
5. taking care of oneself as a parent.

Triple P was introduced to Sweden in 2008 after cultural adaptation. The first trial was held in 2009–2011 in Uppsala municipality, and the second, an RCT, in 2013–2017. Preschool teachers were trained to deliver three variations of Triple P (levels 2–4) as part of a research project. Initially, parental participation was good, but the numbers dropped after one year, which threatened programme sustainability over time (the municipality may stop the funding if parents showed insufficient interest).

To address this challenge, specific flyers targeted at mothers and fathers were produced. The flyers were designed to capture parents' attention, convey the potential benefits of participation, clarify what participation involved, and address some of the common barriers (such as the stigma associated with participation in parenting programmes). The main messages were that it is not always easy to be a parent, and it is okay to seek help.

The flyers effectively increased programme uptake among parents after their introduction in March 2016, with an increase in both the number of seminars and the average number of parents attending them (which had dipped to 3.79 before the flyers were introduced but had grown to 9.05 by the end of the year). Uppsala municipality decided to continue using the flyers even after the project ended.

The experience in Sweden shows that non-medical workers with no previous therapeutic experience can successfully be trained to deliver high-intensity parenting interventions such as level-4 Triple P. Awareness of the programme and consequent uptake can be increased by using

simple, relatively inexpensive direct-to-consumer marketing strategies. As researchers, the team found it very helpful not just to be in close touch with the municipality, but also with teams in other countries who were using the same programme. Contact has been made with colleagues in the Netherlands, with very useful discussions on issues and challenges taking place.

Family–Nurse Partnership in Norway and United Kingdom (Northern Ireland)

Ms Tine Gammelgaard Aaserud, Nurse Family Partnerships, Norway, and Ms Deirdre Webb, Family Nurse Partnerships, United Kingdom (Northern Ireland)

Ms Gammelgaard Aaserud explained that the Family–Nurse Partnership (FNP) is a home-visiting programme for vulnerable first-time mothers. The intervention aims to improve pregnancy outcomes, child health and development, and the parents' life-course. FNP is an evidence-based programme, originating in the United States. Evidence of impact is built from three RCTs in the United States, with trials also conducted in the Netherlands and United Kingdom (England).

Women are recruited to the programme as early as possible during pregnancy, and no later than the 28th week. Structured, intensive follow-up at home for up to 100 hours during the child's first two years is its central component, adopting a strengths-based and change-focused approach. FNP is underway in nine countries and regions, some since the 1970s, including five in Europe.

In Norway, a pilot has been underway with 150 families since 2016. The aim is to target first-time mothers with challenging life situations, offering them FNP in addition to usual services. The programme is delivered by specially trained public health nurses and midwives.

Experiences from FNP in Norway suggest it is important to:

- find the right sites in which to pilot the programme, which means working closely with local leaders;
- continue to adapt the programme materials and interventions to the Norwegian context, but maintain fidelity to the core model elements of the programme, including when recruiting and supporting nurses;
- establish and maintain an international clinical advisory group to enable access to support and shared learning; and
- identify an international mentor to support implementation of the pilot.

Very few women recruited to the programme have left.

Ms Webb described the situation of United Kingdom (Northern Ireland), which opted for FNP because of its strong evidence base in transforming the life chances of some of the most disadvantaged children and families, helping to improve social mobility and break the cycle of intergenerational disadvantage. It started in 2010 and today has five supervisors and 37 family nurses (27 whole-time equivalent). The focus is on first-time parents from ages 12 to 19. Funding just acquired means, however, that referral criteria can now be extended to include older parents (up to 24).

Around 800 women have undertaken the programme, with 400 currently going through. Evidence collected to date shows substantial increases in child development (socioemotional, behavioural and speech development) and reductions in safeguarding issues (parents being able

to work better with the safeguarding system), injuries and hospital admissions, and low-birth-weight deliveries.

Two evaluations have been carried out, and a qualitative reevaluation study on gathering 100 stories from parents and stakeholders on their views of the programme has just ended. The reevaluation study reveals that transformational change in families' lives has been achieved, with mothers feeling much better about their children, feeling healthier, more in control and less anxious. A feasibility study looking at augmenting the programme with an element on intimate-partner violence has commenced in partnership with colleagues in Norway.

Experience of FNP introduction and implementation in Northern Ireland suggests:

- senior clinical leads are required to prepare organizations and develop strategic communication plans with key stakeholders;
- countries should start with reasonably sized teams and recruit the right nurses;
- education and training of the family nurses/supervisors is vital;
- a valid research and information system is necessary;
- stories and photographs should be used to tell the journey from the beginning; and
- quality improvement and service development methodology will continue to improve the quality of the programme.

Expanded postnatal home visiting programme in Rinkeby, Sweden

Dr Anneli Marttila and Ms Johanna Mellblom, Directorate of Social Affairs, Sweden

Support for children in Sweden is delivered by health-care services, which see practically all children, and social services and protection, which work mostly with children and families with problems.

The extended postnatal home visiting programme initially started as a project 2013 with financial support from the Public Health Agency. The aim is to improve prerequisites for good health development among children growing up in the neighbourhood through early support for their parents. It follows two conceptual frameworks – Marmot's proportionate universalism, and WHO's nurturing care framework.

Families in Sweden receive one home visit, but five extra home visits have been introduced to all first-time parents registered at Rinkeby child health-care centre to provide greater support. The visits, which are performed by existing services, focus on health, nutrition, early learning, security and safety, and responsive caregiving, adopting respectful and responsive approaches that reflect the needs of the families. The goal is to create a dialogue through home visits every two weeks until the child is 15 months, providing educational tools as needed.



Results so far indicate that almost all eligible families (94%, 119) have accepted home visits and agreed to participate in the study. Seventy-nine per cent of fathers have participated. Comments from parents indicate that they feel they are being supported socially through the visits, which enables them to link with other services, and their confidence as parents has increased.

The programme is now being implemented in other disadvantaged areas of Sweden.

The Safe Environment for Every Kid (SEEK™) model³

Professor Howard Dubowitz, Safe Environment for Every Kid (SEEK™), University of Maryland School of Medicine, United States

While services have become better at responding to child abuse situations, the priority must always be to prevent it happening in the first place and, at the same time, promote children's health, development and safety. The SEEK™ model has these goals in mind.

The SEEK™ goals are to:

- help address common psychosocial problems
- support parents and parenting
- strengthen families
- promote children's health, development and safety
- prevent child abuse and neglect.

In most countries, some form of paediatric primary care service offers routine care to young preschool-age children. This provides an opportunity to achieve SEEK™ goals. Professionals working in paediatric primary care services typically enjoy very strong relationships with families, which positions them well to know what is happening in the family and identify and address problems.

The main targeted psychosocial problems, which are strongly related to child maltreatment and for which sound resources to deal with them exist in many communities, are:

- parental depression
- major stress
- substance abuse
- intimate-partner (domestic) violence
- harsh punishment
- food insecurity.

Implementation of SEEK™ in Europe requires the existence of some kind of routine health care for children. Leadership commitment is important, and system cultures should encourage innovation and quality improvement. Ideally, professionals providing the care should have an ongoing continuous relationship with families. Community resources to help address identified problems are required.

Two large RCTs of SEEK™, one in a population with a high level of low-income families in Baltimore, United States, and the second among middle-income, suburban, mostly white families, have been carried out. The studies sought to establish if primary care professionals were able to change attitudes and behaviours on the targeted problems. Improvements were seen

³ This presentation was delivered via a videoconference link.

in both studies based on three methods – self-report, medical records and direct observation – with improvements sustained for up to 36 months.

In relation to how effective SEEK™ is in helping prevent maltreatment, the studies have reported over a 30-month period fewer minor assaults on children among families exposed to the SEEK™ model over controls, dramatically decreased instances of delayed immunizations (an indicator of neglect), and an almost 50% reduction in reports to child protection services.

