Service of Early Intervention in the Czech Republic and the Republic of Finland: An Illustrative Case Study

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HOW TO CITE:
Strnadova, A., & Potmesil, M. (2025). Service of Early Intervention in the Czech Republic and the Republic of Finland: An Illustrative Case Study. *International Journal of Special Education, 40*(1), 148-158.

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DOI:
https://doi.org/10.52291/ijse.2025.40.12

ABSTRACT:

The study provides information on the conditions for delivering Early Special Educational Intervention for children with disabilities and other disadvantages aged from zero to six years and their families in the Czech Republic and the Republic of Finland. Data and information were collected using a questionnaire and supplemented by interviews with counsellors. The next step was the analysis and description of the information that had been collected. The study aimed not to compare early intervention services in terms of evaluation and better/worse findings. The study presents a comparison of the different parameters of the service at each of the national levels. In conclusion, the authors suggest some possibilities for modifying or expanding the early intervention service in response to the findings. The study should serve practitioners and academics alike as a resource for planning research and theoretical activities.

Keywords: Early Intervention, Czech Republic, Republic of Finland, Illustrative Case Study, Children at an Early Age, Children with a Handicap

INTRODUCTION

Early intervention is aimed at a target group consisting of families with children with disabilities or otherwise at risk in their development, and is usually understood as a service. In this context, it is an offer to the family, which can accept or refuse it. The current level of medical care gives the possibility of life, even to children who have come into the world with severe disabilities (WHO, 2022; Shiras et al., 2022; Adams et al., 2020). Early intervention aims to reduce, as far as possible, the negative impact of a child's disability on his or her development and the functioning of the whole family. Timely and accurate medical diagnosis and subsequent support for the target group in the form of a multidisciplinary approach, especially special education and psychology, enables the quality of life to be maintained at an acceptable level (Calder et al., 2018; Patel et al., 2008; Swallow et al., 2013).

Li and Potměšil (2015) state the objectives of early intervention: to provide parents with information and skills to enable them to become actively involved in mitigating the negative consequences of disabilities or factors that threaten their child's development. Parents are also offered sufficient information about the social security system, and (where relevant) the necessary assistance and the development of parental autonomy in supporting activities that lead to the highest possible level of integration of the child and family into mainstream society or support the child's preparation for the next level of the education system (Li & Potměšil, 2015). The basic concept of early intervention is support focused on the family and the child with a disability. All other requirements and possibilities of this specific intervention are derived from this theory, concerning the training of counsellors and the organisation of a comprehensive approach involving different disciplines and, of course, about the requirements and needs of the child-client's family (Lietz & Geiger, 2017).

An early intervention programme inevitably includes a special aspect – taking care of intact children within families that include a disabled child (Giallo & Gavidia-Payne, 2006). Practice tells us that a large group of such children are often put into a position they find very difficult to cope with, which may negatively affect their intellectual, social, and moral development. The family's attention tends to be concentrated on the disabled child, and enormous effort, time, and energy will be devoted to the disabled child (Vitoň, 2015, in Li & Potměšil; Sheppard & Moran, 2022). On the other hand, the intact child tends to be put into the role of a mere observer of events in which uncommonly stringent requirements are placed upon them. They are often expected to display behaviour considerably higher than is usually required from children of their age and to become actively involved in "special education" activities (Oppenheim-Leaf, 2015, in Li & Potměšil, 2015). The intact sibling of the disabled child finds him-/herself in an onerous situation (Granat et al., 2012; Burke & Montgomery, 2000).

Early intervention is, in essence, a voluntary activity that needs to be presented and offered to the parents. Whether they accept the service and are willing to cooperate is entirely up to the parents. Some early intervention rules are based precisely on these facts. Li and Potměšil (2015) summarise the rules: respecting the client's requirements, protecting clients' privacy, family autonomy, the existence and the right of choice, the multidisciplinary team ensuring a natural environment, and providing continuous care.

As a comprehensive term, early intervention appears in various guises worldwide (Brown & Guralnick, 2012). The characteristics of early intervention differ from country to country (Meyer et al., 2019).

Czech Republic and Finland

Early intervention in the Czech Republic has been provided to families with children with disabilities in the age range of zero to seven years, starting in the 1990s. The leading umbrella organization in the Czech Republic is Společnost pro ranou péči (translated as the Society for Early Intervention). These activities were organized voluntarily. Concerning trends and experience abroad, the volunteer character was gradually transformed into a professional form. In the form of the service offered, the activities were profiled mainly as field-based, with the possibility of using an outpatient setting. The aim was to minimise the impact of the child's disability on the functioning of the family as a system that should provide basic functions and security for its members. The year 2006 was a turning point. This year, early intervention as a service was enacted by Law 108/2006 on Social Services (Act on Social Services No. 108/2006 Coll). Thus, early intervention was legislatively classified as a preventive social service to support the functioning of the child and the family. Early intervention is described as support for a family with a child with a severe disability. If early intervention is perceived as a social service, it is terminologically defined as an "early intervention service"; in other cases, it is described as early intervention (Dokoupilová et al., 2015). The service is focused on support provided to the family and the child's development because of his/

