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Monica Martinussen (Editor)

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RKBU Nord
Regional Centre for Child and Youth Mental Health and Child Welfare, Northern Norway.
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Preface

The Third Nordic Family Centre Conference was held in Tromsø June 10-12, 2013. The program had a large number of interesting presentations from both invited speakers and participants. The power-point presentations are available on our web page, familienshus.wordpress.com. All presenters were invited to submit full papers to the proceedings, and those who did are included in this book.

The conference included themes such as early interventions, family support, child poverty, user participation, social and cultural factors, collaboration and how to organize and improve services for children and their families.

On behalf of the program committee and RKBU Nord we thank all the presenters and participants for their contributions. Finally, we would like to thank the Faculty of Health Sciences and the Norwegian Research Council for financial support.

Monica Martinussen (Editor)
RKBU Nord, University of Tromsø

1st. row from the left: Mariann B. Hansen (RKBU Nord), Monica Martinussen (RKBU Nord), Anita Skogstrand (RKBU Vest), Vibeke Bing (Backa Läkarhusgruppen), Ellen Olafsen (R-BUP sør/øst). 2nd. row from the left: Reidar Arnesen (RKBU Nord), Frode Adolfsen (RKBU Nord), Mia Mantonen (Det Finlandssvenske kompetenscenteret), Anne Lise Knatten (RBUP sør/øst). Anne Brenne (RKBU Midt) was absent.

A self-reflection tool to support improvement work at family centers

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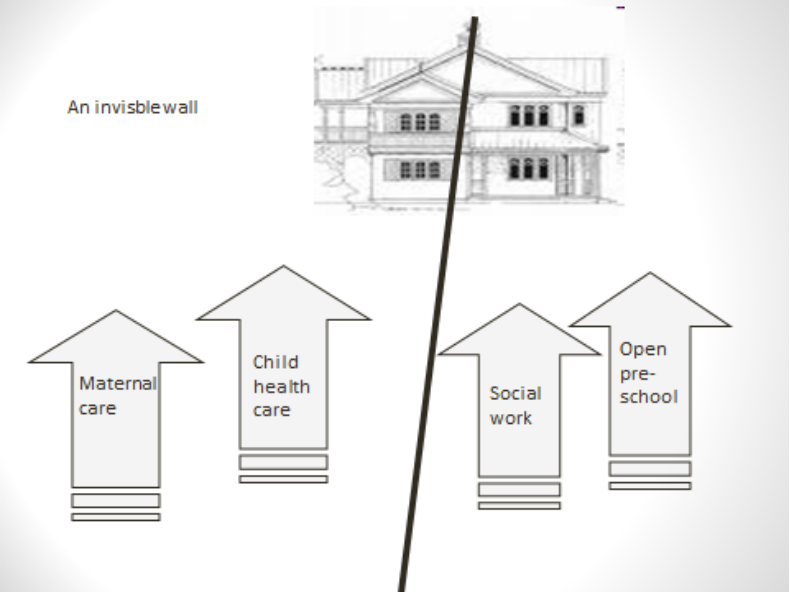
Abstract

Family centers, as a multi-professional and multi-agency arena meets several challenges in the daily practice. The professionals need to come together in meeting parents' and children's fluctuating needs whenever they turn up at the open space of the open pre-school. An easy flow in the daily co-operation between the professionals adds an additional dimension to what a co-located facility can offer. The aim in this study has been to develop a self-reflection tool which can be used in improving reflection-in-action in order to reach the potential of professional compliance at family centers.
In this presentation, the development and the content of a tool supporting professionals in their efforts to come together and form an activity in common will be demonstrated. The tool consists of 27 aspects of family center activities that have evolved in research and evaluations of family centers in Sweden. The aspects are categorized as; universal activities, early support to parents, accessibility, learning, early support of professionals, equality, and collaboration. Each aspect is formulated as a claim which the professionals rate from one to five. At first, each individual professional on their own reflect and rates. Second, the professionals reflect and collaboratively try to rate how well the whole family center performs. Third, they together choose areas to improve and when and how to follow up on their efforts. The self-reflection tool is aimed to be used regularly each year.