Cost analyses shows that SEEK™ costs US\$ 210 for each case of child maltreatment prevented. This represents a huge cost saving compared to a very conservative estimate of the fiscal costs of maltreatment of US\$ 1933–21 400 for medical and mental health care for a physically abused or psychologically maltreated child.

With any innovation, challenges are faced. Obtaining buy-in from primary care providers and providing facilitation for change can be challenging. Lack of resources and evaluation processes can also present obstacles. Having an organized network, however, helps to facilitate quality-improvement innovations and creates the environment for a learning collaborative.

Kidpower, Sweden

Ms Amanda Golart, Kidpower, Sweden

The rights and protection of children are in a lot of people's hearts, but also in laws in many countries, and in many research projects and programmes. For children to be protected from maltreatment, it is essential that they and the adults who care for them have developed and practised skills to take charge of their safety. If children do not recognize potentially dangerous situations and do not have the skills to take action, they will be less safe. Just as they need to know how to cross a road safely or to swim to save them from drowning, so they must learn how to move away from potential dangers, protect their feelings when someone is verbally abusing them, stop someone touching them in unsafe ways, and be persistent in getting attention from busy adults.

Adults need to know how to intervene and stop an unsafe situation. They also need to know how to advocate with people in positions of authority on behalf of children, and have the courage to overcome the discomfort of intervening.

How things are taught is as important as what is taught. Kidpower has taught millions of people of all ages and abilities around the globe how to use their personal power to stay safe from abuse, bullying, sexual assault, prejudice and other maltreatment since 1989. It is not about scaring children, but meeting them where they are in a very child-centred way. The aim is to give children, young people and adults skills they can use right away and throughout their whole lives. Kidpower is evidence-based, trauma-informed, culturally sensitive, effective and very positive. Although no official research has yet been done in Sweden, studies documenting Kidpower's effectiveness have been conducted in Canada, New Zealand and the United States.

Evidenced-based prevention of school bullying: the KiVa antibullying programme

Dr Miia Sainio, KiVa (Finland), and also speaking on behalf of KiVa (Estonia)

KiVa is formed from the first two letters of the words in Finnish that mean “bullying” (**K**iusaamista) and “against” (**V**astaaan).

Ten per cent of school-aged children globally across all kinds of society are bullied. This does not mean it is part of normal growing-up – action is needed because of the long-term psychological and physical impacts of bullying.

Twenty years ago, the Finnish Government recognized the problem of bullying in schools and developed policies to combat it, but bullying continued to increase. The former Minister of Education realized more systematic tools were needed and decided to fund the development and evaluation of a programme. KiVa started in Finland in 2006 at the University of Turku, funded by the Ministry of Education and Culture. Around 90% of schools had registered for KiVa by 2011. The longer schools stay with the programme, the better their results through steady decreases in bullying and victimization.

It builds on the theory of the participant role approach, suggesting that influencing the behaviour not only of those who perpetrate bullying, but also of bystanders, is essential in bullying prevention. This idea was incorporated into student lessons and also taught through online and visual representations in schools. Annual surveys are taken forward to enable teachers to monitor what is happening in their school.

The KiVa antibullying programme is evidence-based. It was first rigorously evaluated in an RCT in 2007–2009, followed by a study from the first year of national dissemination of the programme in 2009/2010. After one year, compared to control schools, KiVa was found to have resulted in a 30% reduction in self-reported victimization and a 17% reduction in self-reported bullying. It also influenced multiple forms of victimization.

KiVa has changed attitudes to bullying and victimization in schools in Finland, but the concern is that not all of the involved schools are actually using the programme. Reviews of programme use show that about 42% are persistent users, about 24% drop-off after a couple of years, and around 6% never truly become involved. Thirteen per cent of schools develop a renewed interest some couple of years after initial implementation. The question, then, is how to sustain participation consistently.

Research on this question has identified factors relating to:

- the programme itself, with teachers wanting it to be easy to start and to follow: motivation is kept high when teachers see evidence with their own eyes of the impact of the programme;
- lack of resources to develop and update the programme materials, leading to teachers using the same materials year on year;
- capacity and values at school level, with headteachers who support the programme and active staff members: it needs to be recognized that KiVa is not simply a one-year approach, but that it needs to be sustained over time, with one headteacher commenting the “It takes a couple of years to become a KiVa school”; and
- societal and political factors.

In Estonia, KiVa was tested prior to implementation. It was successful in reducing rates of bullying and victimization, so the decision was made to adopt it for the country. This required significant work to translate the materials and prepare country-specific videos to accompany the programme, and extra training and support opportunities for headmasters and teachers were offered through, for example, coaching and summer schools.

Several cohorts have now been reviewed, with a very positive trend in decreasing bullying and victimization seen. The programme has now extended to include Russian-speaking populations in Estonia.

Lessons from implementation strategies of the Olweus® Bullying Prevention Program (OBPP) in Norway, 2001–2018

Mr Andre Baraldsnes, Uni Research Health, Norway

The OBPP has been implemented in around 500 schools in Norway. While many continue with the programme, some drop off along the way. This leads to consideration of the core implementation components that drive implementation, sustainability, success and outcomes for a wide range of projects, including bullying-prevention programmes:

- staff performance evaluation
- decision-support data systems
- facilitative administrative supports
- systems interventions
- recruitment and selection
- pre-service training
- consultation and coaching.

Structured interviews with seven high-performing municipalities revealed that the programme's support system, support for recruitment, and provision of consultation and training was considered insufficient. The programme therefore took steps to strengthen in all three areas by establishing resource teams within schools – rather than just having an OBPP instructor at school level, having small anti-bullying teams in place that include health personnel and school psychologists, and which engage headmasters much more comprehensively. This is now being tested; it is anticipated that these measures will provide better support for leadership teams and teachers in schools and enhance motivation to make the programme succeed.

There is a strong need for intersectoral work between the health and education sectors at national, municipal and institutional levels to secure evidence-based programmes and measures against bullying, based on cross-sectoral science and experiences. Such measures must be taken forward in collaboration with, and reflecting the ethos, strengths and practices of, the schools and kindergartens targeted.

OBPP in Lithuania: implementation, results and challenges

Ms Ieva Zuzeviciute, Centre for Special Needs Education and Psychology, Lithuania

The OBPP programme aims to reduce the frequency of bullying in secondary schools. It consists of three core elements:

- **school-level activities**, including the enhancement of teacher competence, collaboration, supervision, and cooperation with parents to address bullying situations;
- **classroom-level activities**, including rules aimed at discouraging bullying behaviours and promoting prosocial behaviours, class meetings, learning activities (such as discussions, exercises and role play) and cultural events; and
- **individual activities**, including specific rules and actions for addressing individual bullying incidents through interventions with victims, those perpetrating the bullying behaviour and their parents.

The Lithuanian Ministry of Education and Science signed the contract with Olweus International in 2008. Currently, it has 50 instructors (with plans to train 15 more) and the programme has been implemented in 423 schools; 40 more will join in autumn 2018. One hundred and forty of the schools are still using the quality assurance system, having implemented the programme, found it was successful and decided to continue. Eighty-two are certified Olweus schools, meaning they meet all requirements and are implementing the programme successfully.

A two-week survey is carried out every November to evaluate the current situation in schools. Results show a constant decline in the number of students being bullied 2–3 times a month or more over all five survey rounds. The most encouraging feature is that a number of schools have remained with the programme since its inception, and they have achieved a reduction of 51%. Numbers of students adopting bullying behaviours has also declined steadily, with a 57% reduction in the inception schools. Teachers are becoming more proactive in intervening in bullying situations, with a 55% increase in such instances between 2008 and 2018.

Important issues arising from experience of using the OBPP in Lithuania include:

- ensuring government recognition of the issue of bullying;
- adopting a unified approach to the problem; and
- recognizing the importance of school headteachers' attitudes towards, and responsibility for, implementing the programme; staff members assign the programme less importance when headteachers are not active supporters.