her specific needs. The service includes the following basic activities: upbringing, educational, and activation activities; mediating contacts with the social environment; social therapeutic activities; assistance in asserting a right, justified interests, and looking after personal matters (Act No. 108/2006 Coll.). Currently (2024), 49 early care service providers are in the Czech Republic. Depending on the type of disability, the specialization of the centers focuses on families and children with visual, hearing, physical, and combined disabilities, as well as children with ASD. There is a waiting list because of the lack of capacity in each centre. Waiting times range from 35 to 434 days. The service is free of charge for parents. Funding is 60-80% provided by the Ministry of Labour and Social Affairs, with the rest of the funds being raised by individual centres through projects or sponsorship (Společnost pro ranou péči, 2022).

In the Czech Republic, 49 Centres provide early care for families of children with disabilities from 0 to 7 years of age. The number of clients who can use the services is only 14% of the total number of 920 families. The number is only an estimate as not all centres are registered and share client data.

Funding difficulties are a significant reason for the lower availability of early intervention.

Regional authorities and the Ministry of Labour and Social Affairs (MPSV) typically cover approximately 60 to 80% of the net service costs in providing early intervention services. However, the level of financial support varies significantly between regions, with differences reaching up to 100% for a single full-time position of an early intervention counselor. These disparities considerably impact the quality and availability of services for end users.

In practice, multi-source funding requires the administration of more than 40 projects annually within a single centre serving approximately 100 families with children with disabilities. This administrative burden is currently unsustainable.

Furthermore, subsidies from the MPSV and regional authorities do not allow financing service vehicles, which are essential for providing field-based early intervention services. As a result, acquiring such vehicles is particularly challenging for service providers, and they must rely primarily on support from foundations, charitable funds, and fundraising activities.

The education of counsellors is provided at the bachelor's and subsequent master's levels at the Faculty of Education of Palacký University in Olomouc as a type of non-teaching study. Early intervention counsellors (mostly female staff) must undergo continuous education in specialization courses and lectures (Act No. 108/2006 Coll.).

In Finland, Early childhood education and care (hereafter "ECEC") consists of services for children from birth to approximately seven years of age (Heiskanen & Viitala, 2019). The national core curriculum for ECEC (Finnish National Agency for Education, 2018) emphasises providing support as soon as possible when the need for support appears. Every child who needs support is entitled to receive it. Sufficiently timely and properly targeted support can support a child's development, learning, and overall health and well-being. At the same time, support can be used to prevent problems from arising. ECEC and the entire educational system in Finland are developed following the principles of inclusion (Finnish National Agency for Education, 2018). The care is provided within the health or social care system; these two systems are generally integrated relatively well because local government, municipalities, and municipal joint organisations run public health and social services, and collaboration across sector borders has been relatively uncomplicated to organise (Paavola & Pesonen, 2021; Tiirinki et al., 2022).

The roots of the Finnish ECEC system emerged from the private kindergartens and kindergarten teacher seminars of the 1890s. Before 1973, there were all-day and half-day kindergartens or separate groups for all-day and half-day activities in the same kindergarten. After 1973, the kindergartens and nurseries were joined together to form daycare centres – this decision could be interpreted as the starting point of the Educare ideology (Kalliala & Onnismaa, 2010; Pölkki & Vornanen, 2015). In current daycare practices, the partnership in upbringing (parents and the staff members) and drawing up an individual educational plan for a child with parents are strongly emphasised (Alasuutari & Karila, 2010). Around the 1980s, an obligation was introduced for daycare to provide exceptional care or a rehabilitation plan for children with special educational needs and/or from risky environments (Heinämäki, 2008a). As Pölkki and Vornanen (2015) state, nowadays, several types of ECEC institutions exist alongside each other. Finnish families with children have equal access to high-quality early childhood education services everywhere in the country. Parents can choose between municipal daycare (a daycare centre managed by highly trained staff or in the home of a family daycare provider) and private daycare in a childminder's home, usually with significantly less training, subsidised through a private daycare allowance. Moreover, one par-

ent can stay home on a child's home care allowance if the child is under three. Daycare costs depend on the family's size and the respective income level (in 2013, the price varied between 18 and 233 EUR a month for one child) (Lindeboom & Buiskool, 2013). Because Finnish daycare includes education and care, the staff must have at least secondary-level education, and one-third must have a post-secondary degree (Bachelor of Education, Master of Education, or Bachelor of Social Sciences) (Heinämäki, 2008a). Based on the Child Welfare Act 2007/417 (Heinämäki, 2008b) and the National Curriculum Guidelines for ECEC (2004), ECEC should offer early and exceptional support for children in need or at risk of serious problems. In Finnish daycare, children with special needs are usually included in the general system of ECEC. A child with special needs may also be placed in a special educational needs (hereafter "SEN") group (5%) or an integrated group (10% of children with SEN). Still, 85% of children with SEN receive mainstream education instruction from a special needs preschool teacher who visits the institution regularly (Heinämäki, 2008a).