Introduction

Inter-disciplinary and inter-professional work at co-located facilities of family centers requires skills of fluently co-operating in every-day work around the families (Abrahamsson, 2007a). Often the personnel are not aware of pre-conceptions and cultural baggage from their professional and organizational backgrounds they bring into the work. They often get surprised of the implications of these challenges when they are in place in the new inter-professional work. In a research project, the personnel together with a researcher investigated problems in co-operation at one family center. One personnel concluded, "It was not as easy as we thought it would be". An invisible wall was identified. On one side were the midwives and nurses, and on the other side the social worker and pre-school teachers. Primarily, the discrepancies were explained by their respective professional and organizational backgrounds. The invisible wall was found to consist of variations in ways of planning work, organizational culture, views on knowledge and science. In the health sector, the beliefs are based more on rational thinking originated in medical science, and in the hierarchical organization in health care. In the social sector, the beliefs are based more on – "it depends-on-thinking" - on various perspectives on what counts as knowledge in social science and in the more flat and complex organizations (Abrahamsson, 2007b).

Figure 1: The invisible wall



The personnel of family centers strongly believe in that the service to parents is meaningful and effective. The personnel's beliefs are confirmed in several qualitative studies from the perspective of parents who in general are positive to this service (Lindskov, 2010; Socialstyrelsen, 2008; Warren-Adamsson, 2006). They find the service from the personnel of different professions at family centers easy accessible, and supportive to their needs (Abrahamsson & Bing, 2011; Abrahamsson, Bing et al 2009). The potential of family centers is thus great, however the personnel need to see and recognize the whole opportunity in their work in order to use this potential at best (Abrahamsson & Bing, 2011). A characteristic of the inter-professional co-operation in family center work has been identified and conceptualized as professional compliance (Abrahamsson & Samarasinghe, 2013). The concept of compliance is in general used in the meaning of patients' obedience to medical advices in health, whereas professional compliance is the other way around, the 'obedience' or responsiveness of personnel to parents' needs. In Abrahamsson and Samarasinghe (2013), this concept has been developed and concluded to be the crucial mechanism to the outcomes at open pre-schools activities at family centers in Sweden. The professional compliance is the way personnel adapted according to parents' situation and readiness for support.

Acting in a compliant way in the relation to parents' and children's needs requires however, a break in routine practice - a reflective practice (Amble, 2012). Despite practical experience and possessing knowledge in action, a vast amount of knowledge remains tacit (Bouchamma & Basque, 2012). Tacit knowledge implies that personnel are unable to provide plausible explanations or detailed description of the phenomena that constitute their daily duties. Reflection-in-action may bring tacit knowledge to the fore although it needs training for developing sensitivity to the recent moment and improvisational ways of responding to it (Tsoukas & Yanow, 2009). An easy flow in every-day inter-professional co-operation by reflective personnel can add the extra that makes the sum bigger than it's' parts. The aim in this study has been to develop a self-reflection tool which can be used in improving reflection-in-action in order to reach the potential of professional compliance at family centers.

Method

An interactive research design was used in the stepwise developing the tool of reflection (Cook, 2006). 20 family centers in Sweden have been involved. The initial questions of research were; What do we know of parent's needs? And therefore what is most relevant of making explicit among the personnel? The point of departure was therefore based on earlier research on what we know of parent's and children's needs, and therefore was most relevant of making explicit among the personnel. In the first step of developing the self-reflection tool the relevant topics were defined. This work was performed by a researcher together with a working group which consisted of members in a steering group and coordinators from 12 family centers. The topics were than operationalized into statements. The most relevant statements were prioritized in order to make the tool workable. The researcher presented the preliminary tool to the working group, and got feed-back. The revised tool was than tested at the 12 family centers in one county, and at one family center in another county. The personnel were asked to make comments to the statements and to the tool in general. These comments together with a statistical analysis (factor analysis) were than used to revise the tool and the instructions on how to use it. The steps in the development process were the following; identify relevant research, define topics of interest together with the personnel, operationalize the topics into statements, feed-back from a working group, test the tool and get feed-back from personnel, revise and retest the tool, and again get feedback from personnel.

Results

The tool consists of seven topics. They are based on statements to which the personnel answer on Likert scales 1-5. The topics are ; General work at the family center (3 statements), early support to parents (5 statements), accessibility of the service (2 statements), learning of parents (4 statements), early support by the personnel (7 statements), equality of parents (2 statements), and co-operation (4 statements). It is also to recommend the family centers to add topics and statements according to their speciality i.e. if there are other professions in the house, targets groups they want to focus, special needs and interests of families the house wants to lift and develop ways to meet.

