



# **HASSELA SKÅNE OUTPATIENT CARE -**

MAPPING RISK FACTORS WITHIN A CRIME  
PREVENTION INTERVENTION

SIMONE ROTHE

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Rothe, S. HASSELA SKÅNE OUTPATIENT CARE - Mapping Risk Factors Within a Crime Prevention Intervention. *Degree project in Criminology 15 Credits*. Malmö University: Faculty of Health and Society, Department of Criminology, 2023.

## ABSTRACT

Crime prevention is taking action early before serious problems arise. Waiting for a problem to arise is costly, inefficient and worse for the individual and society. Nevertheless, much of the preventive work today is devoted to intervening in individuals with obvious and numerous risk factors. The study was carried out in an outpatient care company called Hassela Skåne, the company takes care of exposed high-risk children and youth people who have a high probability of falling into crime or becoming victims of crime. The purpose of the studies was to map Hassela Skåne's data to see what differences there are between their child/youth intervention and family intervention regarding risk factors and goal fulfillment, in order to find possible development paths to a favorable intervention. The material used includes a number of different static risk factors from the outpatient care company Hassela's database, linked to the individuals who are/are being treated at Hassela. The result showed that there were no differences between different types of intervention, neither in terms of risk factors nor goal achievement, but the result is very likely to be influenced by the majority of background factors. Continued research on evaluations within outpatient care in Sweden is requested, in order to build on favorable interventions that can reduce child and youth delinquency.

*Keywords: Children, Crime prevention intervention, Norms, Risk factors, Social vulnerability, Youths.*

*Total number of words: 6516*

# ÖPPENVÅRDEN HASSELA SKÅNE- KARTLÄGGNING AV RISKFAKTORER INOM ETT BROTTSFÖREBYGGANDE OMRÅDE

SIMONE ROTHE

Rothe, S. ÖPPENVÅRDEN HASSELA SKÅNE – Kartläggning av riskfaktorer inom ett brottsförebyggande område. *Examensarbete i kriminologi 15 högskolepoäng*. Malmö Universitet: Fakulteten för hälsa och samhälle. Institutionen för kriminologi, 2023.

## ABSTRACT

Brottsförebyggande åtgärder är att vidta åtgärder tidigt innan allvarliga problem uppstår. Att vänta på att ett problem ska uppstå är kostsamt, ineffektivt och värre för individen och samhället. Ändå ägnas mycket av det förebyggande arbetet idag åt att ingripa hos individer med uppenbara och många riskfaktorer. Studien utfördes i ett öppenvårdsföretag vid namn Hassela Skåne, företaget tar hand om utsatta högrisktagande barn och ungdomar som har en stor sannolikhet att falla in i brottslighet eller bli offer för brott. Syftet med studien var att kartlägga Hassela Skånes data för att se vad det finns för skillnader mellan deras barn/ungdomsinsats och föräldrainsats gällande riskfaktorer och måluppfyllelse, för att hitta möjliga utvecklingsvägar till en gynnsam insats. Materialet som använts innefattar ett antal olika statistiska riskfaktorer från öppenvårdsföretaget Hasselas databas, kopplade till de individer som behandlats/behandlas hos Hassela. Resultatet visade att det inte fanns några betydande skillnader mellan olika typer av insatser, varken vad gäller riskfaktorer eller måluppfyllelse, men att resultatet med stor sannolikhet påverkas av flertalet bakgrundsfaktorer. Fortsatt forskning på utvärderingar inom öppenvården i Sverige efterfrågas, för att bygga vidare på gynnsamma insatser som kan minska barn och ungdomars brottsbenägenhet.

*Nyckelord: Barn, Brottsförebyggande insatser, Normer, Riskfaktorer, Social utsatthet, Ungdomar.*

*Total number of words: 6516*

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# 1. INTRODUCTION

A large amount of criminological research and expertise suggests that criminality is influenced by a high number of risk factors and early norm-breaking behavior (Jolliffe et al., 2017; Moffitt, 1993). The risk factors can, for example, be details that have been noticed by the school, such as truancy, antisocial behavior, or a lack of social competence. Additionally, they can include certain psychiatric diagnoses such as ADHD and Autism, where the child/youth have difficulty adapting and understanding other perspectives. Other risk factors that are considered to be important are early onset of criminal behavior, psychopathic traits, but also environmental factors such as poor living conditions and low socioeconomic status (Odgers & Russell, 2017; González Mor, 2019; Andershed & Andershed, 2019; Wikström & Butterworth, 2006).

In the last five years, reports of concern to the Social Services about children and youths have increased significantly in Sweden. It could be concerns about their health or, for example, absenteeism from school. In 2020–2021, the increase was almost five percent, according to the National Board of Health and Welfare, Socialstyrelsen (2021b). Whether this increase is due to an increase of vulnerable children or higher awareness among adults in the children's proximity will be addressed below. According to Socialstyrelsen (2021d) statistics, the majority of services allocated to these child/youth people are outpatient services. There are outpatient interventions for the whole family but also for individuals.

There are research studies that have studied what crime prevention interventions are needed to prevent individuals' risk factors for a criminal life path. One of these studies has seen that family treatment and the use of scientific methods give a larger and more positive effect compared to others when it concerns the type of treatment for families with risk factors (Borgengren & Wahlström, 2010). The majority of studies show that early interventions reduce the risk of a high number of risk factors and criminality (Wikström & Butterworth, 2006). In addition, one study carried out shows that clients can be exposed to increased risk factors if crime prevention interventions are missing or inadequate (Bonta, Law & Hanson, 1998).

Research evaluations of crime prevention interventions and mapping of these clients' risk factors are, on the other hand, few, as the statistics of interventions are difficult to measure. There is often a lack of systematic documentation regarding the type of intervention, methods and results, and different assessments, systems and routines are often used to enter data (SBU, 2022). The content means that no previous Swedish research has found a targeted crime prevention intervention that is adapted to specific behaviors, based on today's society, organization, and problems (Steketee et al., 2013).

Therefore, there is an incentive to evaluate Sweden's outpatient care interventions and map these clients' risk factors. The study can create an increased understanding of which risk factors exist in outpatient care depending on the type of intervention and make its difficult-to-access statistics visible. This can further shed light on possible risks for other individuals and organizations, and perhaps long-term change the systematic documentation of authorities/companies' interventions. The change can then conceivably provide a more adapted and targeted intervention for the risk factors of at-risk families, which will probably increase the willingness of at-risk families to get help. Finally, this entire process of change can increase the social economy and reduce the risk of ongoing risk factors and crime.