Projecting to 2043, considering demographic trends and the inclusive approach, it's reasonable to estimate that the proportion of children with disabilities in ECEC will remain similar or potentially increase slightly due to improved diagnostic practices. Assuming the total number of children in ECEC remains around 235,000, and applying the 1.7% estimate, approximately 4,000 children with diagnosed disabilities might participate in ECEC in 2043. It is important to note that this is a rough estimate, and actual numbers could vary based on factors such as changes in birth rates, diagnostic criteria, and educational policies.

Qualification Requirements for the Position of Early Childhood Advisor for Children with Disabilities in Finland. To practise as an Early Childhood Advisor for children with disabilities in Finland — commonly referred to as a Special Education Teacher in Early Childhood Education and Care (ECEC) — specific educational and professional requirements must be fulfilled, as established by Finnish legislation and supervised by the Finnish National Agency for Education (Opetushallitus). According to the Early Childhood Education and Care Act (540/2018), the primary qualification requirements include a Bachelor's Degree in Early Childhood Education. The degree must consist of professional studies that provide the necessary competencies for tasks in special education. Master's Degree in Educational Sciences with a Major in Special Education. This academic pathway is designed for individuals seeking to qualify as early childhood special education teachers. Meeting these qualification requirements ensures that educators possess the necessary pedagogical and professional competencies to support children who require enhanced or exceptional support within the Early Childhood Education and Care (ECEC).

Comparative Overview

Early intervention in Finland and the Czech Republic both focuses on supporting families with children with disabilities or other developmental risks. In the Czech Republic, the service is mainly provided within the social services framework, specifically as part of legislatively defined early intervention services. On the other hand, Finland integrates early intervention within social and educational services with an emphasis on inclusivity. Centers in both countries employ highly qualified professionals, typically requiring a university degree (Bachelor's or Master's level), but specialization approaches differ. Finnish services are designed to be available to all needy children, whereas Czech centers often specialize in specific types of disabilities. This structural difference reflects broader service philosophy and system organization differences between the two countries.

AIM OF THE STUDY

The study was undertaken to compare two countries' early intervention systems and provide a picture of common and functional service areas through item-by-item analysis.

The study sought opportunities for suggestions for modifications and information for mutual enrichment on any differences. Hence, the early intervention systems in the Czech Republic and Finland were chosen for comparison. Two sites offering an early intervention service were selected for the present study. The Olomouc region was chosen as the first in the Czech Republic, thanks to good knowledge of the environment and professional contacts. The second area, Finnish Lapland, became the subject of interest due to the long-term residence of one of the study's authors. Both areas are comparable in terms of the number of centers and clients in the early intervention center. From the Olomouc region, four centers were approached with a request for cooperation, and from the Lapland region, three centers were approached, and this request was granted.

Research questions

The study aimed to illustrate centers of early intervention when research questions were used: How is the team of the center's staff profiled? How are the counseling and

intervention in families functionally set up? How is the management of the center designed?

Study description

Each country's early intervention systems evolve continuously, but the evolutionary dynamics are different due to several parameters. The development is determined by several aspects – national characteristics, the history of the country, specific geographical conditions, the current government and its policy, the political arrangement, and many more. For the study presented in this article, two European countries with divergent early intervention systems were chosen – the Czech Republic and the Republic of Finland. The study's results – the systems, their functioning, and the staff members' experiences – can benefit both countries.

The general goal was to compare the functioning of early intervention services in the Czech Republic and Finland and find out if both systems could benefit in a way from the findings. There were altogether seven centres participating in the study. Four centres of the early intervention service in the Olomouc region in the Czech Republic, as listed in the register of social service providers (Ministry of Labour and Social Affairs, 2021), and three centres providing early intervention in the municipality of Rovaniemi in Finland, participated.

All the centres in the Czech Republic are classified as early intervention service providers, according to Act No. 108/2006 Coll., on social services. As for Finland, two centres were classified as providers of Early Childhood Education and Care and one as a family centre.

Method

The method chosen for this study was the illustrative case study approach, which is descriptive, follows the actual reality, and aims to develop examples for further use for praxis and scientific research (Baron & McNeal, 2019).

Measures

Data was obtained from a questionnaire created by the authors of this article. Piloting the questionnaire was the first step in the data collection. The questionnaire consists of eleven sets of questions, with a total of 49 questions. The questionnaire contains open-ended, closed-ended, semi-closed, and multiple-choice items. A sample of some questions: Is completing any specialization course or courses obligatory when a new worker starts working in this centre? – Yes/no. If yes, what kind of specialization course must a worker complete? Are there any rules you must follow to ensure the multidisciplinary concept of care? – Yes/no. How do you negotiate the cooperation (e.g., you call another professional)?

