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Criteria Based Case Review: The Parent Child Psychological Support Program

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Abstract

The Parent Child Psychological Support Program (PCPS) was established in an area of South West Dublin in 2001. Since then until May 2008 it has offered its services to over 700 children and their parents. This preventative, parenting support service is available to all parents of children aged 3 to 18 months within its catchment area. During periodical visits, the infant's development and growth are measured and parents receive specific information about their child's progress. Parents are empowered in their parenting practices, thus promoting consistency and synchrony in parent-child interaction. Between 2001 and 2006, 538 parents and their infants participated in the Program. Out of these cases, 130 (24.16%) were considered to require additional support and were included in the Monthly Meeting Case Review (MM) based on initial concerns. The aims of this study were: 1. to review the first five years of MM cases and to explore the socio-demographic profile of the MM cases in comparison to those not in need of additional support (non-MM) and 2. To illustrate an approach to refining the case review process which will inform practice and provides the service providers with better understanding of the early detection of parent-child relation difficulties. In pursuing this goal the cases screened over five years of practice were analyzed to explore the structure of the different factors by using statistical techniques of data reduction, i.e. factor analysis. The results showed that the MM group differed on several socio-demographic dimensions from the non-MM group and there was a four factor structure underlying the case review decision process. Implications of this research are discussed.

Keywords: Parent-child interaction, case review, prevention, early intervention, family support, child development and growth.

The Parent Child Psychological Support Program

There is a wide diversity of programs aimed at promoting wellness in parents and children community based home visiting (see Holzer, Bromfield, Richardson & Higgins 2006). The increasing demand for 'evidence-informed' services has resulted in a larger number of prevention programs undergoing evaluation and also a need to conduct meta-analytic reviews. MacLeod and Nelson's (2000) study, including 56 programs from 1979 to 1998, is illustrative of this point. This study revealed that programs incorporating client involvement and a strengths-based approach were significantly more effective than programs without these features. Programs that adopt a strengths-based approach emphasize parental skill and proficiency, rather than focusing on shortfalls. In so doing,

programs with this approach aim to further enhance parenting strengths and their application to all parenting/care-giving contexts (MacLeod & Nelson, 2000).

The Parent Child Psychological Support Program (PCPS) was established in an area of South West Dublin in May 2001 with funding from the South Western Area Health Board, now Health Executive Service (HSE). Since 2001 more than 700 parents and children have participated in this preventative parenting support service. The PCPS is based on a sister program, the *Programa de Apoyo Psicológico Materno-Infantil*, in Valencia, Spain, which since 1990, has supported over 2000 parents and their children. Different studies have shown the positive effects of these Programs (Cerezo, Cantero & Alhambra, 1997; Cerezo, Dolz, Pons-Salvador & Cantero, 1999; Cerezo, Trenado & Pons-Salvador, 2006; O'Rourke, 2006). Both Programs were designed and implemented in both countries by the third author.

The PCPS Program is offered to all parents of new born infants within its catchment area. PCPS can be considered as a process oriented preventive strategy with an integrative approach by which the program is aimed, not only at preventing dysfunction or reducing the risk, but also promoting psychological health and well-being (Masten & Coastworth, 1998). Moreover, "the issue is not as much about enhancing competence and particular skills, as it is about strengthening the protective basic systems, from a more developmental and ecological perspective" (Cerezo, 2003, p. 6) The principal and most basic protective systems in human development are manifested in the quality of parent-child attachment relationship, cognition and self-regulation (Masten & Coastworth, 1998; Feldman, 2007; Gergely, 2004). The PCPS Program has been built using these theoretical foundations about preventive programs.

There are also two more core elements: Firstly, the PCPS views parenting as a complex task (Cerezo, 2001). Bujia-Couso (2002), using a job analysis qualitative methodology, found that parenting involves skills that are also contained in the role of primary teachers (i.e. stimulating the innate potential for learning and exploring), managers (guiding and controlling; fostering responsibility and independence) and child care workers (providing care, affection and security). Considering parenting as a complex task allows for the analysis of its skills and difficulties. Secondly, the important parenting task of raising children and establishing warm and nurturing emotional relationships with them, lead to the consideration of parenting practices (Cerezo, 1992; Wolfe & Krupka, 1991). The PCPS views parenting practices as appropriate or inappropriate, rather than "good" or "bad". Parenting practices are appropriate practices when they are sensitive and orientated towards the goal of promoting the child's optimum development and they match the child's needs. Likewise, inappropriate practices are the opposite. Linked to the tasks of parenting are the dimensions of parental satisfaction and self-efficacy or, put another way, the degree to which the parents feel competent and confident in handling their child's problem (Cerezo, 1999; Lohaus et al. 2001). It's essential in the context of PCPS to consider the factors that affect parenting practices, such as parents' mood and distress, financial issues, social support, and relationships with significant others partner, relatives and friends (Pons-Salvador, Cerezo & Bernabé, 2004).