## 1.1 Aim and research questions

The aim of this study is to examine differences in risk factors and the attainment of treatment objectives among youths and children at Hassela treatment center who have undergone individual treatment compared to those who have received family-oriented interventions.

The research questions are:

- What are the differences between Hassela's child/youth intervention and parent intervention in terms of risk factors?
- How does goal achievement differ between the two different intervention at Hassela?

## 1.2. Concept definition

*Risk factor* - A risk factor for a certain behavior is a characteristic, event condition or process that increases the likelihood or risk of a certain outcome (Andershed, 2005). The outcome in this study is norm-breaking behavior. For example, an individual's circle of friends can be a risk factor for an individual adopting the negative behavior of friends to create status.

*Norm-breaking behavior* - Is a violation of social norms, rules or laws. It can be anything from fighting and truancy to stealing (Olsson, 2007).

# 2. BACKGROUND

## 2.1 Social services

Social services are responsible for the distribution of the majority of crime prevention outpatient services<sup>1</sup> in Sweden. When a report of concern about a child/youth who is unwell is received by the Social Services, a preliminary review first takes place. A decision is then made as to whether an investigation should be initiated (Socialstyrelsen, 2019). If the child/youth has progressed in the preliminary examination, the majority of Sweden's Social Services uses the documentation system BBIC<sup>2</sup>(Barns Behov I Centrum). BBIC is a defined as a support that is recommended to Social Services and all other types of social work to investigate and identify risk and protective factors in the child's/youth person's life, both psychosocial factors and signs that the child/youth person is unwell. It is based on an EBP<sup>3</sup>(evidence-based practice). The basic principle of BBIC is created by the American psychologist Urie Bronfenbrenner's tool LACS<sup>4</sup>(Looking After Children System) (Socialstyrelsen, 2018a; Bronfenbrenner, 1988).

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<sup>1</sup> According to the Socialtjänstlagen, Social Services Act (SOL, 2001), an outpatient intervention is a collective name for the majority of interventions for socially vulnerable children, youth and their families. Their interventions are voluntary and focus on the youth needs (Socialstyrelsen, 2021b).

<sup>2</sup> BBIC is a reform for a national uniform evidence-based structure for handling, implementation and follow-up of interventions (Socialstyrelsen, 2018a).

<sup>3</sup> EBP means that social work must strive towards the best available knowledge from a) evidence-based research, b) the client and c) the practice's experience (APA Presidential Task Force on Evidence-Based Practice, 2006; Bergmark & Lundström, 2006; Jacobsson and Meeuwisse 2020 ; Shlonsky & Gibbs 2004).

<sup>4</sup> LACS is a tool with an ecological model of explanation where all factors in a child's life and environment interact and influence their needs (Bronfenbrenner, 1988).

The investigation model in BBIC is illustrated by a triangle (Figure 1). In the middle of the triangle is "The child's needs", which is the goal of Social Services when it comes to interventions for children and young people. On the sides of the triangle are written "Child's development, Parents' ability and Family and environment". These three parts must be investigated to understand what the child's/youth needs are.



Figure 1: BBIC-Triangle. Källa Socialstyrelsen, 2018a

Furthermore, these three parts have four different categorized areas that distribute the risks, such as health, education, safety. Under the areas, there are a total of 37 subdomains based on the child/young person's risk and protection factors. The subdomains could be, for example, lack of access to health care or the lack of leisure time employment. The purpose of the subdomains is to see if there is a development of psychosocial problems or signals, which the child/youth could be harmed by (Socialstyrelsen, 2018a, 2018b).

## 2.2 Hassela Skåne

There are several different types of outpatient care programs, however, the focus of this study is structured outpatient care<sup>5</sup>. The choice is based on the fact that the organization Hassela Skåne has such a program for their interventions. The organization Hassela was chosen because the author is employed by Hassela where the study is carried out. Journal systems within different organizations differ and may contain information that can be missed or misinterpreted (Florin & Ehnfors, 2006) by individuals who are not used to the specific journal systems, which increases the reliability of the data processing.

Hassela works with a treatment project for socially vulnerable children, youth and some of their families with behavioral problems and certain crimes. The treatment work can start as early as early childhood and is intended for the whole family. Hassela's most common interventions are family intervention and child/youth intervention. In the family intervention, work takes place where the whole family is included and where they work towards common goals. This includes the structured conversation individually and jointly with the whole family, as well as participation in family situations and individual meetings. In the child/youth intervention, work is carried out with the client's individual goals. Here, meetings and structured conversations take place individually with the individual. Some conversations and meetings may, however, include the family or the family home in the child/youth intervention, but the same opportunity for requirements as in the family intervention does not exist. Often, the child/youth intervention only gets a focus that is directed at the children's risk factors, even though many of these risk factors go hand in hand with, among other things, the parent's (Hassela, n.d).

The organization's statutes are to work towards relationship building and participation, where availability for clients must be available around the clock. Each client has a responsible handler and an individual assignment with different goals. The assignment was created by Social Services and constructed by BBIC's triangle as described above (Hassela Skåne, n.d).

<sup>5</sup> A structured outpatient care is a structured and individually adapted crime prevention program that has a time-limited treatment period, where the child/youth stay with a therapist for a whole day or part of a day (Socialstyrelsen, 2021b).

The first stage in the treatment work is relationship building. After that, a joint construction of sub-goals and measures takes place based on the client's mission, which should get the client motivated to reach their mission goals and take control of their life. How the treatment work takes place is up to the therapist and the client's needs, as well as the type of intervention the client has been assigned by the Social Services. The treatment work can, for example, take place in public places, in the individual's home and in specific conversation rooms. In the work, there is also a constant collaboration with other actors where the client stays, such as school/work, the Swedish Migration Agency, leisure, kids- and youth psychiatry and youth centers. When the majority of the goals in the assignment have been completed, i.e. that the risk factors should no longer be relevant, the intervention is terminated by Social Services. However, in some cases, the intervention can be terminated for other reasons (for example, the Social Service does not consider the intervention to be suitable for some reason) (Hassela Skåne, n.d).

### **3. Previous Research**

#### **3.1 Risk factors**

The risk factors have been shown to have different meanings and outcomes for each individual (Andrews et al., 2006; Cottle et al., 2001; Odgers & Russell, 2017). The difference in outcome and meaning is, among other things, about people's different background histories (Caspi & Moffitt, 2018). Prominent among the majority of researchers is that early norm-breaking and a high number of risk factors develop persistent and more serious risks for norm-breaking behavior (Andershed & Andershed, 2016). There is a so-called cumulative risk, where a risk factor and the individual's young age increase the individual's risk of developing and being exposed to other risk factors, which can easily lead to criminality (Caspi & Moffitt, 1995; Farrington & Welsh, 2007).