A range of questions was followed: the team in the centre, their education and specialisation, the area and other centres, aids (The term aids includes special toys or compensatory aids for children with disabilities, professional literature for parents.) All are intended for practical activities in families, cooperation with professionals, cooperation with a university workplace, funding, information to the public, supervision, fluctuation of staff, and feelings about the job. The questionnaires were completed by fully qualified workers from the surveyed centres. All questions were fully answered, and everything could be used for further research work.

Procedure

The questionnaires, in an online "Google" form, were sent by the authors of this article via email to the above-mentioned centres with a request for participation. In the email, the purpose of the study was explained. All the centers completed questionnaires, which were asked to complete one questionnaire per centre. The centres' answers appeared a few days after the request. In the Olomouc region, there are four different early intervention service providers, and we asked each provider to fill out our questionnaire. In all cases, the head of the center filled out the questionnaire, answering all questions according to the center. In the center, many professionals work and cooperate, starting with social workers, notable pedagogues, speech therapists, and others.

ANALYSIS OF THE INFORMATION OBTAINED AND ITS COMPARISON

The team in the centre

The first range of questions deals with the centre team. The Finnish centres surveyed are two special ECECs and a family centre, and the respondents themselves are the managers of these centres. In the ECECs, only notable pedagogues work there full-time. Social workers and psychologists work full-time in the family center, and a doctor works part-time. The required level of qualification is a university degree (Master's degree) in the relevant field.

All the Czech centres that were surveyed are early intervention centres. The respondents themselves are the heads of the centres. In all the centres, notable pedagogues work full-time, and so do the social workers. In some centres, there are part-time staff: doctors, psychologists, social pedagogues, speech therapists, or sign language teachers (it depends on the specialisation of the

centre). The required qualification is given by Act No. 108/2006 Coll., on social services: a university degree or a degree from a higher school in the relevant field. All of the respondents were female. Pleasingly, 100% of respondents from both countries were satisfied with their work.

Education and specialization

As for education and specialisation, in all the surveyed Finnish centers, it is obligatory to complete specialisation courses or courses when a new staff member starts working there. Specifically, the first ECEC was an information security course. At the same time, the family centre offers a one-year specialisation course in family matters and therapy. The second ECEC is provided by a specialist in the ECEC course and a methodologist at the centre.

In the family centre and the second ECEC, further education is obligatory. The hours devoted to education in the family center differ depending on each course. As for the second ECEC, the obligatory further education is eight hours or more. In both centres, the possibilities for further education are vast – it depends on what the centre needs the staff member to do at a given moment. The centre, universities, or other organisations organise the courses. Also in both centres, the staff member can choose the education according to his/her professional orientation and preferences. In Finland, the centres do not specialise in one type of disability – their services are available for anyone, with or without a disability, who needs help.

In all the Czech centres surveyed, it is obligatory to complete specialisation courses when a new staff member starts working there. The course focus differs from the specialisation of the centre. In the first centre, the courses are crisis intervention, work with the family, and individual planning, in the second centre an accredited early care counsellor course, in the third centre an early care counsellor course, a vision and child development course, intervention courses, and a psychology course, and in the fourth centre the ABA approach, Handle, Son-rise, sensory integration, and primary reflection.

Also, further education is compulsory. The amount of time that a staff member needs to fulfil annually is given by Act No. 108/2006 Coll., on social services, and it is 24 hours per year. However, the centres agree that staff members complete many more education hours (one centre mentions around 100 hours per year). The options for further education are wide: courses in the organisation, many projects, cooperation with other organisations, an internship abroad, or the offer of educational agencies. All the centres agree that the staff member can choose the education according to his/her professional orientation and preferences. In all except one centre, the activities of the centre specialise in one type of disability: families of children with hearing impairment, families of children with visual and combined disabilities, and families of children with an autism spectrum disorder. The last centre specialises in helping the families of children with physical, mental, and combined disabilities, including autism spectrum disorders.

Area and other centers

All the Finnish centres provide their services in the municipality of Rovaniemi. All surveyed centers communicate with other centers, providing similar services in different municipalities and regions.

The Czech centres provide their services in the region of Olomouc. All of the centres also agree that they communicate with other centres that are similar to their own, both within the region and from other regions.

Aids

The Finnish family centre does not use aids for families because the centre is specialised in therapy. On the other hand, the ECECs use aids and produce them themselves or purchase them. The ECEC centres agree that families cannot borrow aids at home. They also agree that they have enough aid to meet the needs of all the clients' families. The first ECEC centre stated that they lacked the resources to buy aid. The second ECEC has enough resources to purchase aids.