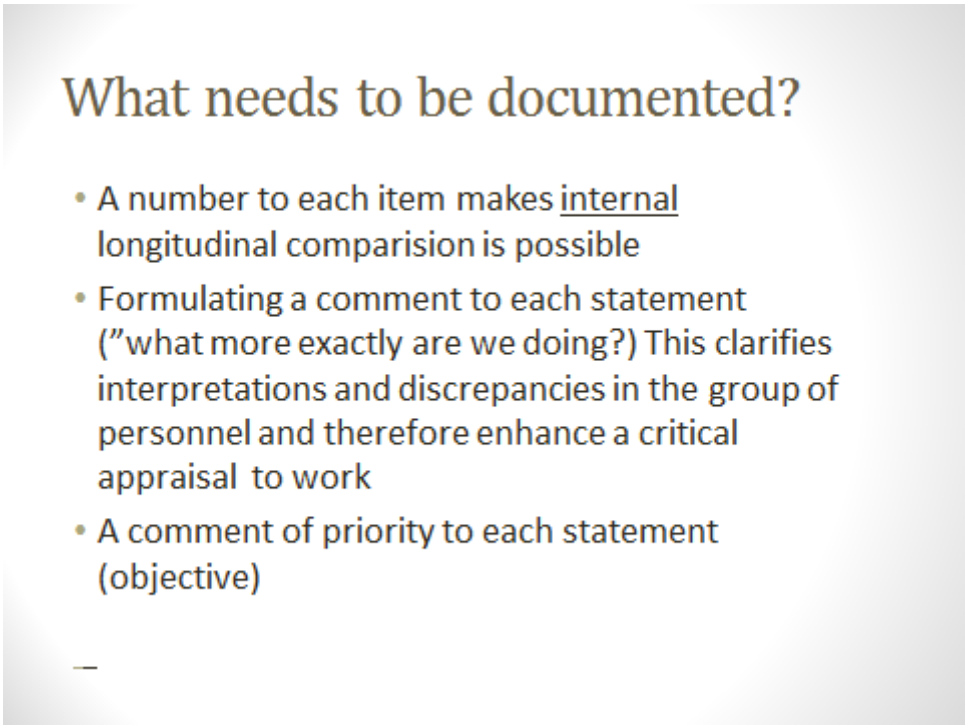
The recommendations of using the tool were at first that each individual is asked to answer “To what extent do you agree or disagree?” to the Likert scale 1-5. Second, the personnel are asked to decide together to which level they agree or disagree to each statement. Further they are asked to formulate a comment to each statement. Third, the planning of the improvement work started. They are asked to prioritize among the statements, formulate objectives, and plan how to perform the improvement work. The tool is aimed to be followed-up regularly each year. In table 1 the topics and a summary of the statements are presented.

Table 1: Topics and statements in the tool of reflection.

Topics	Statements
General work at the family centre	1 - Health promotion arena 2 – Children’s convention 3 - Family center as a resource in the community
Early support to parents	1- Group dynamics at the open pre-school 2 - Acknowledgement from personnel 3 - Parents as resources for each other 4 - Bounding work to all parents (universal) 5 - Bounding work addressing the more needy parents and children (directed)
Accessibility	1 - Getting parents over the threshold of the open pre-school 2 - Quality by using each other’s competence in the house
Learning among parents	1 - Children and parentship 2 - Interplay with the child 3 - Learning of language 4 - Cultural exchange between social groupings (social & ethnical)
Early support by the personnel	1 - Universal and early support 2 - Midwifes identify 3 - Midwifes refer 4 - Nurses identify 5 - Nurses refer 6 - Social workers are visible at open pre-school 7 - Pre-school teachers pay attention to parents and children with more needs
Equality - parents	1 - Both parents get information 2 - Both parents are encouraged to participate with their child in activities
Co-operation	1 - The professionals pre-conditions for co-operation are well-known and respected by each other 2 - Common objectives are formulated 3 - The common objectives are regularly followed up 4 - The managers in the steering group are actively involved in the follow-ups of the objectives in common

The documentation is seen as crucial to increase reflection-in-action and in improving the service. It could also be used to illustrate more exactly the activities of the personnel's, and the objectives to improve the service to external stake-holders as politicians and management in respective organizations. The suggested documentation is illustrated in figure 2.