The PCPS aims to support the tasks of parenting, the child's development and the parent-child relationship during the infant's first two years of life, through a calendar of six visits, from 3 to 18 months preceded by an introductory visit (for a description, see Cerezo & Pons-Salvador, 1999). More specifically, in the introductory visit, key data is gathered regarding the pregnancy, health of parents, the child and other socio-demographic factors (e.g. level of education, marital status, occupation, age, gender, and prematurity of the child). Following this, the Program provides support to parenting through checking the development and growth of the child and anticipating their next expected developmental changes and needs. The parents receive specific information about their child's progress, forthcoming developments and guidelines about solving or preventing conflict. The empowerment of parents in solving conflicts (e.g. feeding, sleeping and crying) is coupled with encouragement and modeling synchronous interaction which is tailored to each specific parent-child dyad. Likewise, factors that affect parenting are addressed with the parents, to find solutions that make their task more manageable and predictable; thus impacting positively on the parent-child relationship. The Program is currently delivered by a multidisciplinary team with backgrounds including Public Health Nursing, Psychology, Social Care, Psychotherapy and Family Therapy. In the past, other disciplines have included Social Work, Speech & Language Therapy and Occupational Therapy.

The opportunity to work closely with the parent at the early stages of their child's life provides a forum for the early detection of difficulties or problems. This allows for earlier intervention, and when required, additional support and intervention and/or referral onwards. This aspect of early detection is an important goal of the PCPS Program that is achieved thanks to a methodology that allows for a comprehensive evaluation of each case from the introductory visit until the final visit, on an on-going basis. Every Program day has an average of 10 appointments and the attendance rate ranges from 75% to 100%, non-attendants are rescheduled. At the end of each Program day, the multidisciplinary team members delivering the Program consider if any family appear to require additional support and intervention. Following this, the manager of the Program takes on board this feedback, considering possible actions within the PCPS or if any follow-up with other professionals is required. When additional support and intervention is necessary the case is reviewed at the "Monthly Meeting". The first evaluation of the PCPS, spanning attendances from May 2001 until November 2002 (Cerezo, 2003), showed that about 26% of the Program's 234 participants required additional support at some point.

The Monthly Meetings (MM) is attended by all team members and the project consultant and is chaired by the Program manager. Each MM firstly reviews all new cases requiring additional support based on concerns and strengths, upon discussion specific strategies and proposed interventions are agreed. Cases previously discussed are also reviewed. Progress and outcomes are evaluated. An additional facet of the MM is that it provides a forum for ongoing training from the Project Consultant for existing team members and new professionals joining the team.

The additional support and intervention incorporates:

- Interventions with parents: specific strategies tailored for individual situations, extra visits, contact by phone, letter, occasionally home visits, or office interviews to talk about some special issue, and

:

- Interventions with other professionals: making representations on behalf of parents, writing letters of support, preparing court/ interagency meeting reports, sourcing additional services or supporting activities the parent may be recommended to avail of.

The present research was part of the complex process of providing an evidence base for services using data routinely collected during the intervention and had a twofold purpose: 1) to explore the socio-demographic profile of the participants in need of additional support in comparison to those participants who were not in need of such support, and 2) to illustrate an approach to refining the review process and to learn from existing practice by exploring a criteria-based review model. In pursuing this goal the cases screened, over five years, based on their relevance to different dimensions, were analyzed to explore the structure of underlying factors by using statistical techniques of data reduction i.e. factor analysis.

Method

Participants

In the first five years of the PCPS operation 538 parents and their infants joined the Program. From this group, 24.2% (130) were included in the monthly meeting case review (here MM group). Therefore, 75.8 % (408) were not included in the monthly meeting case review (here non-MM group). The descriptive socio-demographic profile for the participants is presented in table 1.