Challenges to implementation include maintaining teachers' motivation (the programme requires some extra paperwork and monitoring duties for teachers and they may tend to focus on the effort of the inputs rather than the positivity of the outcomes), unwillingness to use the colleague supervision system (which is also associated with teacher motivation), and schools failing to reinforce student supervision during breaks, which is against OBPP principles; it is important to remind schools that adults should supervise break times.

Child abuse prevention initiatives in Lithuania

Ms Ieva Dulinskaite, Children Support Centre, Lithuania

The Children Support Centre is an NGO located in Vilnius. Its mission is to ensure the psychological well-being of children by providing professional comprehensive assistance for children and families. It was established in 1995, but since 1996 child abuse prevention and assistance for child victims of violence or abuse and their families has been the main priority.

Support includes the provision of:

- professional help for abused children and their families;
- forensic interviews of children and assistance for families participating in legal proceedings;
- training and ongoing supervision for professionals working with child victims;
- multidisciplinary collaboration in working with victims of child abuse; and
- information materials for professionals and the wider community on child abuse issues.

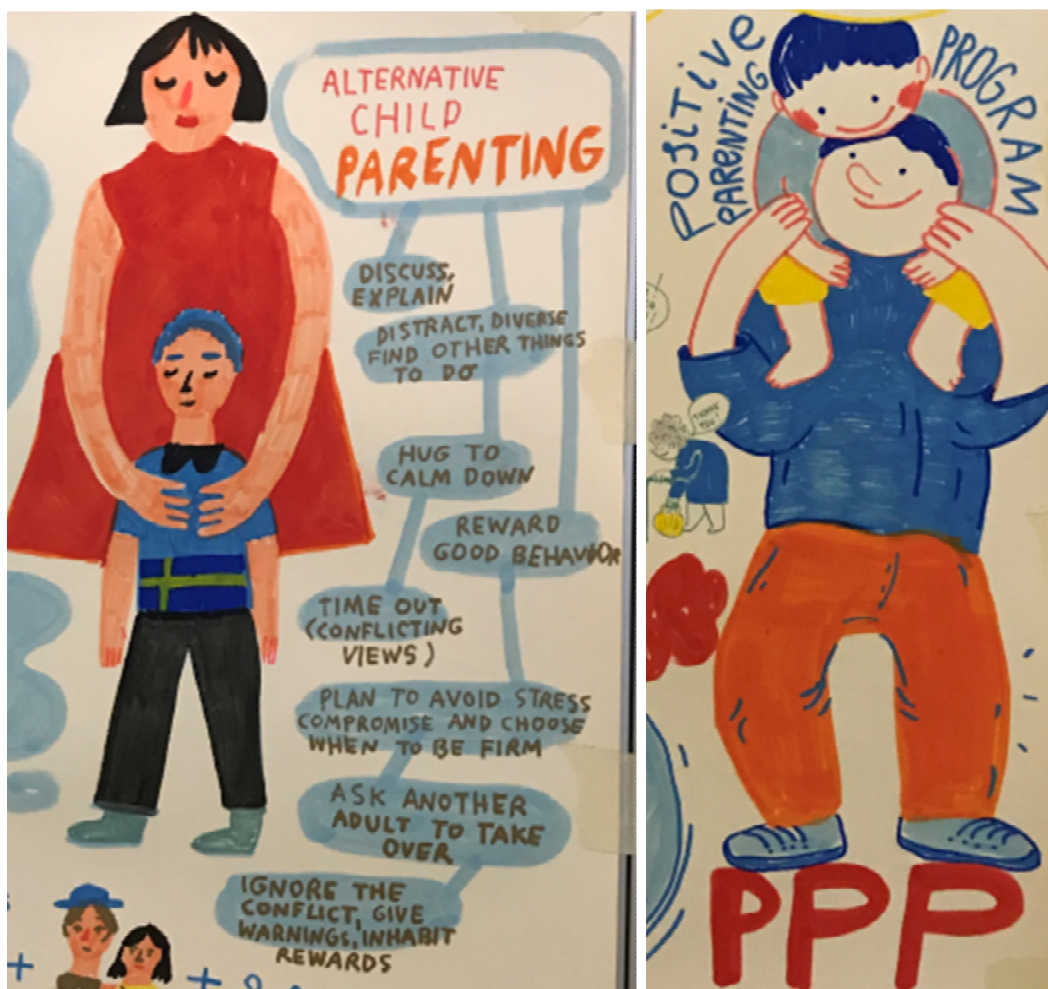
The main programmes with which the Centre works are:

- **Big Brothers, Big Sisters**, in which a professionally supported voluntary relationship between one adult and one child is established, aimed at developing the child's sense of

responsibility, trust and caring for him- or herself and others; over 100 pairings have been established;

- **Second Step**, a social and emotional skills-building programme that has been implemented in over 300 primary schools with 1000 teachers;
- **Positive Parenting** training for parents that focuses on helping them care for their children in a positive way; and
- **Parents' Line**, a professional psychological helpline for parents that is available for four hours in the evenings during week days.

The **Protect and Respect Me** programme, which aims to train teachers and other school specialists to notice the early signs of sexual abuse, create an intervention plan and, in collaboration with outside specialists, ensure that necessary help is provided to the children involved, started initially in 2015 in a couple of schools, but 10–20 more are expected to join in September 2018. Results in the two launch schools show that knowledge on child sexual abuse among teachers and parents increased, and that children of all age groups developed a better and more realistic understanding. Results were better among children in classes 1–5 than those in classes 6–8, suggesting it is very important to start early in helping children understand the issue. A new project, an e-learning platform for parents on child sexual abuse prevention, has now been launched. The course lasts 1.5 hours and covers issues like normal sexual behaviours for life stages and signs of sexual abuse.



Day 2

Keynotes

Promising preliminary results for targeting risk factors in the child's home environment

Dr Steven Lucas, Uppsala University Children's Hospital, Sweden

The project, whose aim is to develop a universal method to identify psychosocial risk factors in the child's home environment and assist in providing supportive services for the family, is being taken forward in BarnSäkert, just north of Uppsala.

Sweden has universal child health services, with more than 99% participation. They run from separate units mostly staffed by nurses and are committed to promotion and preventive work. There are high levels of trust for the centres in communities. This presents a perfect setting to identify psychosocial risk factors and offer support to families, but there are no structured methods for doing so.

Psychosocial risk factors for child maltreatment include:

- financial problems (particularly child poverty)
- depression
- extreme parenting stress
- substance misuse/abuse
- intimate-partner violence.

Studies have shown these issues have been amenable to parental support to decrease risks to children.

Following training, nurses use the short SEEK™ Parent Screening Questionnaire (SEEK-PQ) with the parents and discuss any issues that come up, using motivational interviewing techniques. Flow charts help with decision-making. Finally, the nurses offer parents services available through the community, such as social services, psychology, smoking-cessation services, women's refuges and substance misuse services. The information gathered in the project is beginning to reveal what services are most in demand.

Parents' (mothers and fathers) responses to the SEEK-PQ reveal a high level of psychosocial risk factors (Table 1).

Eleven per cent of parents seem to have issues with alcohol, and this is being investigated. At the start of the project, around 1% of parents claimed to have experience of intimate-partner violence, but the last round revealed 11%. This allows the nurses to open up the conversation to look at the issues.

The current study is a cluster-randomized study over two years, with all child health centres in the country participating. Half of the centres will use SEEK™ methodology and the other half their usual interventions. It is expected that 12 000 children will be exposed to SEEK™ through the study. Results will be published as the study progresses, and data from over 1000 parents have already been collected.