Figure 2: Documentation of improvement work by using the tool of reflection

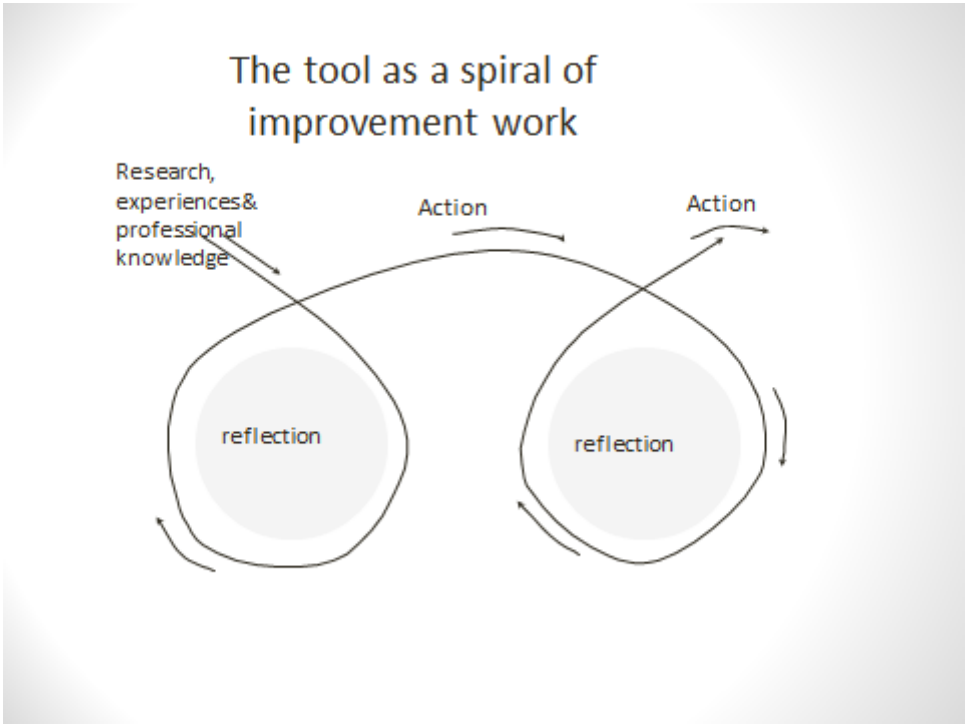


Indications so far are that the use of the tool contributes with insights and common learning in the house since it provides a meeting place of different perspectives. It facilitates to revise objectives in the house based on more comprehensive reflections-in-practice. Therefore the tool seemingly facilitates systematized regular follow-ups of the activities and provides with documentation to politicians and managers. However, there is tendency to rate the statements high which can reflect more the intentions of the personnel than how they really perform their work. The experience of using a comment to each statement may contribute to reflection on the discrepancy between the intentions and what is performed.

Discussion

The tool is a pedagogical tool to enhance reflection-in-actions (Amble, 2012; Argote & Miron-Spektor, 2011). The tool has been developed as a contribution to improvement work at family centers, not as to be used to compare quality between family centers. The cultural inside the family centers vary as how they value their work, and as such the external validity of the measure of quality is low. Further the use can be a way to integrate research-based and practice-based knowledge (Ellström, Ekström, & Ellström 2012). The statements are based on research, the personnel add in their experiences and professional knowledge when they are using the tool to reflect on their practice. Insights and learning are expected to occur when they use it regularly. So fare, in the comments of the personnel who have used the tool this is confirmed. The tool is a starting point – not the final solution. It can and should be altered in line with what happens inside and outside the house, and in the society. See figure 3.

Figure 3



The use of the tool could be seen as a way to increase focus on mutual creation of compatible and shared meanings – a cultural organizational learning (Argote & Miron-Spektor, 2011; N. Cook & Yanow, 2011). As such the learning outcome in a longer time frame can make explicit practical experience and acquisition of knowledge from professional educations (Bouchamma & Basque, 2012). In the second generation of EBP (evidence based practice) (Otto, Polutta, & Ziegler, 2009), a risk of deprofessionalization is seen in the current strong evidence movement which claim that methods of working should be evidence based primarily with the highest level of evidence – the randomized controlled trials. Using the right evidence based methods is seen as more important than the being a reflective professional who are able to make judgments based on professional education and ethical standards. Using a tool like this one may be a contribution to increase professionalism in line with a second generation of EBP, in which the importance of reflexive professionalism is recognized (Otto, Polutta, & Ziegler, 2009).