Some researchers believe that risk factors can change immediately, long-term, or even be immutable. For example, studies have found that genetic risk factors that persist throughout the life cycle, such as gender and some psychiatric diagnoses, can have a longer-term risk of norm breaking (Loeber et al., 2006; Moffitt, 1993). This is because genetic risk factors are seen as impossible to change and are therefore not affected by the individual's age and development. They further describe that other environmental risk factors such as antisocial behavior, defiance or truancy are more short-lived and changeable behaviors. These have a lower risk of long-term norm breaking because individuals enter different ages, mature, or develop in different ways and have different needs (Loeber et al., 2006; Moffitt, 1993).

Other researchers have seen that the riskier norm-breaking behavior in childhood involves a combination of hereditary and environmental risk factors (Raine, 2002; Patterson, 1982; Shaw et al., 1930). Comparative studies were done, for example, on identical and fraternal twins, where Raine (2002) found that an inherited trait such as a hot temperament can be difficult for the environment to accept and manage. In interaction with the environment, the study found that the trait could then lead to norm-breaking conflicts and exclusion, which is consistent with Caspi and Moffitt's (1995) cumulative risk.

At the same time, there are studies where researchers believe that norm-breaking is rather a combination with other risk factors in several areas, such as at school, with the individual, within the family and in social relationships. They explain that different types and



combinations of risk factors increase the successive long-term risk for different variants of norm-breaking behavior, where certain combined risk factors have been shown to give a long-term risk that has continued into adulthood (Andrews et al., 2006; Farrington & Welsh, 2007; Silberg et al., 2015). For example, Odgers and Russell (2017) believe that early exposure to violence often leads to mental illness and a later substance abuse problem, even if the individual does not have a genetic predisposition to mental illness or an addiction gene.

In addition, other researchers have found that the presence of one or more protective factors can be enough for an individual not to carry out norm-breaking behavior. For example, secure adults or a positive leisure activity can mean that the norm-breaking behavior is not carried out (Dodge & Pettit, 2003; Robson, Allen & Howard 2020).

However, researchers see differences in every relationship, development and combination of risk factors and norm breaking. They believe that each individual's different conditions, perceptions and experiences play a big role, because it is seen to influence how they then act (Kvarnlöf & Wall, 2021; Tham & von Hofer, 2009; Wikström & Svensson, 2010).

International research studies have seen that those who have antisocial behavior, ADHD and conduct disorder in childhood also exhibit it in adolescence, due to, for example, family dysfunction (Frick & Loney, 1999; Silberg et al., 2015). According to Frick & Loney, (1999) study, it was also about 50% of the boys compared to 20% of the girls who had serious and stable conduct disorder at a young age who exhibited criminality in adulthood. Girls are said to have a higher level of risk compared to boys, as research studies have shown that girls had more risk factors before committing crimes (Wong et al., 2013). However, society's ideas about gender can influence and distort the results of gender-based crime (Kordon & Wetterqvist, 2010). For example, gender differences regarding several crime types and prosecution levels have decreased in Sweden when it comes to mainly 15–20 year olds (Estrada, Bäckman & Nilsson, 2015; Khoshnood et al., 2021), but also between gender and age in general (Bäckman et al., 2020). The police have signaled that girls have a more active participation in crime than is seen, as they see more and more girls with more passive hidden criminal roles (Polismyndigheten, 2019).

### **3.2 Individual vs Family oriented treatment**

There is limited knowledge in Sweden about the effect of outpatient interventions for young children and their families, and likewise investigations of early crime prevention interventions. The area is unexplored and difficult to access, partly because the majority of outpatient interventions and their methods have not been evaluated in controlled research and are thus not comparable (Persson, Ackesjö & Söderman Lago, 2022; SBU, 2022; Steketee et al., 2013). Also, partly because the Social Service's statistics of all kinds of outpatient interventions are an aggregating task. Some children also have more decisions about interventions where in these specific cases it is not possible to read out the number or type of decisions (Socialstyrelsen, 2021c).

On the other hand, it can be deduced from the National Board of Health and Welfare (2021a) that the number of outpatient interventions has varied since 2004–2020, where the so-called structured outpatient intervention has risen from 0.3 percent to 0.7 percent. In 2020, there were a total of 18,345 children and young people aged 0–20 who had at least one decision on a structured outpatient intervention in Sweden, compared to Scania which was 2,762 (Socialstyrelsen, 2021d).

Standardized assessment methods see that more children have been in need of support compared to what has been seen in regular social childcare investigations (Jee et al., 2010a; Jee et al., 2010b; Andershed & Andershed, 2016), and receiving notifications led to an intervention (Östberg, 2010). However, according to these research studies, it is unclear why the support was distributed in this way.

Although there is currently limited knowledge about the effect of outpatient interventions, research has been able to produce some significant and decisive details to reduce risk factors and crime. In Great Britain, for example, a study was conducted with several thousand students to see the effect of their relationship with the teacher (Sammons et al., 2014). The result showed that the relationship had a significant effect on the student's performance and commitment, and that a negative relationship had the opposite effect. A similar research study from Sweden has produced similar results (Aspelin, Östlund & Jönsson, 2021). Then another study shows that family therapy reduces conflicts in the home compared to what individual cognitive behavioral therapy does, as its focus is on an interaction between all family members. They describe that these are often problems of a social nature, where a lack of social support, family structure and conflicts can inhibit positive behavior (Borgengren & Wahlström, 2010).

The last detail to reduce risk factors and crimes via the Public Service is to use tested, adapted and evidence-based programs and interventions that follow the risk-needs and susceptibility principle "Risk-Need-Responsivity, RNR". This should make it easier to work with the problem and find development paths (Andershed & Andershed, 2019; Dowden & Andrews, 2003; Paalman, 2013).