Table 1. Psychosocial risk factors in parents' responses to SEEK-PQ

Psychosocial risk factors	Women (%)	Men (%)	Total (%)
Child safety	23	23	23
Financial problems	19	23	21
Depressive symptoms	27	26	27
Parental stress	27	30	28
Alcohol misuse/abuse	11	12	11
Intimate-partner violence	15	5	11

A mixed-methods baseline study of the perceptions of nurses involved in the BarnSäkert project aimed to identify what the nurses thought about psychosocial risk factors before the project started and their experiences of dealing with them. Fifty-nine (78%) nurses responded. They were asked how often they experienced families with the risk factors in their practice, grading them as daily, weekly, monthly, quarterly or more rarely (Table 2).

Table 2. Nurses' perceptions

	Daily (%)	Weekly (%)	Monthly (%)	Quarterly (%)	More rarely (%)
Financial problems	3	24	32	14	27
Depressive symptoms	3	22	46	22	7
Extreme parental stress	12	37	34	10	7
Substance misuse/abuse	0	3	7	34	56
Intimate-partner violence	0	2	3	19	76

The percentage of nurses who felt they had sufficient knowledge, competence and confidence to address the psychosocial risk factors was very low for financial problems, substance misuse and intimate-partner violence, and somewhat higher for depressive symptoms, for which they had structured means of addressing in mothers. The nurses nevertheless felt strongly that these issues should be addressed by child health services (80–90% agreeing or strongly agreeing), although less clearly for financial problems (49%), which they felt were the preserve of social services.

Focus groups interviews were then conducted with the nurses to get more depth. Key themes emerging from the interviews were:

- the information parents offer depends on how they are asked;
- building rapport is especially important for discussing sensitive issues – it is worth waiting until the relationship is stronger;
- it is not always easy to focus on these issues, but it is part of nurses' jobs;
- all parts of the organization must be in place for this to work – there needs to be agencies to receive referrals with buy-in from employers to enable time to perform the functions; and
- nurses' work can make a difference for the child – the nurses saw themselves as child advocates who aimed to improve health and prevent maltreatment.

Results from the studies suggest that the SEEK™ model is compatible with nurses' work in child health services in Sweden.

Towards effective child protection systems to respond to child maltreatment

Ms Jenny Gray, Past President, International Society for the Prevention of Child Abuse and Neglect, and social work consultant

Working within the overall umbrella of the UNCRC, effective child protection systems tend to have the following components:

- national frameworks and protocols, with a commitment to multidisciplinary, multi-agency working;
- adequate resources – human and financial;
- competent staff, with opportunities for continuing professional development;
- access to professional supervision and mentoring;
- effective data collection systems;
- research and evaluation mechanisms; and
- a focus on improving outcomes for children.

Effective child protection systems also encompass primary prevention measures in addition to mechanisms for addressing suspected child abuse.

Anyone working with children or who has access to children and families may have cause to suspect abuse and neglect. Making decisions about the best interests of the child requires a thorough multidisciplinary, multisectoral assessment, and agreed interventions may demand input from a range of services. A key principle underpinning all work with children and families is that protecting children from harm is everyone's business and must be carried out in all settings.

Laws to support child protection work is important, as are multidisciplinary, multi-agency protocols and guidelines (international, national, local and organizational) so that all members of the team know what their responsibilities are and what is expected of them. This should be backed by cross-government support. There is also a need for understanding and support from all sectors of the community.

Collaborative working is needed at all levels, with all parts of the system supporting each other:

- **government** – working together across ministries to ensure service provision meets the identified needs of the populations at aggregate levels, and that arrangements are in place nationally to protect children;
- **local government** – working together to ensure local arrangements are in place to protect children from maltreatment; and
- **individual** – people and agencies working together on individual cases to protect children.

Guidelines and protocols should set out for everyone involved their responsibilities in relation to:

- the referral/reporting system;
- how to undertake a rapid multidisciplinary assessment of the nature and level of risk of harm to the child and make decisions, perhaps including removing the child and getting an emergency protection order;
- what legal and social welfare provisions are in place for emergency protection (rescue);
- how to undertake multidisciplinary assessments of child and family long-term needs; and

- what services are provided by different organizations to meet those needs, and in what order they should be provided.

Developing collaborative arrangements among agencies requires professional commitment to working together across sectors, service delivery organizations who value and facilitate staff working together. Collaborations are supported by written agreements (protocols) among all actors, common child protection policies in partner organizations, regular meetings within and between organizations and sectors, and single-discipline and multidisciplinary training.

The Multi-disciplinary Assessment and Participation in Child Protection (MapchiPP) transnational training programme is a very helpful tool for supporting effective collaboration. MapchiPP offers a needs-based approach that is adaptable across countries and can be accessed for free as users wish.

Challenges to the child protection system are, first, to recognize that it is a single system. Secondly, desires to cut costs can sometimes blind people and organizations to the fact that multidisciplinary, interagency collaboration is cost-effective, even in times of austerity. Thirdly, it is sometimes difficult to establish if the services provided are those most appropriate to the problems being addressed, and lastly, recognizing that parameters of success are not necessarily those defined by any organization, but by the degree of improvement in outcomes for children.

Discussion and reflections on child protection systems

Ms Anna Frank-Viron, Children’s House Social Insurance Board, Estonia, wanted to speak about positive values and putting children at the centre of decisions. This means asking children what they want and need, and she detected a move towards this approach in Estonia, where children and parents are involved in the improvement of services, producing papers and setting goals. It is not possible to work positively with children and families without organizational collaboration.

Estonia is using different methods to promote child welfare, including the MapchiPP programme. The child protection department has only been running for two years and has helped to improve the way municipalities and agencies work with children and families.

Ms Frank-Viron believed the video Professor Bellis had shown on Day 1 should be made widely accessible to emphasize to people the harms ACEs can cause but also how positive parenting can protect and nurture children.

Dr Inga Liepina, Ministry of Health, Latvia, stressed that under the law on children’s rights in Latvia, protection is a national priority. Child protection is guaranteed by parents, guardians and various service agencies and institutions

The system can therefore be improved by ongoing training and education of all institutions, organizations and parents. Health-sector specialists should become more proactive in meeting the challenge of child maltreatment and working for a better child protection system that focuses on prevention through surveillance.

Ms Gytė Bėkštienė, Child Care Centre “Užuoveja”, Lithuania, commented on child sexual abuse. The first support centre for sexually abused children and their families in Lithuania, the Child Care Centre “Uzuoveja”, was opened on 3 June 2016 in Vilnius. Its main goal is to create and ensure safe environments for children in which they can receive all the help they need in one

place from different specialists. To date, 352 children (18% aged 0–6 years, 45% 7–13 and 37% 14–17) and 149 of their relatives have received services in the centre, including psychological counselling, psychological assessment of the child, temporary accommodation, social worker counselling, forensic medical examination, forensic interviewing and provision of long-term treatment recommendations.

To lessen negative effects on the child after experiencing abuse, the centre focuses on interdisciplinary collaboration with various institutions, such as child rights protection services, police, pre-trial investigators, health services, organizations that provide services for families and children in crisis, schools and kindergartens.

Dr Jukka Mäkelä, National Institute for Health and Welfare, Finland, noted that the child protection system in Finland came under pressure in 2012 following the murder of an 8-year-old girl by her mother and stepfather. Reports also found that child protection varies among municipalities, which led to a major shift scheduled for 2020, when all social and health sessions will be taken away from municipalities and placed at regional level. This means child protection will be organized in a totally different way.

The Reform to Child and Family Services 2016–2018 programme, a combined effort of the ministries of social affairs and health, and education and culture, has been put in place to help ease transition to the new regional system. Among its many elements is child protection, with measures to reform it including:

- more family-based foster care;
- stronger overseeing structures;
- support for social workers in their work to protect the best interests of the child; and
- adoption of the Reclaiming Social Work model from the United Kingdom to enable a more holistic approach (called the Systemic Model for Child Protection in Finland).

Pilots of the Systemic Model for Child Protection are underway in municipalities. The National Institute for Health and Welfare coordinates training for local trainers (social worker and family therapist pairs) and support for municipalities through, for example, education for managers. Pilot teams are trained on site. National research is being carried out to evaluate the effects of the model.