All the surveyed Czech centers purchased and produced aids by themselves. They also agree that parents can borrow some aids for home usage. The centres unanimously agree that they have enough aid to meet the needs of all their clients. However, two centres claim they lack the resources to buy aids. One of the centres states that they do fundraising activities and try to get funds.

Cooperation with professionals

All the Finnish centres cooperate with professionals from other fields (mainly in the municipality of the city of Rovaniemi). The first ECEC centre collaborates with the child health clinic, schools, the hospital, child and family therapy centres, childcare centres, and various centres for people with mental and physical disabilities. The family centre cooperates with social workers, therapists, and teachers. The second ECEC centre cooperates with schools, the child health clinic, children's hospitals, and social workers specialising in children. All the centres

have established rules for multidisciplinary cooperation. In the first ECEC centre, the meetings with professionals are regular; they set up the meetings using an online calendar or make a call. For the family centre, cooperation is a usual part of the job and is used for solving problems; the staff members decide with the parents which professionals need to be involved in the cooperation, and then the staff members call them and arrange a meeting. The second ECEC centre has many kinds of cooperation; they must maintain professional confidentiality when discussing the child's situation; they also have other types of cooperation, e.g., to improve cooperation between different disciplines. Only in the second ECEC centre is there a case manager for each client.

All the centres agree that the most common problem in establishing cooperation with other professionals is time pressure. The most common problems in maintaining the cooperation are time issues and questions about how well all the participants understand each other and their responsibilities.

The Czech centres also cooperate with professionals from other fields. Most professionals are doctors, teachers from kindergartens and schools, notable pedagogues, psychologists, speech therapists, sign language teachers, counsellors from special education centres, authority child protection, or non-profit organisations. Rules for multidisciplinary cooperation have been set up in all but one center. In those where the rules are established, they are followed: the first centre can organise a team around the child, they initiate a case conference in cooperation with the social and legal protection authority for children, consultations with other invited experts (e.g. in kindergartens and primary schools, accompanying the family to the doctor or an office); the second centre offers the possibility of individual consultations with the consent of the parents, and the multidisciplinary team works together; the third centre invites the relevant experts to case consultation and the experts attend those in person or join online and ideally it is at least once every three weeks. Also, all the centres organise cooperation according to the needs of each family. The respondents agree that they arrange a meeting with professionals as needed, mainly by phone, email, or a combination of both; after arrangements, there is a personal meeting. One centre mentions that if it is the family's responsibility to make the appointment, they let the family be active in making the appointment. In all of the centres, a case manager exists for each client.

According to half of the respondents, the most significant problems in establishing cooperation are time constraints and the capacity of experts. Difficulties in collaboration then arise in communication between the sectors (healthcare and social), placement in school facilities, speech therapy care, and setting up alternative and augmentative communication in the home environment, or generally ensuring other available services. The fourth centre mentions that when establishing interdisciplinary cooperation, a recommendation from a mutual acquaintance is often essential, or the advice is not to be afraid to try to approach the experts yourself; courage is also significant in this process. The majority of the respondents, 85 %, agree that the most common problem in maintaining cooperation is a lack of time options (one centre mentions that nowadays, online meetings help), as well as work capacity or reluctance to meet, which entails fears and ignorance of the benefits of such a meeting.

Cooperation with universities

All of the Finnish centres that were surveyed cooperate with universities. Both ECEC centres collaborate with the Department of Education and the Family Centre with the Social Work and Psychology departments. Both ECEC centres have meetings with the teachers at the university, and they discuss the educational needs of their clients. The family centre cooperates with students from the university.

All of the Czech respondents also cooperate with a university workplace. Specifically, all the centres collaborate with the Faculty of Education of Palacký University Olomouc (one centre specifies that the cooperation takes place with individual pedagogues and the Institute of Special Education Studies). At the same time, another centre also collaborates with the Faculty of Physical Culture of Palacký University, Olomouc. Two centres also mention cooperation with CARITAS, the Olomouc Social Higher Vocational School. One centre cooperates with Masaryk University (Brno), the University of Hradec Králové, and Charles University (Prague). Half of the respondents claim the cooperation is balanced. Three centres describe the cooperation as lectures or cooperation within internships for students in the centres. Other centres cooperate with the university on final theses, conduct excursions, and sometimes participate in round tables (conversations with people around one specific topic). In one of the centres, where collaboration is not balanced, the respondent thinks that balanced cooperation would bring benefits in mutual sharing and finding solutions, in the use of volunteering, and in the systemic interlinking of theory and practice.

Funding

All the Finnish centres that were surveyed are funded by subsidies from public budgets (from the state and municipality). The services are free of charge for the clients.

The surveyed Czech centers are funded by subsidies from public budgets (from the state and municipality), private resources (donations), and two centers are financed by projects or foundations. The services are free of charge for the clients.