A talked-about and well-researched problem that research has seen in risk factors and norm-breaking behavior, in young children and their family's outpatient care, is rooted in Sweden's lack of social prevention (Israelsson, 2021). Which therefore affects the outcome of the outpatient care. Researchers agree that the problem often involves a lack of cooperation and a lack of knowledge in organizations that carry out social work, nationally and internationally (Austin, Dal Santo & Lee, 2012; Cashel, 2002; Johansson & Fogelgren, 2019). For example, it has been shown that the methods and programs we use in Sweden are designed abroad where completely different conditions apply, including the documentation system BBIC (Bronfenbrenner, 1988). And that the risk factors that the Social Services hand over to each client in Individual vs Family oriented treatment, have a lack of evidence-based research. Some studies have also seen that Social Services are often guided by the financial circumstances of their organization and therefore prioritize the most cost-effective treatment, which often lasts for too short a time, instead of providing the treatment that is best for the child (Johansson, Dellgran, & Höjer, 2015; Rogowski, 2008). According to Danermark and Kullberg's (1999) study, the content of involuntary controls such as finance can hinder project implementation and reduce the company's chances of success.

## **4. METHODS**

### **4.1 Materials and selection**

The study uses data on all individuals, aged 0-24, that were subject to treatment at the outpatient care center Hassela Skåne, enrolled from January 1, 2021, through December 31, 2022 ( $n = 152$ ).

All data is based on the statistical risk factors of the organization's clients divided by intervention type (Family intervention and Child/youth intervention) and is retrieved from the organization's record system Secura Nova. Hassela's journal system Secura Nova contains risk factors that were both developed by Social Services and Hassela themselves (Appendix 1). Hassela encodes all this information directly when the client's registers.

From the three intervention that makes up the study population children and youths are between 0-24 years of age ( $n = 66$ ) and family intervention ( $n = 54$ ). Data was collected from a total of 136 clients that are between the ages of 6-21. Fifteen clients that were excluded had a lot of missing data and one client opted out (see Table 1).

**Table 1.** Study population at Hassela Skåne for socially vulnerable children ( $n=136$ ).

<b>Structured Outpatient Care for Children, Youths (aged 0-24), and their Families</b>			
The three programs:	Child intervention (C)	Youth intervention (Y)	Family intervention (F)
	0 – 12 years	13- 24 years	C & Y aged 0 – 24
	$n = 66$		$n = 54$
$n = 16$ clients are excluded from the study population due to missing data or placement in other intervention at Hassela			

Note: In the study, those clients that were registered for care/intervention at Hassela Skåne between January 1<sup>st</sup>, 2021, to December 31<sup>st</sup>, 2022, are included. The study population thus represents client that are between the ages 6-21 years old.

The child and youth interventions are merged in this study to distinguish between two types of interventions (the gray fields indicate the merged interventions). One targeting only children and young, another, targeting interventions targeting children/youths and family members/caregivers as well. Risk factors for caregivers/family members are excluded.

Many risk factors are included in the Hassela register material, but the risk factors below are chosen due to the relevance of this thesis. All risk factors had made the analysis unmanageable. For some individuals, not all information is available for certain risk factors, as these come from Social Services and are not automatically registered in Hassela's record system. There is more information about, for example, the risk factor gender and psychiatric diagnosis, as these have been retrieved by Hassela and automatically registered in their record system.

#### 4.2 Statistical risk factors

A mapping has been done of selected risk factors on the study population.

**Table 2.** Chosen risk factors

<b>Risk factors</b>	<b>Categorical value</b>
<i>Psychiatric diagnosis</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Gender "boy"</i>	(1. Boy) (2. Girl)
Intervention unit at Hassela	(1. Child/youth intervention) (2. Family intervention)
Goal achievement	(1. Yes met the goals) ( 2. No not met the goals)
<i>Health and development</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Access to health and healthcare</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Well-being and attendance at school</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)

<i>Learning</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
School results and study planning	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Play and leisure</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Attachment</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Emotions and behavior</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Attitude and values</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Identity</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Autonomy</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Social behavior</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Violence abuse and exploitation</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Relationship with other children and adults</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)
<i>Relationship with parents</i>	(1. Yes has a risk factor) ( 2. No does not have a risk factor)

Note: In the study includes selected risk factors from clients who were registered for care/intervention at Hassela Skåne between January 1<sup>st</sup>, 2021, to December 31<sup>st</sup>, 2022, are included.

The choice to focus only on four risk factors from Hassela and fifteen risk factors from BBIC one part "Child Development" was made because the scope of all risk factors had become too large and took too long for the author to analyze. The two parts "Parental ability" and "Family and environment" were removed because they fall outside the purpose of the study and because a lot of information about these risk factors was insufficient. The choice of risk factors was seen as important in order to get an actual measure of the child's/youth's development. The delineation was also seen as positive as causality between risk factors was generally impossible to establish, especially as the temporal sequence of the study's risk factors was unclear (Bryman, 2011).

With regard to risk factors from Hassela, the risk factors differ in case of failure, partly because 37 clients have an ongoing effort where the risk factor "goal fulfillment" can therefore not be deduced from all of them, and partly because the risk factors have been variously difficult for Hassela to collect. Thus, 120 individuals were included in the final analysis of Social Services' risk factors, and 62 individuals in the final analysis of Hassela's risk factor goal attainment, 124 in the risk factor gender and 123 in the risk factor psychiatric diagnosis.

### 4.3 Implementation and Ethics

The study was part of a larger project from Malmö University, called "Evaluation of psychosocial and crime prevention interventions by Hassela Skåne and Västerbo Social Care". The project was covered by ethical approval from the Swedish Ethical Review Authority (Dnr: 2022-04128-02). An addendum was made and approved to the original application to the Swedish Ethical Review Authority, containing new statistical risk factors.

These static risk factors were handled in an ethical manner, where the clients themselves had to opt out of participating or refraining from the study. It is a considerable responsibility to have access to so many variables linked to clients, but that was precisely why they were pseudonymized and the data stored securely at Hassela Skåne.

An information sheet with research information was handed over to Hassela and then sent out by the director to all individuals at Hassela in a letter, with the option to opt out (Appendix 4). All clients from the three chosen interventions were thus automatically included in the study unless they withdrew by notifying the research team. In cases where the client was under 15 years of age, the information sheet was sent to the client's guardian. The clients who were still in Hassela Skåne received the information on the spot and in hand. Withdrawing from the research project by opt-out did not influence the treatment at Hassela, which the clients were

informed about. The information letter clearly described what the author intended to do and how to contact the research group if wanting to opt-out. It also stated what the purpose of the study was and that the clients would remain anonymous. They were also informed about that when the essay was finished and graded, all collected material was to be deleted. The clients' security is further strengthened by the fact that the letter contained information on how the four main requirements "Information, consent, confidentiality and use" were followed in the study (Vetenskapsrådet, 2002).