A question that should be raised is what kind of learning is stimulated by using this tool. Work-place learning can be adaptive or reflective (Ellström, Ekholm, & Ellström, 2008). The objective of using the tool is to stimulate reflective learning. However, there is a risk of adaptive learning in using tools. The personnel can adjust to the quantitative part and just fill in the numbers without any further reflections. I some of the so called evidence—based methods, the aim is teaching the personnel to use the method properly in line with the instructions. The learning then is rather adaptive than reflective. The aim with this tool however, is the opposite, to achieve the personnel to reflect and get new insights in how to approach parents and children, and thereby improve the service. Further research is needed to learn more of the impact of using the tool.

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Towards the development of Family Centres in Flanders

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The Government of Flanders, the Dutch-speaking part of Belgium, is working on a new legislative Act concerning the organization of preventive family support. In this Act, the international model of family centers is put forward and adapted to the specificity of the Flemish context.
In this contribution, we present the Flemish approach of the concept 'Family Centre' (*Huis van het Kind*). What is it? What are its objectives? In the second part of the text, we examine building blocks that are important in the realization of Flemish Family Centres.

Flemish Family Centres

Interprofessional collaboration
In Flanders and Brussels, a wide range of actors is deployed in the field of preventive family support, which is a great strength. However, it is found that (some) services lack accessibility due to a variety of reasons (e.g., no uniform and recognisable communication on the different services; too little integration of services; limited referring due to the fact that also for professionals some services are little- or unknown); this makes the support less “visible” for families and it makes it more difficult for them to find the support they need. Moreover, every local actor reaches only part of the (future) families with children and youngsters; it is not always clear if all services together are attuned to the local needs of all families and if gaps and overlaps in the services are restricted as much as possible. At last, expertise and support is spread out over different services; especially in more complex or challenging family situations this makes it more difficult to provide the support that is tailored to the needs of the family.

To further optimise family support services, the Government of Flanders highlights the importance of more and structural interprofessional collaboration in the field. Therefore, the Government of Flanders puts forward the Family Centres in the new Act concerning the organisation of preventive family support, which is in full development. Through the Family Centres, an instrument is provided to the local actors in which interprofessional collaboration is maximally stimulated. With this instrument, the Government wants to invite and challenge local actors to work together towards the provision of family support services in an integrated and accessible way and attuned to the local needs. As such, Family Centres in Flanders and Brussels are (will become) locally embedded partnerships between different actors and organisations that support (future) families with children and youngsters (aged 0 to 18 years). Depending on factors such as demographic characteristics and the amount of services, organisations and partnerships that are already present at the local level, the local partners have to explore if it is preferable to construct their partnership at the level of a municipality, or rather at inter- or intra-municipal level. Furthermore, depending on the local situation, they can explore if this partnership can take shape by offering a set of services for families at one place (i.e., all services under the same roof) or at several places and/ or combined with outreaching services.

Preventive Family Support
Preventive family support aims at promoting the well-being of all (future) parents and families with children and youngsters by supporting them in the field of welfare and health, in order to realise maximum health and welfare gains for every child. Preventive family support plays a crucial role. On the one hand because welfare and health are connected in this kind of support, just like they are connected in the daily life of the families. On the other hand because of its unique position in the course of life, ranging from the prenatal period and childhood to adolescence.

In the legislative Act, the Government of Flanders describes which kind of family support services should minimally be offered in a Family Centre. Minimally, it should organise preventive health care, parenting support, and activities that facilitate encounters and social cohesion.

- Preventive health care is the part of health care which takes up preventive tasks concerning the health of pregnant women, children and their family. Activities include, among other things, vaccination, the early detection of risks and health problems, health promotion, ...
- Parenting support consists of the support of persons responsible for the upbringing of children and youngsters. In Flanders, effort is done to offer parenting support in an accessible, empowering and non-stigmatizing way, based on the idea that it is normal to have questions about the upbringing of children. Activities include, among other things, the provision of information on parenting (individual or group-based), pedagogical advice, the stimulation of encounters between parents and children, practical support,...
- Through activities that facilitate encounters and social cohesion, the Flemish policy responds to the added value of social support as protective factor in parenting and family functioning on the one hand. On the other hand, it intends to create cohesion between families across socio-economic and ethnic-cultural boundaries, and to contribute to the fight against social exclusion mechanisms (see also the principles of “bonding” and “bridging”, Putnam, 2007).