**Table 1: Summary of the socio-demographic descriptive profile
Means and standard deviations in italics**

	MM (n=130)	No MM (n=408)	All PCPS participants (n=538)
Mother's age	<i>29.12 (6.37)</i> rank 15-46	<i>28.7 (5.35)</i> rank 15-43	<i>28.96 (6.06)</i> rank 15-46
Number of children	<i>2.18 (1.57)</i> rank 1-8	<i>1.87 (1.19)</i> rank 1-9	<i>1.93 (1.27)</i> range 1-9
Prematurity in weeks	<i>8.20 (4.02)</i> rank 3-14	<i>6.19 (2.53)</i> rank 3-12	<i>7.07 (3.31)</i> rank 3-14
<i>Percentage of:</i>			
Premature children	11.5	4.2	5.9
Single-parent	26.1	21.1	22.3
Living with partner	73.8	78.9	77.7
Working out	46.1	61.6	57.9
Housekeepers	53.9	38.4	42.1
Children's gender (B-G)	60 – 40	51.7 - 48.3	53.7- 46.3

Regarding the mothers' educational level, the categories about the highest educational level completed according to the Irish Central Statistic Office (CSO) were: "No studies", "less than 3 years", "primary level", "secondary level", "Leaving Certificate", "third level" and "postgraduate level". In this study the first three categories were grouped into "Primary level including no formal education" and the last two were also grouped for the analyses

into “third level and postgraduate level”. For social class groups, CSO classification was used in which social class is defined on the basis of occupation. In two-parent families the social class for the family was allocated on the basis of the parent with the highest social class. Table 2 shows the distribution of social class and mother’s educational level in the groups.

Table 2: Social class and mothers’ educational level distribution in both groups
 (*) No information: 4.8 % of the 538 participants, therefore, percentages computed on n = 512

Social Class	%MM (n=130)	%Non-MM (n=408)
Social Class 1 – Professional Workers	5.7	7.2
Social Class 2 – Managerial and technical	10.7	18.5
Social Class 3 – Non-manual	22.1	29.5
Social Class 4 – Skilled manual	14.8	12.1
Social Class 5 – Semi-skilled	10.7	8.3
Social Class 6 – Unskilled	0.8	1.7
Social Class 7 – All others gainfully occupied and unknown	35.2	22.8
Mothers’ Educational Level*		
Third Level & Postgraduate Level	20.0	31.3
Upper Secondary (Leaving Certificate)	45.6	40.6
Lower Secondary	20.8	21.0
Primary (included no formal education)	13.6	7.1

For the purpose of describing the overall social class profile of all participants in PCPS, a comparison with the national profile (CSO Census, 2002) is set out to show the distribution in both groups (See Table 3).

Table 3: Distribution of social class in the Irish national population and PCPS participants

Social Class	National %	All PCPS participants* %
Social Class 1 – Professional Workers	6.1	6.8
Social Class 2 – Managerial and technical	25.5	16.6
Social Class 3 – Non-manual	16.5	27.7
Social Class 4 – Skilled manual	17.2	12.7
Social Class 5 – Semi-skilled	10.9	9.2
Social Class 6 – Unskilled	5.6	1.2
Social Class 7 – All others gainfully occupied and unknown	18.2	25.8

The comparison of the PCPS participants’ social class profile and the national profile showed that the proportion of professional workers, social class level 1, in PCPS participants were similar to the national figure. There were differences between the groups in levels 2 and 3, with Program participants showing proportionally fewer in the “managerial and technical class” and more in “non-manual class” than the national population. There was a lower proportion of “skilled manual” and “semi-skilled & unskilled” categories while the “all others gainfully occupied and unknown” (social class level 7) was higher. This level 7 in the PCPS population included single mothers working

in the home, and also mothers from two-parent families working in the home and/or unemployed (see Figure 1).