In order to further secure the individuals' anonymity and minimize intrusion into the clients' lives, only risk factors had been handled in the analysis. A presentation of the clients and their risk factors was finally done at the group level, so no individual data has been presented or identified.

The author then mapped all the statistical risk factors from Hassela and Social Services. When the risk factors had been mapped, they were handed over to (LO), the Deputy Manager at Hassela, who in the next step extracted the desired risk factors from Hassela Skåne's record system Secura Nova. All risk factors at the time linked to the clients. LO therefore pseudonymized this and then handed over a fully pseudonymized Excel file to the research group. The Excel file was then transferred into SPSS. The code key is kept locked at Hassela, and the pseudonymized SPSS file is kept on a protected server at the Department of Criminology, Malmö University. The risk factors were handled and processed by the author without being linked to the client's personal data. Finally, the clients' risks were mapped and analyzed at group level and divided based on type of intervention.

An ethical dilemma, that the author works at Hassela, has been resolved by the assistant manager having pseudonymized the material and having the code key in accordance with the legal framework of the business.

#### **4.4 Data treatment and Statistical Analysis**

Given that all variables included in this study are categorical, we use Chi-Square test of proportions in order to investigate if there are any differences in risk factors and goal achievement among children/youths that have been allocated to child/youth- respectively family intervention. A p-value of 0.05 is used as cut-off for significance. Cramer's V is used to assess the size of the effects. The measure ranges between 0 and 1, where higher values indicate stronger effects. All data were analyzed using IBM Statistics SPSS (Version 21) (Bryman, 2011).

## **5. RESULTS**

Only two significant differences have been found between the interventions, in the risk factors *autonomy* and *psychiatric diagnosis* (Table 2). The child/youth intervention has a higher level of the risk factor *autonomy* n=11 (17%), compared to the family intervention n=1 (2%), and the risk factor *psychiatric diagnosis* has a higher level of risk in the family intervention n= 18 (33%), compared with children/youth intervention n= 11 (16%). Other risk factors lack significance and are evenly distributed between the interventions, but nevertheless show a high level of risk. Within the risk factor of *well-being and attendance at school*, the majority of clients have a high but evenly distributed risk factor, in both the child/youth intervention n=48 (73%) and the family intervention n=43 (80%). Similar numbers can be seen in the risk factor *school results and study planning*, where n=42 (64%) clients in the child/youth

intervention and n=35 (65%) clients in family interventions have the risk factor. Similar to the risk factor *play and leisure*, where the child/youth intervention is on n=42 (64%) clients and the family intervention on n=38 (70%) clients. The risk factor *relationship to other children and adults* is also at a higher and evenly distributed level of risk in both interventions, with the child/youth intervention on n=46 (70%) clients and the family intervention on n=32 (65%) clients. Finally, similar figures are shown for the risk factor *emotions and behavior* where the child/adolescent intervention is on n=51 (77%) clients and the family intervention on n=45 (83%) clients.

A medium-sized but still evenly distributed risk can be found in the risk factors health and development, gender, and social behavior. In interventions targeting children and youth, the risk associated with health and development is 50%, while it is slightly higher at 52% in family interventions. Similarly, the risk related to social behavior is 50% in child/youth interventions and 52% in family interventions. As for gender, the risk is skewed towards boys, with 58% in child/youth interventions and 59% in family interventions. For girls, the corresponding figures are 42% and 41% respectively.

The risk factor *autonomy* and *psychiatric diagnosis*, as well as other unmentioned risk factors in the clients have shown a somewhat lower risk level: *goal achievement, relationship with parents, access to health and medical care, social behavior, violence abuse and exploitation, attachment, attitude and values, identity*. All of these unmentioned risk factors are also evenly distributed between interventions.

**Table 3.** Test of differences in proportions in risk factors between treatments

<i>Risk factor</i>	<i>Child/Youth intervention Number (N) (Percent)</i>	<i>Family input Number (N) (Percent)</i>	<i>Effect size</i>	<i>P-value</i>
<i>Health and development</i>	33 (66) (50%)	28 (54) (52%)	0,018	0,840
<i>Access to health and healthcare</i>	11 (66) (16%)	15 (54) (28%)	0,172	0,169
<i>Well-being and attendance at school</i>	48 (66) (73%)	43 (54) (80%)	0,126	0,385
<i>Learning</i>	14 (66) (21%)	12 (54) (22%)	0,012	0,894
<i>School results and study planning</i>	42 (66) (64%)	35 (54) (65%)	0,012	0,893
<i>Play and leisure</i>	42 (66) (64%)	38 (54) (70%)	0,071	0,436
<i>Attachment</i>	1 (66) (2%)	2 (54) (4%)	0,070	0,445
<i>Emotions and behavior</i>	51 (66) (77%)	45 (54) (83%)	0,075	0,409
<i>Attitude and values</i>	11 (66) (17%)	3 (54) (21%)	0,172	0,059
<i>Identity</i>	14 (66) (21%)	13 (54) (24%)	0,034	0,709
<i>Autonomy</i>	11 (66) (17%)	1 (54) (2%)	0,246	0,007
<i>Social behavior</i>	37 (66) (56%)	33 (54) (61%)	0,051	0,577
<i>Relationships with parents</i>	20 (66) (30%)	19 (54) (35%)	0,052	0,570

<i>Relationship with other children and adults</i>	46 (66) (70%)	32 (54) (65%)	0,109	0,233
<i>Violence abuse and exploitation</i>	5 (66) (8%)	3 (54) (6%)	0,040	0,659
<i>Gender "boy"</i>	40 (69) (58%)	33 (55) (59%)	0,106	0,500
<i>Psychiatric diagnosis</i>	11 (68) (16%)	18 (55) (33%)	0,194	0,032
<i>Goal achievement</i>	24 (46) (52%)	24 (37) (65%)	0,128	0,245

## 6. DISCUSSION

This thesis studied the differences in risk factors and goal achievement between two different interventions at Hassela (family intervention versus child/youth intervention). The purpose was to map Hassela Skåne's data to see what differences there are between these crime prevention interventions in terms of risk factors and goal fulfillment, in order to find possible development paths to a favorable intervention. The analysis showed two significant differences between the interventions for the risk factor *autonomy* and *psychiatric diagnosis*. In *autonomy*, the child/youth intervention had a higher risk level compared to the family intervention. This difference could indicate that the risk factor *autonomy* is something that needs special attention in the child/youth intervention, compared to the parental intervention. The author has not found any research study that could refer to the risk factor difference. However, based on practical/clinical experience, lack of autonomy the author considers it wise that this risk factor should end up in the majority of cases in child/youth interventions, as the risk factor is largely about the individual's own learning and responsibility. This is provided that the parents do not neglect/complicate this risk factor by inhibiting the individual in its development via reprimand or by treating the individual too protectively.