Dr Anneli Marttila, Directorate of Social Affairs, Sweden, supported by **Mr Henrik Ingrids, Division for Families and Social Services**, described the activities and priorities of the National Board of Health and Welfare. Sweden has universal and preventive services. Since 2014, social services have had to start an assessment when a child has been subjected to violence, abuse or has witnessed domestic violence.

The National Board of Health and Welfare safeguards health and welfare and enables equal access to good health and social care through guidance, knowledge, follow up and evaluation. Guidance in relation to asking about violence includes recommendations for staff in maternity care and adult psychiatric care to always ask questions about violence, and for staff in child psychiatric care to raise the subject of violence in their assessment.

The Board has developed a national model for assessment, planning and follow up called Children's Needs in Focus. This aims to strengthen children's participation and influence,

improve cooperation with the child’s family and network, create a structure to enable systematic and easier follow up, and contribute to increasing quality.

Challenges for social services work in child protection include: social services balancing Sweden’s traditional practice of working closely with parents against the need to capture child perspectives – they need support and guidance in managing this difficult role; ensuring equity in how similar cases are handled in social services, indifferent municipalities and even within the same municipality; and the need to recognize children as agents in their own lives, taking into account their voices in their own cases.

Mr Ingrid’s added that Sweden has finally incorporated the UNCRC into legislation. This is a major and very positive step in the context of child protection. Adopting the UNCRC into legislation gives professionals in the health and social care sectors a very clear mandate to address child protection issues as well.

The development of child protection systems and possibilities for Lithuania

Associate Professor Rasa Naujaniene, Vytautas Magnus University, Lithuania

Until the 1990s, high-income countries tried to achieve a constructive balance between supporting families and protecting children; since then, a third approach has emerged, emphasizing the state’s role in promoting child development. This broader conception of child welfare/protection was inspired in part by the UNCRC, which underlined their social, political and legal rights.

Several factors separate child protection, family services and child development orientations (Table 3).

Table 3. Orientations

Factors	Child protection	Family services	Child development
How the problem of abuse is characterized	Abuse is framed as the harmful behaviour resulting from dysfunctional parenting	Problem is framed as manifestation of family dysfunction resulting from psychological difficulties, marital troubles, and socioeconomic stress	Frames problem as violations of child rights to protection and unequal outcomes for children
How the main driver for intervention is named	Main driver for intervention is parents that are neglectful and abusive towards children (maltreatment)	Main driver for intervention is needs of family unit for assistance	Main driver for intervention is the individual child’s needs in a present and future perspective
Aim of intervention	Priority given to protecting children from harm or reduction of harm	Priority given to working with the family to reduce harm to children, helping children and parents in a supportive way by focusing more on a partnership with parents (prevention and social bonding are included)	Harm reduction and overall child well-being in the present, not the future
Mode of intervention	Legalistic/investigative, with a focus on families identified	Therapeutic/needs assessment looking for a voluntary,	Best interests’ determination and

Factors	Child protection	Family services	Child development
	as high risk or requiring immediate intervention	collaborative solution	early intervention
State–parent relationship	Right to family privacy respected but adversarial/coercive if action required	Partnership with parents and offer of help to families	State supports parental responsibility but has an independent relationship with the child
Role of the state	Sanctioning: the state functions as a watchdog to ensure child's safety	Parental support: the state seeks to strengthen family relations	Duty bearer: the state has obligations to promote and protect children's rights to protection
Relationship of child protection and family support services	Child protection services separate from family support services	Child protection services are embedded in broader family support programmes	Child protection services are located in broader welfare services for all children in need

The child-focused approach combines many features of the child protection and family services systems in a search for a balanced approach that places the individual child more directly at the centre and introduces early interventions and regulatory/needs assessment. Some high-income countries turned to this approach around the turn of the century.

Countries nevertheless started to move from differences to convergence in approaches. In the mid-1990s, countries could be characterized as being oriented mainly toward family-services approaches (Belgium, Denmark, Finland, Germany, the Netherlands and Sweden) or towards child protection approaches (Canada, United Kingdom (England) and the United States). By 2010 it was not possible to differentiate sharply between the countries. All countries (including Norway) included some mix of family-service, protective and developmental orientations as they struggled with the complexities and tensions of balancing practice objectives in the realm of child welfare.

In Lithuania, the dominant approach since 1990 has been child protection. Child protection is separated from social services. Social workers from public agencies or NGOs provide a support function for families defined as being at social risk, while law-educated chief specialists at child protection units provide the decision-making control function in child protection cases. Family social workers were introduced in 2007, but there have been some difficulties in securing collaboration between child protection units and family social workers.

Lithuania turned from the Soviet planned economy to a free-market economy in 1990, with neoliberal influences. The neoliberal economic influence is characterized by insufficient investment in human capital and welfare programmes, including child welfare. Consequently, professionals – in Lithuania's case, family social workers – are being exposed to a public who hold them directly responsible for child abuse and maltreatment problems or system

malfunctions. This had led to the development of defensively orientated family social work, when priority is given to writing reports, filling case files and other paperwork tasks.

Reform of the system of protection of child rights and the centralization of child protection will start on 1 July 2018. Child protection system will introduce more investigatory risk control, reactive interventions (including mobile teams) and surveillance of families considered to be at risk.

Intersectoral coordinators for child welfare issues were introduced in every municipality at the end of 2017. The aim is to encourage collaboration (in the social services sector) between child protection units and family social work organizations, and (intersectorally) among social workers and other welfare workers, family doctors, nurses, school workers and the police.

Discussion on child protection reforms in Nordic and Baltic countries

Dr Turid Heiberg, Council of the Baltic Sea States (CBSS) Secretariat, spoke on successes and challenges in implementing the Barnahus (children's house) programme. The Barnahus model offers the child victim/witness of violence a child-friendly, safe and professional environment to disclose – which is fundamental to the criminal investigation, the judicial process and the follow up of the child. The interview is recorded and used as evidence in court.

The Barnahus model is based on supporting cooperation among forensic, legal, medical therapeutic follow-up and child protection services. The main component is to support investigation of child maltreatment in the best interests of the child. The child is the central focus, and the aim is to offer the child victim/witness of violence a child-friendly, safe and professional environment to disclose. A key feature is to avoid re-traumatizing the child through the process, ensuing the child is interviewed only once. The model is integrated into the national social welfare, health and/or justice systems of most countries.

Relevant disciplines and agencies are gathered under one roof, providing a multidisciplinary response to each child, including medical and mental health examination, and treatment. This also means that the case can be followed through a designated person.

Barnahus has developed a vision paper as part of the PROMISE project that sets out four main principles:

1. respect for the participatory rights of the child
2. multidisciplinary and interagency collaboration
3. comprehensive and accessible services
4. high professional standards, training and sufficient resources.

Challenges are many, however, the biggest being securing buy-in from different government sectors and some professionals, such as judges. There is a risk that Barnahus becomes just another small system within a much bigger system, and lack of follow-up for children exiting Barnahus at municipality level is an ongoing challenge.

Dr Jukka Mäkelä, National Institute for Health and Welfare, Finland, described LASTA – a method for intersectoral work in child abuse. LASTA is a Finnish project that aims to develop a systematic interagency approach to make the processes launched by allegations of child abuse more child-friendly. It is a Barnahus-type model based on multiagency cooperation, but with a twist: no new structures could be created, so it needed to be developed within the existing

framework. It reflected the need to create a new way of supporting interagency cooperation, as there was immense variation in how child abuse cases were handled.

Finland has five highly regarded forensic child and adolescent psychiatry units with high levels of expertise. They adopt a child-friendly approach but their processes are lengthy. Reporting to the police and social services of suspected violence against children (around 8000 per year) is mandatory. LASTA's aim is to support the decision-making of the police and child protection agencies by bringing the cases to greater public awareness.