Information to the public

The first ECEC centre disseminates information about the service in the city newspaper and on the website; the family centre is on the centre's website and through various city announcements; and the second ECEC centre is through a briefing at the town hall. The activities in all surveyed Finnish centers include a popularisation and educational component. All of the centres have information on their websites. The family centre and the second ECEC centre have information available in counselling centres for pregnant women (leaflets), the information available in newspapers or magazines, or through lectures in schools. The family centre also hosts lectures for the public.

As for the Czech centres, spreading awareness of the services for the public varies: at one centre, it is in the form of screening by experts, and through the media and state institutions, the centres also conduct lectures. Another centre also uses websites and social networks; the third centre spreads awareness through doctors' recommendations and as part of the Early Care Week event. Another centre also mentions meetings in various commissions at the regional office and the Municipality of the City of Olomouc. The popularisation component in most of the centres that were surveyed includes the following: information available on their website; information available on leaflets in counselling centres for pregnant women; information available in newspapers or magazines; lectures in schools or lectures for the public. Some centres also organise educational events such as sign language interpretation or the Early Care Week event.

Supervision

Both ECEC centres state that there is no supervision as a form of psychological support for staff members. In the family centre, the staff members can choose their supervisor. Every staff member has the opportunity to be supported in their work, and all the staff members help each other. Their head person is a psychologist and family therapist – they can also use her as a form of supervision.

In all the Czech centres that were surveyed, supervision exists. However, the form of the supervision varies. In the first centre, supervision can take the form of individual or group, case or team, once a month with an external supervisor. Supervision in the second center also occurs once a month with an external supervisor. The third centre has team supervision once every three months and individual supervision once every three months. The fourth centre has external group supervision once every three months, or earlier as needed. Another form of supervision that one respondent would appreciate is team supervision in places other than workplaces. Another respondent would also value group team supervision and supervision for the organization's leadership.

Fluctuation of staff

Only the second ECEC centre states that it faces the problem of frequent fluctuations in the staff. They are not sure why this problem occurs.

One of the four surveyed centers has a problem with frequent staff turnover (fluctuation). According to the respondents, the frequent fluctuation of employees in some centres may be maternity leave, better financial rewards in another job, and the significant mental demands of work in direct care.

Workload

All of the Finnish respondents are very satisfied with their jobs. The respondents from both ECEC centres agree that they aim to help children; the respondents from the family centre emphasise the excellent relationships among the staff members and the pleasant atmosphere in the centre. The respondent from the first ECEC mentioned the opportunity to help children and their families as motivation for her job. The respondent from the family centre enjoys how the social sphere cooperates with psychologists and social workers with a university education to help the families. Regarding the question about improving anything about the job, all three respondents agree that the centres need more employees to meet the needs of all the families and children.

Most Czech respondents agree that their motivation for working in this service is the meaningfulness of the service and helping families in need. One respondent states that the motivation is personal; she has an autistic adult daughter, and she and her husband founded the organisation almost twenty years ago. All the respondents stated they are delighted with their work for various reasons. The reasons for the first respondent are the highly expert nature of the work, the possibility of job growth,

supporting families in challenging situations, and good financial rewards. In the case of the second respondent, the reason is that his idea of work matches the mission of the service and its fulfilment. The third respondent has a high-quality team of people; the work is meaningful, diverse, and has a broad scope and impact. The fourth respondent also mentions the meaningfulness of the work and states that they see how their work changes the lives of children with autism spectrum disorder and their families (for the better). All the respondents also stated that there was something they would like to improve about their work. The first respondent would appreciate improved collaboration across disciplines and greater openness to new and innovative approaches. The second respondent would like to work on improving the quality of service provision. The third respondent would appreciate less administration and 100% of public resources, as well as improving the timeliness and availability of the service for all families in need. The fourth respondent would appreciate having more resources and personnel for PR (public relations).

For this study, two similar populations and area size regions were analyzed. Therefore, it has been selected to compare the Olomouc region in the Czech Republic and the region of the municipality of the city of Rovaniemi, the Republic of Finland. All the early intervention service providers from the mentioned areas were approached for research collaboration. That makes the total number of four early intervention service providers in the Olomouc region and three early intervention service providers in the municipality of the city of Rovaniemi.

A summary comparison of the information gathered and responses to the research questions is presented in Table 1.

Tabele 1.