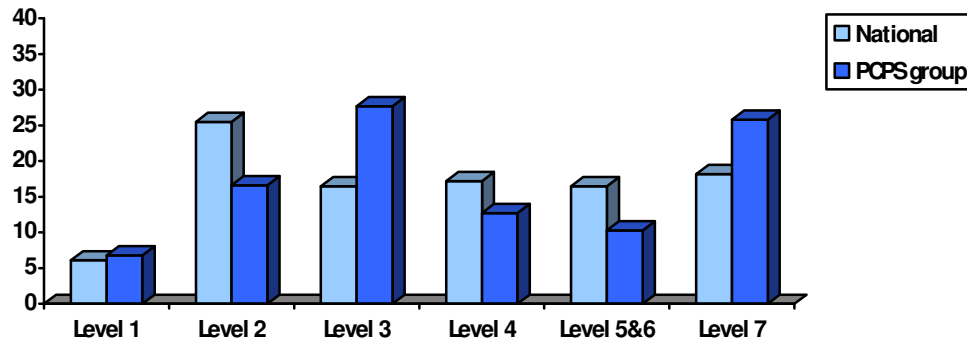


Figure 1: Social class levels and PCPS participants in percentages

Regarding the mothers' educational level, considering the whole group, the figures for the highest educational level completed were: "Primary level included no formal education": 8.4%, "Secondary level": 20.4%, "Leaving Certificate ": 40.7%, "Third level" 25.8% and "Postgraduate level "2.0%. No information: 2.6%.

Procedure

The first two authors reviewed all the cases that were selected as MM cases from the period May 2001- May 2006. A template was designed to collect the information systematically. This template included the initial concerns and the details regarding the mother and child, plus all the actions that were taken once the case was selected as a MM case. The use of this template produced different categories according to the factors on which the initial concerns were based. One extra category included children who were in foster care and had a HSE social worker involved, and due to the particular characteristics of that group, they were not included in this study and will form part of future research. The categories were further analyzed and twelve variables emerged from this.

Variables and Instruments

The variables are connected with the area of needs that were detected. These variables and the instruments of measurement employed for the analysis were as follows:

A) Regarding parents or parenting

1) High scores in factors affecting parenting (i.e. distress, unhappiness, rigidity, problems with child/family/other): This aspect is evaluated through a questionnaire, adapted from the work of Milner (1986, 2000) that explores these factors. Parents filled out the questionnaire at the beginning of the Program (Pre) and again at the 5th visit (Post). These pre and post measurements aid the assessment of how well the parents are coping and how much of an impact their participation on the Program has had.

2) Interaction highly intrusive and lacking structure: This variable is measured using a coding system developed to code early mother-child interaction in free-play situations and

allows for observation and measurement of parent-child interaction in a sequential basis, in real time (Trenado & Cerezo, 2007: Codes for Early Mother Child Interaction- revised version, CITMI-R).

3) One or more problems in common child rearing issues (i.e. sleeping, feeding, crying/irritability and other problems): This variable is measured from information received from the parent at each visit and is collected with the scheduled interview Infant Problems and Parental Practices (IPPP: Pons-Salvador & Cerezo, 1999).

4) Parental conflict (couples experiencing serious relationship difficulties e.g. domestic violence, separation): This information is also sourced from the General Information form completed by parents or which emerges during the course of Program attendance.

5) Inappropriate parental expectations (too high/low): This comes from information which parents share regarding their beliefs about parenting informs the measurement of this variable.

6) Lack of social support (e.g. isolation, cultural barriers): This information is recorded in the Factors Affecting Parenting Questionnaire and/or may arise from the course of Program attendance.

7) Marital status: included here are single-parent families or mother living with her partner.

B) Regarding the children

1) Delays in one or more development areas (i.e. adaptive, gross-motor, fine-motor, and language and social-personal area). This variable is measured by observing, measuring and recording the child's performance during the developmental exam according to the protocols of Knobloch (1980).

2) Socio-emotional development issues (e.g. insecure attachment or disorganized traits). Information on this variable comes from the "Strange Situation" procedure developed by Ainsworth et al (1978).

3) Medical issues and their impact: This is included because of the frequency or the severity in disruption in family life, high demands on the caregiver (e.g. neurological conditions). Information is sourced from the General Information form completed by parents at the introductory visit or during the course of the parent and child's Program attendance.

4) Premature infant: Information is sourced from the General Information form completed by parents at the introductory visit.

5) Growth: delays in weight below the 3rd Centile. This variable is obtained by measuring the baby's height and weight at each visit. Information is also received from the parent regarding feeding patterns. This information is sourced from the General Information form completed by parents at the introductory visit.