In order to realise the abovementioned three pillars, a Family Centre may cover a variety of services. It always accommodate an infant welfare centre where preventive health care, follow-up of the development of the child and parenting and psychosocial support is offered by a nurse, doctor and volunteer worker during minimally 10 contact moments during the first three years of life. These infant welfare centres have a high accessibility, as approximately 96% of all families are reached minimally once (numbers from the annual report 2011 of Child & Family) and as they are nicely spread over Flanders and Brussels. Therefore, they consist of an important service to be offered in the Family Centres. Next to this infant welfare centre, a Family Centre has to provide minimally two other services. It may include services such as a (toy) library and a parenting shop (for more information on parenting shops, see Travers & Strynckx, 2012). It may also be the place where pre- and postnatal gym takes place, where young parents go for breastfeeding advice and parenting support, where lectures and workshops are organised, a place to play and to meet other people, ...
In sum, when it comes to the subject of family support services offered in a Family Centre in Flanders and Brussels, it is a necessary condition that the three pillars (namely, preventive health care, parenting support, activities to facilitate encounters and social cohesion) are present and it is a sufficient condition that – next to the infant welfare centre – two other services are frequently provided.

Building blocks for Family Centres in Flanders

It is clear that the concept of Family Centers is not new. The implementation of Family Centres in Flanders and Brussels fits in with the international evolutions which aim at co-operation between actors that work for (future) families with children and which has shown to result in positive benefits for children, their parents and family (e.g.; Kekkonen, Montonen, & Viitala, 2012; Warren-Adamson, 2001).
Furthermore, the concept is also not new in Flanders and Brussels. Several initiatives which come close to the idea of a Family Centre already exist in Flanders and Brussels. By means of the new Flemish Act, the Government of Flanders wants to provide a regulatory basis that further stimulates actors in the field of preventive family support to work towards the provision of integrated, easy accessible services that are tailored to the local needs in order to reach maximal health and welfare gains for each child.
The following building blocks are important elements in the realization of Family Centres in Flanders.

- Cooperation

The Family Centre must not be started from scratch. First and foremost, it is a partnership between actors that support (future) families with children and youngsters. It is therefore mainly an organisational concept which does not necessarily refer to one physical place. Maximum accessibility of the family support services must obviously be aimed at, but can be realised in many different ways starting from a partnership. In order to fully respond to the local reality, the Flemish legislative Act does not specify in which way this must be realised.

Providing services through a partnership is not always self-evident, but offers a lot of opportunities. It results in an added value, on the one hand for the families, on the other hand for the actors, which obviously also indirectly leads to an added value for the families themselves.
Values for the families include, among other things:

- an increase in the accessibility of the provision, since the Family Centres make themselves known by using a universal name and logo ("Huis van het Kind");
- an increase in the usability, since this universal name reflects a set of services which is geared to the local needs and in which families may find different meanings, depending on their momentary needs;
- an increase in the acceptability of the provision, certainly for families living in a socially vulnerable situation, since the Family Centres are open to *all* (future) families with children and youngsters and therefore do not stigmatise (Tunstill, Blewett, & Meadows, 2009);
- an improvement of the geographical spread of family support services in Flanders, since the aim is to realise Family Centres throughout Flanders.

Values for the actors include, among other things:

- more opportunities to share and develop expertise, which results in an increase in the competences of the actors;
- identification of the gaps and overlaps in the family support services, which allows for reflection at the local level on a different/more efficient way of using resources, and for a better reporting to policymakers;
- easier access to complementary service provision and easier referral to partners in the network;
- as a result of the better referral, the exchange of competences, the increase in expertise, the elimination of overlaps in the provision, bringing together resources (e.g. announcement, infrastructure, reception, ...), every single actor involved may realise efficiency gains.

- Local embeddedness

With the Family Centres, the legislator wants to offer an instrument to local authorities and initiatives to develop preventive family support. Local differentiation is a priority in this context, as it is the only way to respond to local needs and local reality. For instance, the needs of families, the presence of actors and organisations, ..., in the countryside differ from those in the cities. The way the Act is developing, allows local differentiations and even encourage it by stating that the services should be attuned to the local needs and by stating that the Family Centres should get shape in alignment with the social policy of the local authorities.