	Finland	Czech Republic
How is the team of the center‘s staff profiled?		
The team in the centre	Special pedagogue, social worker, psychologist, family therapist, doctor (part-time).	Special pedagogue, social worker. Only in one of the centres: social pedagogue (part-time) and psychologist (part-time).
Qualification requirements	University degree (Master’s degree) in the relevant field.	University degree (Bachelor’s or Master’s) or degree from a higher school in the relevant field.
Compulsory courses for aspiring counsellors	Education and specialisation are mandatory (e.g., ECEC specialist course, an information security course, a course in family matters and therapy, and the methodology of the centre).	Some specialisation courses are mandatory (e.g., early intervention counsellor course, crisis intervention course for working with families, and individual planning).
Further education	Mandatory in all except one centre. There is no exact number of hours. Courses are organised by universities, the centre, or other organisations. Each staff member can choose the courses according to their specialisation and own preferences.	Mandatory, min. 24 hours annually – in practice, it is much more. Courses are organised in the centre, in educational agencies, lectures by doctors, courses abroad, and webinars. Each staff member can choose the courses according to their specialisation and own preferences.
How are the counseling and intervention in families functionally set up?		
Activities of the centre	Specialising in every type of disability, the services are available to anyone who needs help.	Specialised in one type of disability, except for one centre (specialised in physical, mental, and combined disabilities, including autism spectrum disorders). One centre is specialised in visual and combined impairments, a second centre in hearing impairments, and another in autism spectrum disorders.
Area and other centres	Services are provided in the municipality of the city of Rovaniemi, and the centres that were surveyed communicate with other centres both in and outside this region.	Services are provided in the region of Olomouc, and the centres that were surveyed communicate with other centres both in and outside this region.

Aids	The ECECs purchase or produce aids by themselves, and families can borrow aids for use at home. The ECECs have enough aids to meet the needs of clients. The first ECEC does not have enough resources to buy aids, the second ECEC does.	All the centres purchase or produce aids by themselves; families can borrow aids for use at home. All the centres have enough aids to meet the needs of their clients. Two centres do not have enough resources to buy aids.
Multidisciplinary team	Wide cooperation with multiple professionals from various fields: social workers, therapists, teachers, child health centres, child hospitals, and child welfare.	Cooperation with professionals according to the centre's specialisation: doctors (neurology, neonatology, ophthalmology, paediatrics, phonetics, audiology), kindergarten teachers, a counsellor from special education centres, children's social protection authority, speech therapists, special education teachers, occupational therapists, non-governmental non-profit organisations, psychologists, vision therapists, experts in sensory integration and nutritional counselling.
Rules for cooperation	There are established rules for cooperation in all of the centres that were surveyed. Cooperation is regular and is a common part of their work.	There are established rules in three of the four centres that were surveyed. Overall, the centres cooperate with other professionals according to the family's needs.
Arranging meetings	Centres arrange the meetings via phone or online calendar.	The majority of the centres arrange the meetings via phone, email, or a combination.
Case manager	Only in one of the ECEC centres is there a case manager.	In all centres, there is a case manager.
How is the management of the center designed?		
Problems with establishing the cooperation	The biggest problem is time constraints.	Half of the respondents claim that the biggest problems are time constraints and the capacity of professionals. Problems appear within communication between the resorts (healthcare and social).
Problems with maintaining the cooperation	Two centres mention a lack of time options. The other centre mentions that professionals' opinions vary. The other centre underlines the problem of mutual understanding.	The majority of the centres mention a lack of time options to meet, work capacity, or reluctance to meet.
Cooperation with universities	Two ECECs cooperate with the department of education; the family centre cooperates with social work and the department of psychology. Both ECECs have meetings with teachers and discuss the educational needs of their clients. The family centre cooperates with students.	All the centres cooperate with multiple universities: departments of education, special education, sports, or social work. Types of cooperation: lectures, final theses, excursions, round tables. One centre claims the cooperation is not balanced: the cooperation could bring benefits.
Funding	Subsidies from public budgets. Services are free of charge for clients.	Subsidies from public budgets and from private resources (donations); two centres from projects or foundations. Services are free of charge for clients.
Information to the public	It varies, with city newspapers and websites; city announcements; briefings at the town hall; leaflets in counselling centres for pregnant women; lectures in schools or for the public.	It varies across social media, state institutions, lectures in school or for the public; websites; the Early Care Week event; meetings at the town hall; leaflets in counselling centres for pregnant women; newspapers, and magazines.

Supervision	In ECEC – no form of supervision. In the family centre: every staff member can choose their supervisor; all the staff members support each other.	The form of supervision varies: individual or group, case or team, once a month with an external supervisor; once a month with an external supervisor; team supervision once every three months, as well as individual supervision once every three months; external group supervision once every three months, or earlier as needed.
Fluctuation of staff	Only one ECEC faces the problem of frequent staff turnover.	One of the four centres faces the problem. The reason could be maternity leave, better financial rewards in another job, or the great mental demands of the work.
Workload	All the respondents are very satisfied with their jobs; they aim to help children, the relationships among the staff are very good, and there is a pleasant atmosphere and good cooperation. The respondents agree that the centres need more staff members to meet the needs of all families and children.	All the respondents are very satisfied with their jobs. Most of the respondents agree that their motivation is the meaningfulness of this service; the highly expert nature of the work, the possibility of job growth, good financial rewards; a high-quality team of people. Suggested improvements: improving cooperation between sectors, greater openness to new approaches; improving the quality of service provision; less administration and 100% of public resources, improving timeliness and availability for all families in need; more resources and personnel for PR.