Statistical analyses

To address the issues related to the first research question, the analyses conducted to compare groups were ANOVAs. Chi-square analyses were carried out when the variables were nominal. For the second research question a Factor Analysis was applied. Analyses were carried out using the statistical package SPSS 15.0

Results

Results are presented in two sections responding to the two main questions: Were the PCPS participants in need of additional support different in basic socio-demographic dimensions

from the rest of PCPS participants? Secondly, is it possible to detect a factor structure underlying the case review decision process?

Socio-demographic profile of the PCPS participants vs. non-MM PCPS participants

The socio-demographic information related to MM PCPS participants and non-MM PCPS participants and means and standard deviations are shown in Table 1. The analyses between participants that needed additional support (MM cases) and participants not in need of additional support (non-MM) showed no significant differences, in the mothers' age, $F(1,536) = .527, ns$, or in marital status. Thus, although the proportion of single-parent families over two-parent families was higher in the MM group the analysis showed that the differences were not statistically significant, $chi-square (1, N = 538) = 1.465, ns$. However, the differences between groups were statistically significant regarding infant's gender, prematurity and the number of children in the family. Boys were more represented than girls in the MM group (60/40% vs. 52/48%), $chi-square (1, N = 538) = 2.721, p = .049$, $Cramer's V = .071$. Likewise, there were more premature infants in the MM group than in the non-MM (11.5% vs. 4.2%), $chi-square (1, N = 538) = 9.577, p < .001$, $Cramer's V = .133$. And one-way ANOVA revealed that the number of children per family was significantly higher in the MM group, $F(1,536) = 4.990, p = .026$.

Regarding the number of mothers describing themselves as working in the home or as employed elsewhere, there was a statistically significant higher proportion of stay-at-home mothers in the MM group than in the non-MM group (54% vs. 38%, respectively) $chi-square (1, N = 538) = 9.568, p = .002$, $Cramer's V = .133$. Likewise, the analyses showed that the MM group, compared with non-MM group, had proportionally less with higher education and these differences were statistically significant, $chi-square (3, N = 524) = 9.641, p = .022$, $Cramer's V = .101$. A careful inspection of the data showed that the differences were not in the middle levels (Secondary and Leaving Certificate) as the two groups, MM and no MM mothers, showed a remarkable similarity in their proportions, but rather in the extreme categories: "Primary level included no formal education" (14% vs. 7%) and "Third level and Postgraduate" (20% vs. 31.3%). With regard to the comparative analyses of social class the 7 CSO categories were reduced to 6 with categories 5 and 6 being collapsed in one "semi-skilled and unskilled" given the low number of cases in the 6th category. There were significant differences between the groups, $chi-square (5, N = 512) = 11.397, p = .038$, $Cramer's V = .152$. It was less likely for the MM group to be in three first social levels than for the non-MM group (see Figure 2).

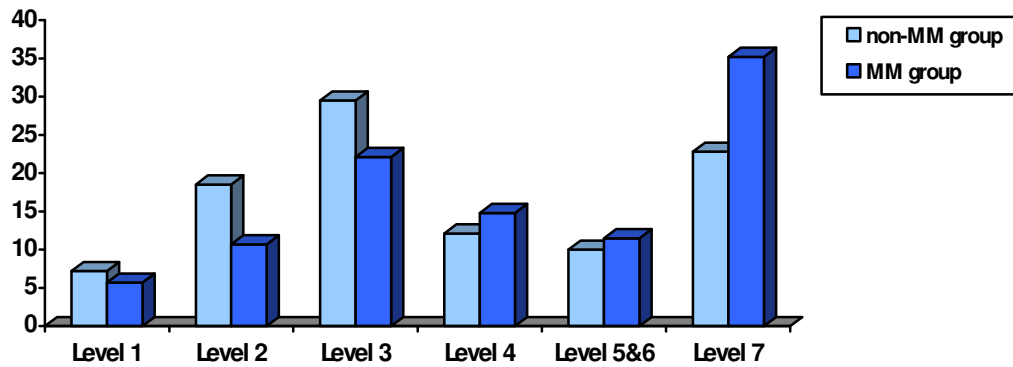


Figure 2: Social class levels and PCPS participants in both non-MM and MM groups in percentages

In summary, the group in need of additional support (MM) compared with the rest of participants showed no significant differences in the mother's age or in marital status. There were significantly more boys and more children in the MM families. In the MM group there was higher rates of prematurity, a significantly higher proportion of stay at home mothers and significantly more mothers with lower levels of educational attainment.