LASTA has created a risk-assessment form through clinical and theoretical cooperation and practical experience that combines questions used by child forensic assessment units, police and child protection units and performs a systematic search for risk factors of abuse as recorded in medical, social science and psychology databases.

Experiences of using the risk-assessment form show that:

- police send the requests quickly;
- sometimes physical examinations that had not been requested previously can be done;
- police get more background information, especially in unclear cases; and
- the multiprofessional meetings enable more children to be reviewed than would have been the case if the police and/or social worker worked alone.

Supporting health professionals to recognize signs of child maltreatment

Preview of forthcoming WHO guidelines for the health sector response to child maltreatment

Dr Alexander Butchart, Coordinator, Violence Prevention, WHO headquarters

Every day around the world, hundreds of millions of children who are or at risk of being maltreated engage with health-care providers, without the providers knowing or suspecting the abuse. The health sector has a major part to play in the public health response to child maltreatment. Much greater success could be achieved if every health-care worker was alert to the possibility that evidence of child maltreatment may exist in as many as one in three of the children they see and that there are things they can do, even without sophisticated referral systems.

The aim of the WHO guidelines is to speak to those front-line health-care providers, particularly in low-resource settings, on what they can do in the immediate and short-term for children exposed to physical, emotional and sexual abuse and neglect, and what they can do for perpetrators, taking into account ethical, human rights-based, and trauma-informed good practices.

The guidelines therefore begin at the point where a health-care provider engages with a child and/or caregiver for anything – not where abuse is the presenting problem. They cover responses to the point where a specialist referral is made.

WHO has a rigorous guideline development process that involves a huge amount of systematic reviews, expert group opinions and practitioner reviews, and is driven by the GRADE

approach.⁴ The ultimate arbiter of the worth of any recommendation made in a WHO guideline is how effectively it improves the well-being and welfare of the relevant population group, in this case, children.

Draft recommendations seeking to address two questions (is universal screening more accurate in identifying children exposed to child maltreatment than clinical inquiry?; and does universal screening compared to clinical inquiry result in better child well-being and welfare outcomes?) have now been produced. In identification, factors addressed are health-care providers being alert to the clinical features of child maltreatment and associated risk factors, considering exposure to child maltreatment when assessing children with conditions that may be caused or complicated by maltreatment, and ceasing to use universal screening (such as standard questions for all children and caregivers) for child maltreatment, as evidence suggests little effect. Clinical enquiry by health-care staff who have been alerted to the fact that abuse is often not disclosed and is not the presenting problem, but that certain symptoms and signs may signal the existence of child maltreatment, seems to be superior to using some of the screening instruments that have been developed.

In interventions, draft recommendations include: psychological interventions, such as cognitive behaviour therapy and interpersonal psychotherapy, for children and adolescents with emotional disorders; behavioural interventions, individual or group cognitive behavioural therapy with a trauma focus, or eye movement desensitization and reprocessing being considered for children and adolescents with posttraumatic stress disorder; and parenting interventions that focus on goal-oriented, client-centred interviewing styles and which teach parents communications skills and promote safe, stable and nurturing parent–child interactions. No recommendation has yet been made for interventions with perpetrators – more research is necessary.

Among the best-practice statements under preparation is one on appropriate reporting or referral. Mandated reporting is common across countries, but there is little evidence for its effects on children. No recommendation has been made for mandated reporting, but in jurisdictions where it is legally required, the health and safety concerns of the child should outweigh the legal requirements. If reporting means jeopardizing the child’s well-being, it should not be done.

Norwegian centre for violence and traumatic stress studies

Ms Anne-Marthe Solheim Skar,⁵ Norwegian Centre for Violence and Traumatic Stress Studies
The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS), established in 2004, conducts research, communicates knowledge, and provides informed advice related to implementation, prevention and treatment of trauma and trauma-related responses.

Commissioned by health authorities in 2008, a group of researchers and clinicians at NKVTS conducted an RCT comparing trauma-focused cognitive behavioural therapy (TF-CBT) to therapy as usual. The results suggested that TF-CBT is more effective than therapy as usual for treating traumatized young people.

Following this, the Norwegian Ministry of Health initiated national implementation of TF-CBT. The ambition is to transfer evidence-supported models into regular clinics sustainably and with fidelity. Successful implementation requires change at practice (clinicians), organizational

⁴ GRADE stands for **g**radings of **r**ecommendations **a**ssessment, **d**evelopment and **e**valuation.

⁵ Ms Solheim Skar was unable to attend the workshop. This summary is based on her submitted abstract.

(leaders) and system (funders/government) levels. The implementation project works at all these levels through Fixen's implementation model.

Challenges include reluctance to screen for trauma, lack of leadership support, large caseloads, and therapist turnover. Most clinics have nevertheless succeeded with implementation; they have introduced systems that contribute to good patient flow, are focused on providing the best possible services to children, reflect the new method, are supported by leading professionals, and have participation from most leaders through follow-up phone consultations.

Recommendations for health professionals on recognition of victims of child abuse

Dr Dzintars Mozgis, Centre for Disease Prevention and Control, Latvia

In Latvia, there are indications that child abuse has been a taboo subject – until now. This is evidenced by the very low number of registered cases of abuse, at the same time as a big number of children sustained unexplained injuries. Recommendations have now been developed to support health professionals (including family doctors, paediatricians and others) in recognizing the signs that may indicate potential or actual child abuse and the sequence of actions that follows in such cases.

The most important messages highlighted in the recommendations include:

- child abuse may take place in apparently functional and secure families, not just in those that are socially vulnerable;
- commonly, it is not a single sign but rather a set of signs that points towards some type of abuse;
- to detect signs of physical abuse, health professionals have to look for them;
- sexual abuse may have happened recently, but usually it will have happened some time earlier – perhaps several weeks or months ago; and
- implausible explanations of what happened may point to potential abuse.

The recommendations define the various forms of abuse with typical signs that may indicate their presence. Doctors are guided on how to identify injuries that are social (caused through play, for instance) and those caused by abuse (the different distributions of the injuries are described). The sequence of actions to be followed if a health professional suspects child abuse is set out, including conducting a careful examination, questioning the child and caregivers, fully recording findings and reporting to the police.

General discussion on detecting child abuse for health professionals

It is one thing to produce guidance, and another to help people act on it. How can this be facilitated?

In Finland, coordinators have been introduced to each municipality – they are called pilots, in the sense of leading – and they are responsible for holding interdisciplinary training and other activities to support implementation. They form a supportive network throughout the country and provide every community with someone they can contact if they need support or training. In the United Kingdom, a network of teachers, doctors and nurses who have wide experience of child abuse cases has been identified as a group of known persons people can go to for advice and help, and plan what needs to be done next.

What is the most effective way to report, and to whom should reports be made?

The police tend to be the recipients of mandatory reports in many countries, but in Norway, it is child protection services. They, it is felt, are in a better position to foster dialogue with parents, particularly if they are already known to the system. The principle is that the children are not placed outside the home, and the parents get support.

In the United Kingdom, following an inquiry into the death of a young girl, an easily accessible document was developed for agencies called *What to do if ...*. It is written in short and longer forms for a multidisciplinary and public audience to set out what they should do if they have concerns. Training materials were then developed (again, short and long forms) for anyone who has contact with children and who may be involved in initial assessments and reporting. More intensive training for those who may need to take the child and family through the whole system was then developed.

The United Kingdom's first port of call for reporting is child welfare services, but people can also report to the police, particularly in crises that require immediate action. Mandatory reporting is not in place, but all the training and guidance points to teaching people what to do and to ensure they take it seriously as a professional responsibility, which is different from being mandated by law. This kind of approach is likely to be supported in the upcoming WHO guidelines.

The impact on mandatory reporting on children's well-being has not yet been evaluated. It must be asked – is it good for the child? Are there follow ups of children who have been through the mandatory process to see how they are faring 3–5 years later and which can be compared with those who have experienced a non-mandatory approach? That is the really interesting research question.