DISCUSSION

This study highlights key areas for improving early intervention (EI) services in the Czech Republic and Finland. This study aimed not to make comparisons in the sense of evaluating the individual systems in both countries, nor to look for the strengths or weaknesses of early intervention. Similarities and differences in the system, its functioning, the requirements for counsellors, and the benefits for clients can be found in the text.

Early intervention in Finland and the Czech Republic focuses on the target group of families with children with disabilities or other developmental risks. In the Czech Republic, the service is mainly provided as part of the social service of early intervention. Early intervention is part of social and educational services and support in Finland.

Rather than summarizing findings, this section discusses implications for practice, policy, and future research.

Implications for Practice

A critical takeaway is the importance of robust multidisciplinary cooperation. In Finland, systematic collaboration across sectors ensures that families receive cohesive support. In contrast, Czech EI services face structural barriers to cross-sector cooperation, suggesting the need for integrated protocols and dedicated collaboration time. Moreover, supervision practices supporting staff psychological resilience should be expanded, especially given the emotional intensity of EI work.

Implications for Policy

To strengthen early intervention, policymakers should address funding disparities that limit service accessibility. Both countries need additional resources to hire staff and reduce client waiting times. Moreover, public information campaigns could raise awareness of EI services, especially in the Czech Republic, where even professionals sometimes lack knowledge about available support. Introducing policies that mandate and fund interprofessional collaboration meetings would mirror Finland‘s success in multidisciplinary teamwork.

Implications for Future Research

Further studies could examine:- How multidisciplinary cooperation quantitatively affects child and family outcomes. Long-term effects of systematic supervision on staff retention and well-being. Comparative analyses of funding models and their impact on service delivery across European regions. Research should also explore how technology could facilitate EI delivery, particularly in areas where in-person services are limited by funding or geography.

CONCLUSION

The early intervention system in Finland is very inclusive, with professionals communicating regularly and effectively in multidisciplinary cooperation, and the early intervention system is more directed towards the education sector. In the Czech Republic, the early intervention system also supports families with children with disabilities. However, there are gaps in multidisciplinary cooperation; the system is located within the Ministry of Social Affairs and needs more financial support. The need for more financial support also applies to Finland, as the answers indicate, the centres need more staff to support and assist as many families with children with disabilities as required, if not all.

As multidisciplinary collaboration is key to providing support and assistance, we suggest improving the quality by fine-tuning the collaboration system to a level where professionals from different disciplines communicate regularly and have a defined time and space for communication, which becomes a regular part of their work process. The case manager would organise and plan the necessary meetings together with others. The family would benefit from this cooperation, and the process of providing help and support would improve.

Some people know about early intervention services, but not the general public. Another proposal would be to strengthen the publicity component, including more lectures or educational events for the public.

Working in early intervention services is very demanding psychologically. This can be closely linked to supervision. Therefore, sufficient supervision is proposed to support staff members and prevent burnout and other potential psychological problems.

One of the most positive findings from this study may be that early intervention workers are delighted in their jobs and see their work as meaningful. This keeps them motivated.

In conclusion, the early intervention systems in the countries under consideration differ in some aspects. One thing that both countries undoubtedly have in common is that sufficient support for families of children with disabilities must be provided as early as possible when the need for support arises. It must be professional and of high quality.

As a result of the analysis of the information gathered, several recommendations can be made to address some of the difficulties:

- Mandatory in-service training for counsellors should be supplemented with training in some therapy, communication training, or other self-development training to increase counsellors' psychological resilience.
- Concerning the problem of counsellor shortages and the need for a waiting list for new client families, it would be appropriate to try to replace some in-person activities with courses and written information and instruction in keeping with the long tradition of the John Tracy Center for working with DHH children and their families (John Tracy Center, 2022);
- Public Information. This area could prepare future teachers to deliver an educational event, such as a seminar or workshop, for students around 17/18. This age group is already mentally mature enough to receive and process information about the existence of disabilities and the possible support for families by early intervention centres.

Despite these differences, both countries recognize the necessity of early, professional, and comprehensive support for families with children with disabilities. Key proposals based on the study include: Mandatory in-service training focused on resilience and therapeutic skills. Alternative support models (e.g., online training for parents) to alleviate staff shortages. Expanded public education efforts about early intervention. The high levels of job satisfaction among EI workers in both countries remain an encouraging sign for the future development of these essential services.

ACKNOWLEDGEMENTS

The text has undergone revision by a professional translator, Simon Gill, a native English speaker.

DECLARATION OF INTEREST STATEMENT

The author reported no potential conflict of interest

FUNDING

The Palacký University Project IGA_PdF_2022_010 supported this article as well as the project US-WEINOE 1S-1213-001-1-10-06.

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