It's important to point out that PCPS is a universal service and, therefore, the parents came from all social classes and the same applied for the MM group, as Graph 2 shows. This underpins the PCPS core belief that risk is dynamic and not necessarily affecting people from the lowest social class, which explains why PCPS addresses the entire population in its catchment area and not just, so called, "high-risk" groups.

Factor Analyses on the variables the MM PCPS participants

A factor analysis was conducted on the matrix of 130 subjects and 12 variables to answer the question about detecting a factor structure underlying the case review decision process. The determinant value for the correlation matrix was .159, the KMO statistic, Kaiser-Meyer-Olkin, measure of sampling adequacy, was .57, acceptable, and Bartlett's test of sphericity was highly significant (*chi-square*, *df*: 66 = 183.90, $p < 0.0001$). Therefore, factor analysis was appropriate for this data.

The method use for extraction was Principal Components. Following Kaiser's recommendation factors with eigenvalue greater than 1 were selected. The number of factors retained was 4. Table 4 displays the first four factors extracted with their eigenvalues associated and the percentage of variance explained after the extraction and after the orthogonal rotation. The four factors explained 55.41% of the variance. To maximize the loading of each variable on one of the extracted factors, whilst minimizing the loading on all other factors, a rotation method was applied on the extracted components. Orthogonal rotation, varimax, was chosen because factors were expected to be independent.

Table 4: Total variance explained. Extraction method: Principal Component Analysis. Rotation Method: Varimax

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2,184	18,196	18,196	2,184	18,196	18,196	2,150	17,916	17,916
2	1,719	14.322	32,518	1,719	14.322	32,518	1,634	13,613	31,529
3	1,498	12,482	45,001	1,498	12,482	45,001	1,525	12,711	44,239
4	1,249	10,407	55,408	1,249	10,407	55,408	1,340	11,169	55,408

Table 5 shows the factor loadings for each variable onto each factor. The table only displayed loading higher than .40 and the variables are listed in the order of size of their factor loading. It can be seen that there are four factors and variables load highly onto only one factor.

Table 5: Factors loading from the rotated factor structure matrix for the case-review criteria. Extraction method: Principal Component Analysis. Rotation method: Varimax with Kaiser Normalization. Rotation converged in 6 iterations

Case-review criteria	Factors			
	1	2	3	4
"Caregiver-child relationship"				
Caregiver-child interaction issues	.852			
Inappropriate expectations about the child	.801			
Difficulties in attachment area	.612			
Difficulties with child-rearing issues	.440			
"Child physical factors"				
Medical issues		.832		
Premature		.770		
"Factors affecting parenting":				
High level of factors affecting parenting			.771	
Lack of social support			.637	
Single-parent family			.515	
"Parental Conflict's Impact on development and growth"				
Delayed in growth				.713
Delayed in one or more development areas				.538
Parental conflict				.513

In the context of the variables loading in Factor 1 "Caregiver-child relationship" can be identified as a common theme. The variables were interaction issues, in terms of lack of attunement (.852), inappropriate expectations about the child (.801), insecure and disorganized attachment, as indicators of child's emotion regulation (.612), difficulties with child-rearing issues, i.e. crying, feeding, and/or sleeping (.440).

Factor 2 "Child physical factors" with variables loading in this factor: medical issues (.832) and prematurity (.770).

Factor 3 "Factors affecting parenting": high level of factors affecting parenting, a variable that include parent's report of distress, unhappiness and problems with family, (.771) social

isolation, lack of friends, supportive family, etc, (.637) and marital status, being single parent (.515).

Factor 4 “Parental Conflict’s and child’s development and growth” could be the label for the common theme in this factor, where the variables loading were child’s delayed growth (.713) child’s delayed in one or more areas of development (.538) and high parental conflict (.513).

In summary, the case review decision process used in the first five years of PCPS, based on initial concerns, reveals a coherent four factor structure. The variables grouped into those mainly related with: the child caregiver relationship (factor 1), the factors that negatively affect parenting and parenting practices (factor3), medical issues (factor 2) and homes with high level of emotional conflict in the parents’ relationship and the child showing clear delays in growth and development (factor 4).