- People-centred care

For (future) parents and families with children and youngsters, it is desirable that they can turn to the Family Centres for a *diverse* set of services. The integration of different services makes it possible to offer a continuum of support to families that can be maximally *tailored to their unique needs.* Family needs should be met on the basis of an *integrated* approach, taking into account the context a family lives in.
In the legislative Act *user participation* is put central, as this is an important condition in realising easily accessible services that are tailored to the local needs and as this is important in the realisation of people-centred care.
The Family Centres want to focus particularly on the reinforcement and the *empowerment* of (future) families with children and youngsters. This implies that the different services recognise and reinforce parents and persons responsible for the upbringing of children in their role and is therefore in line with the expertise of the parents themselves and activates them to look for solutions themselves. Within the preventive family support, prevention therefore has a double meaning: promoting positive strengths and reinforcing children and their families on the one hand and avoiding risks and preventing problems on the other hand.

- Progressive (or proportionate) universalism

The service provision in the Family Centres should be open to all families. Every child and parent should have the opportunity to meet other families, to receive support and enrichment. This also

implies that they should not have any difficulty in reaching the Family Centres and that the services should be maximally accessible.
In the Family Centres, a continuum of services should be provided. Next to the universal service that is for example provided via the inclusion of the infant welfare centres in the Family Centres, a complementary provision of services, also ranging in intensity of support, should be developed as well, which is tailored to specific needs and/or specific families, including families living in more vulnerable situations.
With this starting point, the Family Centres also position themselves as players in the fight against child poverty. A diversified set of services, "underpinned by policies improving the well-being of all children, whilst giving careful consideration to children in particularly vulnerable situations" is presented as a good practice at the international level (European Commission, 2013, February 20, p.2). Furthermore, studies show that this approach has positive effects on the perceptions of vulnerable families, as parents perceive this way of service provision as less or not at all stigmatising (Tunstill et al, 2009).
In Flanders, various good practices are available which make the family support services accessible to families living in more vulnerable situations, such as cooperation with experts by experience, outreaching and working with volunteers and professionals from diverse socio-economic and ethnic-cultural background.

- Interaction between formal and informal support

Within the field of family support it is an important goal to provide the support as closely as possible to the living environment of the family. Not only formal support - provided by professionals - plays a role in that respect, but informal support occupies a prominent position as well. Therefore, informal support is an integrated part of what is regarded as support by families.
Within the domain of preventive family support, informal support is partly provided by volunteers who commit themselves with a view to social cohesion and the creation of unity within a society. For individual families, the commitment of volunteers often means an important source of parenting support (and in a broader sense: family support) because volunteers can often respond in a more flexible manner to the questions and needs of families (which includes providing practical support, lending a listening ear, playing with the children, ...).
However, informal support can be provided by professionals as well. For instance, the professional network may focus on the creation of conditions allowing families to develop and reinforce their social network (e.g. playing and meeting initiatives). It also implies that professional service provision must not ignore the important function which the social network may have.
Care and service initiatives in Flanders are organised by actors with different backgrounds, by authorities, non-governmental organisations, by liberal professions but also by civil society organisations and even by parents themselves. We want to see that same diversity reflected in the Family Centres, in order to make the most of the reinforcing interaction there may be between formal and informal support.

- Support and innovation

The Act attaches great importance to quality and competent professionals. In order to realise this, an expertise centre for parenting support is provided, which will be assigned to gather, enrich and disseminate knowledge and expertise with regard to upbringing and parenting support.
Next to this expertise centre for parenting support, in Flanders several other expertise centres are working on themes such as preventive health support, health promotion, innovation in the early years, ,... Also these expertise centres are crucial to enrich the development of the Family Centres.