Youths in the family intervention had a higher level of psychiatric diagnoses then compared to the child/youth intervention. This is in line with previous research by (Silbert et al., 2015). Possible due to families that have children with diagnoses are more prone to seek family-oriented help. At the same time, it could be easier for parents to blame the problem on the child's diagnosis.

The fact that the other risk factors did not show any significant differences between interventions may be due to the fact that outpatient care is voluntary care. Sofia Möller<sup>6</sup>, Director of Hassela Skåne explains that in all assignments they receive, Hassela wants to include the parents in the intervention (Family Interventions), but due to outpatient care being a voluntary care, the assignments are distributed either to child/youth interventions or family interventions. In many cases, the parents do not see their part in the child's risky behavior but want their child to get help. Sofia explains that they have the right to refuse a family intervention and instead choose an intervention for the child alone. They may also be that the parent already has a stake in other outpatient care activities and is therefore only applying for the child. Problems arise when social services place a family in different outpatient services. It immediately becomes much more difficult to treat the family/youth and that important information is lost between the operations and the operations as there is no reporting system/record between the operations or any law that requires both operations to take place at

<sup>6</sup> Sofia Möller, Director, Hassela Skåne AB, Telephone call 17 May 2023.

the same operation. Hassela's distribution of intervention is therefore misleading. This further results in the Social Service's assessment and previous research assessment on family intervention often being lost. The result shows exactly what could be expected based on the description of previous research results, where evaluations of crime prevention interventions such as family interventions versus child/youth interventions are few, as the statistics of interventions are difficult to measure (Persson, Ackesjö & Söderman Lago, 2022). The social services that allocate clients to various interventions need to have time, knowledge, and routines regarding which statistics they should measure in order to draw attention to this problem. Ideally, the author believes that specialists are needed in this field who only work with statistics. In this way, the statistical pitfalls in outpatient care are enabled to be made visible and improved.

At the same time, the result can be interpreted as that the interventions have no significance because there were no differences in goal achievement. The stakes can be just as good or contain just as many flaws. A difference in goal fulfillment had made visible whether an intervention was positive or negative for the client, as well as enabled conceivable development paths to a favorable intervention. However, there are difficulties in drawing this conclusion about the relationship between treatment and goal fulfillment in the material studied, because according to Hassela, Social Services may have discharged clients for other reasons. On the other hand, clients who had low goal fulfillment may have received an incorrect/inadequate assessment of risk factors from the start of their assignment by Social Services. If this is the case, the problem that the research describes may be due to Social Services' lack of evidence-based knowledge (Austin, Dal Santo & Lee, 2012; Cashel, 2002). The lack of evidence can be a negative consequence because the Social Services cannot confirm or guarantee that the decisions taken were the best for the child. The problem then continues like a cogwheel to Hassela and the other outpatient care, which must relate to the risk factors that the Social Service has decided for the individual. The content is that the client does not achieve the goals in the assignment and receives an increased cumulative risk, so that instead there is a placement or change of outpatient care, contrary to what the purpose of outpatient care is. If individuals have an early norm-breaking behavior that they do not get help with due to a lack of social prevention, the risk, as previously mentioned, is great that the individual develops and is exposed to other risk factors and commits a criminal act, which becomes more difficult for society to stop (Bonta, Law & Hanson, 1998).

It should also be noted that the gender distribution was evenly distributed and that there was no significant difference regarding gender and type of intervention. However, in line with previous research the proportion of boys enrolled in either of the interventions was larger than compared to the proportion of girls. Previous research has shown that being of male gender is a risk factor for crime (Bäckman et al., 2018; Wong et al., 2013).

The results of the other risk factors were in line with what could be expected based on the description of previous research results. That is to say that risk factors have different meanings and outcomes for each individual because everyone has different experiences and experiences. And that risks have shown up in more areas in the clients' environment.

### **6.1 Future studies and limitations**

In future studies, gender differences between the risk factors may be interesting to investigate over time to provide increased knowledge about the possible change of gender in modern Sweden. A deeper investigation at more outpatient care companies may need to be done to see



if the gender differences have blurred, or if it has to do with an evenly distributed gender distribution when the Social Services allocates interventions to young people.

In addition, further studies should be carried out in general within outpatient care because more people need to invoke the difficult-to-measure value of statistics and the need for change. This could create positive changes in social work and, in the long term, increase trust in the system.

A limitation that can be seen in this work is the delineation of risk factors. The fact that the author only focused on Hassela's risk factors and some of Social Services' risk factors has contributed to the author omitting other risk factors that might have been able to change the result. This could cause the result to reduce its credibility. However, there was no room for the author to analyze all risk factors because it would have taken up too much space and the author needed to adhere to clear guidelines. From another point of view, a targeted selection for the selected risk factors does not have to be negative because it creates the opportunity to explain specific risk factors different outcomes in depth. The author could also have added interviews with clients if time had been available to contribute more information to the study.

In addition, there is nothing we can distinguish between clients who came to Hassela because of their own behavior and those who came to Hassela because of a risky/bad environment. This possibly affects the results, but it is information we do not include in the survey because this information is difficult to map from the Social Services.

Another possible limitation is that we did not analyze the client's enrollment age. The enrollment age is important because previous studies have shown that the early interventions have a stronger impact on young people.

Finally, there is a limitation concerns the definitions and meanings of certain concepts in BBIC. The concepts are seen as diffuse and can cause ambiguity in guidelines, which creates unequal decisions in interventions and risk factors in children, which also creates statistics that are difficult to measure for the author as well as researchers. A clear structure when working with children and their parents needs to be in place to increase society's trust in the system and safer welfare.

## **7. CONCLUSIONS**

There are no significant differences between Hassela Skåne's interventions, family intervention versus child/youth intervention, in terms of clients' risk factors and goal fulfillment, in the following years 2021 and 2022. Only one significant difference could be found between the interventions, in the risk factor "Independence", where the child and youth intervention had a higher level of risk compared to the parent intervention. The difference, however, is seen as natural because they seem to be about a risk factor that older youth acquire independently of their parents. In contrast to previous research, the results show that the gender distribution was evenly distributed between the interventions and that no significant differences could be found in terms of risk factors between girls and boys. Continued research on evaluations in outpatient care in Sweden is needed to prevent crime and create favorable interventions for children and young people.