Discussion

The findings showed that the cases, selected according to the PCPS protocol for additional intervention and support, were similar to the rest of PCPS participants with respect to mother’s age and marital status. However, in this group of selected cases (MM group) compared with the rest of PCPS participants, there were more boys, a higher number of children per family, a higher number of premature children and a higher number of stay-at-home mothers.

Although the educational level of MM mothers showed differences with non-MM mothers in the extreme categories (i.e. “Primary level included no formal education” and “Third level and Postgraduate”) and mainly in primary level, it’s remarkable that both groups were similar in Secondary and Level Certificate categories. Likewise, 20% of MM mothers were in the category of Third level and Postgraduate level as the highest educational level completed. Likewise, regarding social class, MM mothers were distributed in all CSO social-class levels, however for them it was statistically less likely, than for the non-MM group, to belong to the first three levels. In terms of social class levels, all the PCPS participants compared with the national profile, showed the same proportion of social class 1, higher proportion of “non-manual level” and less proportion of “managerial and technical level”, “skilled manual” and “semi-skilled & unskilled”, social class levels, 2, 4 and 5-6, respectively. Social class level 7 was also higher than in the national distribution, and it included single mothers working in the home, and also mothers from two-parent families working in the home and/or unemployed.

One of the characteristic of the PCPS program is that it addresses the entire community, instead of risk-groups because, as these findings showed, there are difficulties in the parent-child relationship and life circumstances in families across all social and educational levels. Additionally, in parenting, what can be found are “risky parenting practices”, alongside good parenting practices; rather than “risky individuals”. This approach is also coherent with the positive approach of supporting and enhancing existing strengths, on which the PCPS relies.

The case review process decision was reanalyzed and the findings of this study showed that the variables used in the selection process of cases in need of additional support can be

grouped into four factors that explained 55.4% of the variance. The factorial structure appears to be coherent with the main axis of the PCPS in terms of the major areas: on the one hand, variables related with the caregiver–child relationship: such as interaction issues, inappropriate expectations about the child, too high or too low, difficulties with child-rearing issues and difficulties in the attachment area as indicators of the child’s socio-emotional development; on the other hand, factors negatively affecting parenting such as distress, unhappiness, social isolation, and single parenting. It needs to be pointed out that although the distribution of single parent families was similar in the MM group and the rest of the participants, in the factorial analysis with the selected group of cases this variable (single parenting) was shown to be associated with social isolation and factors affecting parenting. There was also a factor reflecting physical aspects of the child with the variables of medical issues and prematurity. Finally, a fourth factor emerged that was less expected but nevertheless very interesting. The variables loading in this factor were child’s physical and behavioral delay: growth under the third percentile and development delay in more than one area, plus parental conflict in a wide sense, including, in some cases, issues of domestic violence and separation. Although more needs to be explored in this cluster of variables, these cases showed high levels of family stress that was impacting on their parent’s wellbeing. It could be speculated that the couple’s emotional situation could make them less emotionally available to the child.

This study illustrates the possibility of learning from practice and refining the decision-making in a criteria-based case review process in a program like the PCPS. This study also contributes to the process of developing evidence-based services. Longitudinal studies consistently show that with parent and infant populations, problems can arise at any moment and circumstances may change: what is considered a risk situation may change to a non-risk one and vice-versa. Therefore, the early detection of further difficulties in parenting, as a main PCPS goal, requires an approach that allows for the identification of those cases on an ongoing basis that are in need of additional support and resources. This process can benefit from studies that explore the profiles and underlying factors in the population which the service addresses. One implication of this first approach to refine the case review process for practice and service development in PCPS has been to include the four major factors as a basic structure upon which cases are discussed as part of the Program’s case-review decision process.

This research illustrated some of the complexities and challenges that professionals face when they work in primary care services, in particular with infants and young children whose early life experiences impact on and influences their developmental tasks. Parenting is a hard job with joys, challenges and the need to adapt to the growing child’s needs. Competent parenting practices must be supported, encouraged and responded to taking into consideration the needs of the child and parent in each particular dyad. Therefore, early intervention, support and preventative services are essential for all parents. The PCPS focuses and targets earlier intervention, which results in better outcomes for the child’s development, parent–child interaction and more appropriate parenting practices. This study can be a step in the direction of improving practice through refining the review process.

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