Regardless of whether reporting is mandatory or non-mandatory, the issue of competence is important, particularly in recognizing where the line should be drawn when someone's level of competence has ended, and someone else's should start. In Sweden, despite having mandatory reporting, nurses often take it on themselves to work with families for lengthy periods to a point that is beyond their level of competence, instead of handing the case on to social services. These are issues that need to be underscored regardless of reporting – it is about knowing what to do, being a professional and doing it right.

Group work

Countries' situations in relation to action plan implementation

Participants were divided into country groups to discuss the implementation of their respective national action plans. In summary, many countries reported having national action plans, but most, if not all, have only been partially funded. Countries have systems in place for information exchange and promote multisectoral approaches to address child maltreatment prevention. While good surveillance and monitoring systems exist, they have not been measured consistently, leading to data inconsistency.

Countries reviewed their national action plans as part of the group work, rating on a scale of 1 (poor) to 5 (excellent) how their country is implementing each of the INSPIRE strategies, except for “Income and economic strengthening”. The average of the scores is shown in Table 4.

Table 4. Averages on country implementation of the INSPIRE strategies

INSPIRE strategies ^a	Implementation and enforcement of laws	Norms and values	Safe environments	Parental and caregiver support	Responsive services	Education and life skills
Country average score ^b	5	3	3	4	4	4

^aThe strategy “Income and economic strengthening” was not included in the exercise.

^b Scoring: 1 = poor, 5 = excellent.

Closing

Following brief statements from representatives (**Ms Viktorija Blosakova**, Ministry of Welfare, Latvia; **Dr Alexander Butchart**, WHO headquarters; **Ms Dimitrinka Jordanova Peshevska**, School for Political Sciences and Psychology, the former Yugoslav Republic of Macedonia; **Ms Freja Kärki**, Norwegian Directorate for Health; **Dr Nataliya Korol**, WHO country office, Ukraine; **Ms Pirjo Lillsunde**, Ministry of Social Affairs and Health, Finland; **Ms Helen Nilsson**, Nordic Council of Ministers; **Ms Ruta Pabedinskiene**, Ministry of Social Security and Labour, Lithuania; **Ms Jóna Pálsdóttir**, Ministry of Education, Science and Culture, Iceland; and **Ms Brit Tammiste**, Criminal Policy Department, Estonia), **Dr Dinesh Sethi** closed the workshop. The following observations were made.

- Cooperation is a vital element for everyone working in the field of child maltreatment.
- Multisectoral collaboration needs to be considered and implemented at different levels – nationally, the focus should be on, for example, coordination committees providing stewardship and focusing more on preventive strategies.
- While the meeting has discussed important issues, it has been light on gender-based issues – maltreatment affects girls differently from boys, and this needs to be addressed.
- It is important to change societies’ and countries’ norms and values in relation to, for instance, domestic violence and corporal punishment. All forms of media can be used to heighten awareness of these issues and help to change norms and values.
- Prevention strategies should be based on common principles, such as having only the best evidence-based programmes and making them widely available, focusing on universal prevention and school-based programmes, and having implementation mechanisms and multisectoral cooperation through, for instance, thematic and regional networks. It is also crucial to ensure everyone working to implement prevention strategies shares the same values and understands why evidence-based programmes are so necessary.
- The Nordic Council of Ministers is able to provide funding to support activities like workshops and study visits.



Annex 1

PROGRAMME

DAY ONE: MONDAY 19 JUNE 2018

<p>09:00–09:30 Chair: Ms Ingrida Zurlyte, Head of WHO country office (Lithuania)</p>	<p>Official welcome</p>	<p>Professor Aurelijus Veryga, Minister of Health of Lithuania Ms Vilma Augienė, Vice Minister of Social Security and Labour of Lithuania Mr Grazvydas Kazakevicius, Vice Minister of Education and Sciences of Lithuania Dr Dinesh Sethi, WHO Regional Office for Europe Ms Helen Nilsson, Nordic Council of Ministers</p>
<p>09:30–09:50 Chair: Mr Algirdas Šešelgis, Vice Minister of Health, Lithuania</p>	<p>The life-course approach to prevent child maltreatment and European progress in implementing the European child maltreatment prevention action plan</p>	<p>Dr Dinesh Sethi, Violence and Injury Prevention Programme (WHO Regional Office for Europe)</p>
<p>09:50–10:20 Chair: Mr Algirdas Šešelgis, Vice Minister of Health, Lithuania</p>	<p>The cost and consequences of Adverse Childhood Experiences (ACEs) and how they can be avoided and video animation on ACEs</p>	<p>Professor Mark Bellis, Public Health Wales, United Kingdom</p>
<p>10:20–10:40 Chair: Mr Algirdas Šešelgis, Vice Minister of Health, Lithuania</p>	<p>Current situation in Lithuania: working by sectors</p>	<p>Ms Rūta Pabedinskienė, Adviser, the State Child Rights Protection and Adoption Service under the Ministry of Social Security and Labour</p>
<p>11:10–11:30 Chair: Ms Freja Kärki, Norwegian Directorate for Health</p>	<p>Presentation of INSPIRE strategies and implementation guides</p>	<p>Dr Alexander Butchart, WHO Coordinator Violence Prevention (WHO headquarters)</p>
<p>11:30–12:30 Chair: Ms Freja Kärki, Norwegian Directorate for Health</p>	<p>Presentation of two strategies: 1. Norms and values 2. Implementation and enforcement of laws</p>	<p>Changing norm on corporal punishment in Sweden: lessons for Europe Keynote: Professor Staffan Jansson, Professor Emeritus, Karlstad University and Örebro University</p>
		<p>Successes and challenges of the child rights protection in Lithuania Keynote: Dr Aušra Kurienė, Children Support</p>

Centre

13:30–15:00

Chair: Dr Austeja Landsbergiene,
Director, Vaikystes Sodas

Presentation of parent and caregiver support strategy

Keynote: Mr Bjørn Brunborg, The Incredible Years, Norway

Keynote: Dr Yulia Shenderovich, University of Cambridge, United Kingdom

Example of National Programmes

Ms Piia Marjatta Karjalainen, The Incredible Years, Finland

Dr Raziye Salari, Triple P – Positive Parenting Programme, Uppsala University, Sweden

Moderated discussion

Example of national programmes:

Ms Deirdre Webb, Family Nurse Partnerships, Northern Ireland, United Kingdom, and **Ms Tine Gammelgaard Aaserud,** Nurse Family Partnerships, Regional Centre for Child and Adolescent Mental Health, Norway

Dr Anneli Marttila and Ms Johanna Mellblom, Home Visitation, Directorate of Social Affairs, Sweden

Moderated discussion

15:00–15:30

Chair: Dr Larisa Boderscova, National Professional Officer, WHO country office, Republic of Moldova

Presentation of two strategies:
1. Safe environments
2. Education and life skills

Keynote: Professor Howard Dubowitz, Safe Environment for Every Kid (SEEK), University of Maryland School of Medicine, United States (via videoconference)

Example of national programme:

Ms Amanda Golar, Kidpower, Sweden

15:35–16:15

Chair: Dr Robertas Povilaitis, Director, Child Line, Lithuania

Panel on violence prevention in schools

Examples of national programmes:

Dr Miia Sainio, KiVa (Finland) and KiVa (Estonia)

Dr André Baraldsnes, Uni Research Health, Bergen/Olweus Programmes (Norway)

Ms Ieva Zuzeviciute, Centre for Special Needs Education and Psychology, Olweus (Lithuania)

Ms Ieva Dulinskaite, Children Support Centre (Lithuania)

Moderated discussion – (10 mins)

16:30–17:00

Chair: Dr Dinesh Sethi, WHO Regional Office

Strengthen the governance for prevention of child maltreatment through multisectoral action by developing and implementing

Dr Dinesh Sethi, WHO Regional Office for Europe

Facilitators:

Estonia (Ms Hanna Vseviov, Ministry of Social

for Europe	national plans.	Affairs)
	<ul style="list-style-type: none"> • Groupwork #1 on intersectoral collaboration to implement existing national plans 	<p>Finland (Ms Pirjo Lillsunde, Ministry of Social Affairs and Health)</p> <p>Latvia (Dr Inga Liepina, Ministry of Health)</p> <p>Lithuania (Ms Audronė Astrauskienė, Ministry of Health of Lithuania)</p> <p>Norway (Ms Freja Kärki, Norwegian Directorate for Health)</p> <p>Sweden (Mr Henrik Ingrid, Ministry of Health and Social Affairs)</p>

17:00–17:30

Chair: Dr Dinesh Sethi , WHO Regional Office for Europe	Plenary: feedback from the breakout session groups	All
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DAY TWO: TUESDAY 19 JUNE 2018

09:00–09:10

Chair: Professor Mark Bellis , WHO Collaborating Centre on Investment for Health and Well-being (Public Health Wales, United Kingdom)	Recap/debrief	Rapporteur
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09:10–09:30

Chair: Professor Mark Bellis , WHO Collaborating Centre on Investment for Health and Well-being (Public Health Wales, United Kingdom)	Evaluation of SEEK programme in Sweden	Keynote: Dr Steven Lucas , Associate Professor of Paediatrics, REACH Department of Women’s and Children’s Health, Uppsala University, Sweden
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09:30–10:15

Chair: Professor Mark Bellis , WHO Collaborating Centre on Investment for Health and Well-being (Public Health Wales, United Kingdom)	Towards effective child protection systems to respond to child maltreatment	<p>Keynote: Ms Jenny Gray, Past President ISPCAN and social work consultant</p> <p>Discussants and reflection on child protection systems:</p> <p>Ms Anna Frank-Viron, Children’s House Social Insurance Board, Estonia</p> <p>Dr Inga Liepina, Ministry of Health, Latvia</p> <p>Ms Gytė Bėkštienė, Child Care Centre “Užuoveja”, Lithuania</p> <p>Dr Jukka Mäkelä, National Institute for Health and Welfare, Finland</p> <p>Dr Anneli Marttila, Directorate of Social Affairs, Sweden</p>
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10:15–10:50 Chair: Professor Mark Bellis , WHO Collaborating Centre on Investment for Health and Well-being (Public Health Wales, United Kingdom)	Moderated discussion on child protection reforms in Nordic and Baltic countries	Keynote: Dr Rasa Naujanienė , Vytautas Magnus University, Lithuania Discussants: Dr Turid Heiberg , (CBSS) Secretariat Dr Jukka Mäkelä , National Institute for Health and Welfare, Finland
11:20–12:30 Chair: Ms Jenny Gray , Past President ISPCAN and social work consultant	Presentation of response and support services strategy	Speaker: Dr Alexander Butchart , WHO headquarters Example of national programmes: Ms Ane-Marthe Solheim Skar , Norwegian Centre for Traumatic Stress Studies Dr Dzintars Mozgis , Centre for Disease Prevention and Control, Latvia Moderated discussion: examples from other countries
13:30–14:30 Chair: Dr Alexander Butchart , WHO headquarters	Groupwork #2 on intersectoral collaboration to implement existing national plans and how the Nordic Baltic Network can help	Dr Yongjie Yon , WHO Regional Office for Europe Facilitators: Estonia (Hanna Vseviiov, Ministry of Social Affairs) Finland (Ms Pirjo Lillsunde, Ministry of Social Affairs and Health) Latvia (Dr Inga Liepina, Ministry of Health) Lithuania (Dr Robertas Povilaitis, Child Line) Norway (Ms Freja Kärki, Norwegian Directorate for Health) Sweden (TBC)
14:40–15:40 Chair: Dr Alexander Butchart , WHO headquarters	Plenary: feedback from the breakout session groups	All
16:00–16:40 Chair: Dinesh Sethi , WHO Regional Office for Europe	Panel on multisectoral collaboration and action on how governments can respond to and prevent child maltreatment	Panelists: Ms Brit Tammiste , Criminal Policy Department, Estonia Ms Pirjo Lillsunde , Ministry of Social Affairs and Health, Finland Ms Jóna Pálsdóttir , Ministry of Education, Science and Culture, Iceland Ms Viktorija Blosakova , Ministry of Welfare, Latvia Ms Ruta Pabedinskiene , Ministry of Social Security and Labour, Lithuania Ms Freja Kärki , Norwegian Directorate for Health

Ms Dimitrinka Joranova Peshevska, the former
Yugoslav Republic of Macedonia

Dr Nataliya Korol, WHO country office, Ukraine

16:40–17:00

Chair: Dr Dinesh Sethi,

WHO Regional Office

for Europe

Closing and reflections

Ms Vilma Augienė, Vice Minister, Ministry of
Social Security and Labour, Lithuania

Dr Alexander Butchart, WHO headquarters

Ms Helen Nilsson, Nordic Council of Ministers

Dr Dinesh Sethi, WHO Regional Office for Europe

Annex 2

PARTICIPANTS

LIST OF PARTICIPANTS

COUNTRIES	
Estonia	
Ms Anna Frank-Viron Children’s House Social Insurance Board	Ms Ingrid Ots-Vaik Ministry of Social Affairs
Dr Tiia Pertel National Institute for Health Development	Ms Brit Tammiste Criminal Policy Department
Ms Hanna Vseviov Ministry of Social Affairs	
Finland	
Pirjo Lillsunde Ministry of Social Affairs and Health	Dr Jukka Mäkelä National Institute for Health and Welfare
Iceland	
Ms Jóna Pálsdóttir Ministry of Education, Science and Culture	
Latvia	
Ms Viktorija Bolsakova Ministry of Welfare	Ms Kristine Lace-Strodaha State Police
Dr Inga Liepina Ministry of Health	Dr Dzintars Mozgis Centre for Disease Prevention and Control
Ms Lauma Zarina State Police	
Lithuania	
Ms Ana Aidietienė Švenčionys District Municipality	Ms Aušrutė Armonavičienė Ministry of Health
Ms Audronė Astrauskienė Ministry of Health	Ms Vilma Augienė Ministry of Social Security and Labour
Ms Audronė Bedorf Child Rights Protection Ombudsman Institution	Ms Gytė Bėkštienė Child Care Home “Užuovėja”

Ms Ieva Braškienė
Child Rights Protection Ombudsman Institution

Ms Edita Bishop
Ministry of Health

Ms Ligita Čeledinienė
Department of General Education

Mrs Asta Dilytė
Department of General Education

Ms Simona Grėbliūnaitė
Vilnius City Municipality Administration

Ms Ramunė Guobaitė-Kiršlienė
President Administration

Mr Gražvydas Kazakevičius
Ministry of Education and Science

Dr Aušra Kurienė
Children Support Centre

Mr Ričardas Kukauskas
Children Welfare Centre “Pastoge”

Ms Almeda Kurienė
President Administration

Dr Austėja Landsbergienė
“Vaikystės Sodas” chain of preschools

Ms Jurgita Makūnaitė
Vilnius City Municipality Administration

Ms Evelina Martinkienė
Vilnius City Municipality Administration

Ms Aira Mečėjienė
President Administration

Ms Kristina Medžiaušytė
Ministry of Health

Ms Sonata Mickutė
Ministry of the Interior

Ms Rima Mockevičienė
Alytus City Municipality Administration

Ms Eglė Neciunskienė
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Ms Rūta Pabedinskienė
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Ms Lolita Plančiūnaitė-Vaičiulienė
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Ms Gabrielė Platakytė
State Child Rights Protection and Adoption
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Ms Aistė Pupinytė
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Ms Teresa Roščinska
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Mr Audrius Ščeponavičius
Ministry of Health

Ms Gražina Šeibokienė
Ministry of Education and Science

Mr Algirdas Šešelgis
Ministry of Health

Ms Asta Šidlauskienė
Public Institution “Social Partnership Centre”

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