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# APPENDIX

## APPENDIX 1

### RISK FACTORS IN THE CLIENT AND ITS IMMEDIATE ENVIRONMENT

#### Risk factors – Hassela

##### 1 Insert length

-Definition: The total time the client was logged in until it was logged out.

-Answer options: Written by number of days

##### 2 Treatment unit at the organization Hassela Skåne AB

-Definition: The type of input the client received when enrolling with Hassela.

-Answer options: Junior 0-12, Youth 13-24, Family treatment

##### 3 Number of risk factors

-Definition: A risk factor for a certain behavior is a characteristic, event relationship or process that increases the probability or risk of a certain outcome (Andershed, 2005).

-Answer options: Written according to the number of risk factors/variables

##### 4 Goal achievement

-Definition: When the client finishes his work with Hassela and has met the majority of his goals or when the client has finished his work with Hassela without meeting the goals.

-Answer options: Yes or No

##### 5 Gender

-Definition: The gender with which the client defines himself.

-Answer options: Man or woman

##### 6 Age

-Definition: 0-increasing.

-Answer options: Written based on the age when the client was enrolled at Hassela for the first time.

##### 7 Any psychiatric diagnosis with medication

-Definition: Neuropsychiatric impairment

-Answer options: Yes or No

#### Risk factors – BBIC

##### (Child Development)

###### 1. Lack of health and development

- Definition: That the child/young person has a lack of physical and mental health, functional impairment, hygiene, diet, physical activity or used drugs such as alcohol/narcotics.

- Answer options: Yes or No

###### 2. Lack of access to health care

- Definition: That the child/young person has a lack of dental check-up, medical check-up, vaccination or lack of knowledge about the care of the older young person.

- Answer options: Yes or No

### 3. Lack of well-being and attendance at school

- Definition: When the child/young person has a high absence from school, has changed schools several times or, for example, dropped out of school completely.

- Answer options: Yes or No

### 4. Lack of learning

- Definition: When the child/young person has learning difficulties, difficulty concentrating, motor difficulties, diagnosis, mother tongue other than Swedish and has difficulty, for example, getting started with tasks at school.

- Answer options: Yes or No

### 5. Lack of school results and study planning

- Definition: That the child/young person does not meet the course requirements or that they do not receive sufficient help from the school or parents, and that the young person does not have a plan for their future regarding education and work.

- Answer options: Yes or No

### 6. Lack of play and free time

- Definition: When the child does not play in an expected way based on his age or, for example, when the child does not participate in any leisure activity.

- Answer options: Yes or No

### 7. Lack of connection

- Definition: When the child/young person does not seek comfort and support from parents or has an insecure lost attachment to parents and other adults in their presence.

- Answer options: Yes or No

### 8. Lack of emotions and temperament

- Definition: When the child/young person has difficulty recognizing and managing their emotions when they are happy, angry, scared, sad. Or that the child/young person is often angry, scared, sad and worried.

- Answer options: Yes or No

### 9. Lack of attitudes and values

- Definition: That the child/young person has difficulty feeling guilt and compassion for others or exhibiting negative attitudes/values and problem solving.

- Answer options: Yes or No

### 10. Lack of identity

- Definition: That the child/young person has a lack of self-esteem, insecure gender or sexual orientation. That they have rebellious norm-breaking behavior or ignorance about their origins.

- Answer options: Yes or No

### 11. Lack of independence

- Definition: When the child or young person finds it difficult to find employment on their own or, for example, when they are unable to take care of themselves in relation to their age.

- Answer options: Yes or No

### 12. Lack of social behavior

- Definition: When the child or young person has risky behavior in the form of, for example, lying or manipulating people to get what they want or hanging out with people who drink a lot of alcohol and commit crimes or are defiant in their behavior.

- Answer options: Yes or No

### 13. Lack of relations with the parents

- Definition: When the young child has an unpredictable relationship with parents, experiences rejection from parents, has an unreasonable amount of responsibility for everyday chores and, for example, avoids talking to parents about troublesome things.

- Answer options: Yes or No

14. Lack of relationships with other children and adults

- Definition: That the young child is exposed at school and has difficulty creating relationships with friends and other adults.

- Answer options: Yes or No

15. Presence of Violence, Abuse and Exploitation

- Definition: That the child/young person has been or is exposed to mental and physical violence or abuse, has witnessed this or sexual abuse. As well as exploited through coercion into marriage or a criminal act.

- Answer options: Yes or No

(Parenting ability)

16. Lack of basic care

- Definition: For example, the parent neglects the child's health and medical care through unclean clothes, lack of food or routines.

- Answer options: Yes or No

17. Lack of everyday routines

- Definition: That the parent fails to provide the child with predictable everyday routines such as times for sleep, food, school and other activities.

- Answer options: Yes or No

18. Lack of liability

- Definition: That the parent gives an unreasonable amount of responsibility to the child/youth and has insufficient supervision of his/her child/youth or forgets booked times for restraint and leaving at e.g. school.

- Answer options: Yes or No

19. Lack of stimulation and commitment

- Definition: When the parent does not get involved with the child and does not allow the child to bring friends home or makes up activists with the child. It can also be e.g. support the child/young person to choose education or to let them take their own initiative.

- Answer options: Yes or No

20. Lack of guidance and parenting strategies

- Definition: When the parent has difficulty setting boundaries and managing conflicts or has e.g. authoritarian parenting style.

- Answer options: Yes or No

21. Lack of stability in contact

- Definition: That the parent has an unpredictable relationship with the child/young person or e.g. creates a lack of stability in the child/young person's everyday life.

- Answer options: Yes or No

22. Lack of emotional regulation and protection

- Definition: That the parent does not understand what the child needs or lacks in the emotional support in the child/young person's emotional development. It can also be when the parent burdens the child emotionally with their own problems.

- Answer options: Yes or No

23. Lack of emotional support

- Definition: That the parent does not have the ability to show love and tenderness to their child/young person. The parent also does not show pride for the child or reject the child's views.



- Answer options: Yes or No

24. Lack of protection against mental and physical violence

- Definition: That the parent uses physical and emotional violence in, for example, their parenting strategy and has difficulty seeing the risks of violence.

- Answer options: Yes or No

25. Lack of protection from witnessing and experiencing serious conflicts or violence between adults

- Definition: That the parent has a normalizing image of violence or serious conflicts and practices this in the home between adults.

- Answer options: Yes or No

26. Lack of protection against sexual abuse and sexual exploitation

- Definition: When the parent has a lack of protection against sexual abuse and has difficulty seeing these risks for their child.

- Answer options: Yes or No

27. Lack of protection against exploitation

- Definition: When the parent has a lack of understanding of the harmful effects of exploitation, such as marrying off the child or forcing the child into other negative activities.

- Answer options: Yes or No

(Family environment)

28. The family lacks composition

- Definition: When the family has a vulnerable family constellation such as a deceased parent, parent serving a prison sentence, divorced parents or care of a person who can harm the child.

- Answer options: Yes or No

29. The parents have poor health and behavior

- Definition: When a parent has, for example, a lack of health or behavioral problems, functional impairment, or developmental disability.

- Answer options: Yes or No

30. The siblings have poor health and behaviour

- Definition: When a sibling has, for example, a lack of health or behavioral problems, functional impairment, or developmental disability.

- Answer options: Yes or No

31. The parents have a lack of experience from their own upbringing

- Definition: When a parent/parents have been exposed during their childhood to such as violence, separation, placement.

- Answer options: Yes or No

32. The family has significant lack of past events

- Definition: When the family has experienced previous difficult events or that the child/siblings have previously been exposed. For example, death or previous violence.

- Answer options: Yes or No

33. The family has a lack of stability and quality in the accommodation

- Definition: When the family has a lack of stability and quality in the accommodation, such as being homeless, living in cramped quarters, not having their own bed or that the child has moved many times

- Answer options: Yes or No

34. The parents lack work or other employment

- Definition: For example, when the family has a lack of education, long-term sick leave, late and long working hours.

- Answer options: Yes or No

35. The family has insufficient finances

- Definition: When the family has insufficient finances where the family lacks a stable income to pay food and bills or where the youth themselves have little knowledge of their finances.

- Answer options: Yes or No

36. The family lacks social networks and integration

- Definition: When the family has few or no social networks to turn to, for example relatives, friends or neighbours.

- Answer options: Yes or No

37. The family lacks professional networks

- Definition: For example, when the family has conflicts with professionals or other authorities, or when the child/family lacks access to support and help in areas such as dental care, healthcare and school.

- Answer options: Yes or No

## APPENDIX 2



Dnr 2022-04128-02

Umeå avdelning övrig

### BESLUT

2022-10-11

#### Sökande forskningshuvudman

Malmö universitet

#### Forskare som genomför projektet

Marie Väfors Fritz

#### Projekttitel

Utvärdering av psykosociala- och brottsförebyggande insatser av Hassela i Skåne samt Västerbo Social Omsorg AB

#### Uppgifter om ansökan

Ansökan om ändring inkom till Etikprövningsmyndigheten 2022-07-25 och blev valid 2022-08-11. Av myndigheten begärd komplettering enligt beslut inkom 2022-09-21. Grundansökan med diarienummer 2020-03895 blev godkänd 2020-10-13 av Etikprövningsmyndigheten.

Ändringen avser tillägg av statistiska variabler att forska på (områdesinformation, familjekonstellation, språk etc). Se variabelbilaga.

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Etikprövningsmyndigheten beslutar enligt nedan.

### BESLUT

Etikprövningsmyndigheten godkänner den forskning som anges i ansökan om ändring, med följande villkor:

1. Stryk skrivning i forskningspersonsinformationen om att forskare i projektet ska titta i enskilda personers journaler, då detta inte är det förfaringssätt som angetts i ansökan. Vidare bör även skrivning om försäkring via Västerbro Social Omsorg strykas då denna ändring enbart omfattar personer som får/fått stödinsatser via Hassela Skåne.
2. Kodnyckel ska för övrigt förvaras på ett säkert sätt i enlighet med vad forskningshuvudmannen har beslutat i frågan.

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Det här beslutet kan överklagas hos Överklagandenämnden för etikprövning. Hur man överklagar framgår av bifogad anvisning.

Etikprövningsmyndigheten  
2022-04128-02-318750  
2022-10-17

## APPENDIX 3

### INFORMATION SHEET

2022-07-25  
2022-04128-02-292405  
Etikprövningsmyndigheten

#### **Information for the research subjects**

In this document you will receive information about the project and what it means to participate.

#### **What kind of project is it and why do you want me to participate?**

The purpose of the project is to investigate various risk factors among children and young people who need outpatient interventions and how these have changed over time. With the help of your participation, we hope that the project will lead to better aid and support interventions. The project is run by Malmö University.

#### **How is the project going?**

Everyone who receives/received support at Hassela is asked if we can have access to their information in Hassela's journal about the goals and risk factors that Hassela works with to improve clients' situations.

The research project is not part of the support that your child/children either previously received from Hassela or that he/she/they currently receive from Hassela. Therefore, you can choose at any time to no longer be part of the project and still continue your possible contact with Hassela.

The research is covered by the Confidentiality Act and all journal data, as well as your support at Hassela will be processed so that unauthorized persons cannot access them. Only participants in the research project processes the data.

#### **What happens to my/my children's information?**

The project will collect information from Hassela's journal system. Where information about you/your children and other clients was/are registered. This information we will collect in a data file and process at group level, not individual family level. We who researchers therefore only receive the data file and there are no names or personal data of you/your children. Malmö University is responsible for this data and the purpose of the processing of your/your children's data is to be able to carry out the research project described above. In cases where you have previously approved participation in the research project, the journal data is linked to the already collected data contained within the project through a key (not name and social security number) with a code number that allows these to be linked for scientific research purposes and is done in accordance with the Ethics Review Act (article 9.2 j GDPR).

All documents and files are stored securely in a special safe that is locked with a special code that only those responsible for the project have and on a secure server

at Malmö University. We who are in the project at Malmö University will analyze the data file. We will then write about this and, among other things, publish it and present it at various conferences. No names and personal data will be published, everything is at group level.

**How do I get information about the results of the study?**

If you want to know more about the project or take part in the results that come out of the project, you are welcome to contact the responsible researcher.

**Participation is voluntary**

Your participation is voluntary, and you can choose to cancel your participation at any time by contact those responsible for the project. If you choose not to participate or wish to cancel your participation you do not need to state why, nor will it affect your future support or treatment at Hassela. Just contact the person responsible for the project via email or phone and we will remove your research documents from the study.

**Responsible for the study**

The person responsible for the project is Marie Väfors Fritz at Malmö University, Jan Waldenströms gata 25, marie.vafors.fritz@mau.se 040-665 78 29. Malmö University has a data protection officer who you can reach via e-mail: dataskyddsbud@mau.se or by phone: 040-665 70 69