Conclusion and challenge

With the new Flemish Act concerning the organisation of preventive family support, the Government of Flanders wants to focus on a facilitating and stimulating regulation towards more and structural interprofessional collaboration with the aim to optimise the support for (future) families with children and youngsters. Next to the focus on cooperation, other important building blocks to (further) realise Family Centres in Flanders and Brussels are local embeddedness, people-centred care, progressive universalism, interaction between formal and informal support, and support to professionals and innovation. The challenge in Flanders and Brussels, in the period to come, is to realise the added value of this concept, both for families and for professionals. Therefore, the Act must provide a

stimulating regulatory basis. Next to this, we invest in supporting and facilitating the sharing of knowledge, expertise and good practices that can be found in Flanders and Brussels. In this way, the Government of Flanders wants to succeed in the realisation of Family Centres, as an instrument to optimise family support in Flanders and Brussels.

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Interprofessional collaboration for the benefit of children and families through interprofessional professional education

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Abstract

Interprofessional networking seems to be an answer to the future challenges for working with children and families. Novia UAS has created an interprofessional curriculum for students in social and health care. Students develop competences in interprofessional working methods while developing specific knowledges in their own field. They also learn about child- and family-centered perspective, resource-promoting professional practice and methods for interprofessional networking. These competencies are accomplished by taking part in interprofessional development projects.

Introduction

Society as well as social and health care are changing. Especially the living conditions for children and families concern researchers as well as practitioners. In order to achieve a relevant response to these changes, interprofessional collaborative competencies are needed. Inter-professional collaboration, in turn, demands inter-professional education and training.

During the development project “Interprofessional Social- and Health Care“ the department for social and health care at Novia UAS in Turku developed a sustainable interprofessional pedagogical praxis. The result of this project is an education where Nurses, Public Health Nurses and Bachelors of Social Services learn inter-professional collaborative practice from a resource promoting perspective. The praxis focuses on research and development, which implies a continuous reassessment of knowledge, structures and ways of working.

This article describes the practice of developing and internalizing inter-professional skills related to working among children and families. This part of the population is and will be the most important.

Inter-professional support for children and families
The approach to children and families is related to transformations in the society and culture. Today we define children as unique, competent and active individuals with both inherent and acquired resources of their own. Recent research in the field of resilience has focused on so called resilient children and protective factors. Protective factors can be individual, such as an easygoing temperament, intelligence and a good social competence. External protective factors that can be found in the child’s environment can be supportive parents or qualitative daycare with knowledgeable and caring professionals. One significant finding is that resilience is a process instead of a stable character trait. This research area can give important knowledge that can be used when developing and framing interventions and methods for children in need. (Werner 2000; Andershed & Andershed 2005, 190-198; Marklund & Simic, 2012, 36-53).

Expectations of parenthood depend of the child´s age and therefore change with time. Setting rules and providing love and safety seems to be a common task for all kinds of parenthood. (Bremberg 2004, 48). Already in the early 2000s researchers claimed that the concern for children´s wellbeing and parenthood is increasing. (Bardy 2001, 14-15; Rantala 2002, 169-170; Viljamaa 2003, 9). These results are verified by later research and a new trend is that parents themselves are concerned about their own capacity of being good parents (Lammi-Taskula & Salmi 2008; Perälä et.al. 2011). The polarization in wealth means that children are divided into those who have resources and those without (Salmi & Lammi-Taskula 2012, 25-26). Upbringing children becomes a project for parents who

transmit resources to their children. Good parenting means that children experience a good childhood resulting in an increased amount of social capital. (Alasuutari 2003, 164-165; Bergnéhr 2008, 195-196; Rönkä 2009, 274-277; Bäck-Wiklund & Bergsten 2010, 36-37 86, 106-107).

Modern parenting relies on knowledge and expertise. A new kind of intellectual parenthood is becoming more common. (Bremberg 2004, 44; Vidén 2007, 122). In some areas children's competence highly exceeds parents' knowledge and skills. This opposite trend means that children's and parents' negotiation positions are changing. (Aronsson och Čekaite 2009,137).

Providing for children's wellbeing is no longer an isolated task for parents. Child health clinics, day care, schools are active parts in the upbringing of children. The collaboration includes children's upbringing, development and education. (Grunderna för planen för småbarnsfostran 2005, 36-37).

The Health Care Act (1326/2010), the new Social Welfare Act (The Ministry of Social Affairs and Health 2012) and The National Development Plan for Social Welfare and Health Care (Kaste Program) presuppose that social and health care should be organized and implemented through inter-professional collaboration. The aim is to form unified and effective service models. Optimal service delivery depends on practitioners who have the knowledge, skills and attitudes that enable them to be inter-professionals (Hammick et al. 2009, 37).

The Kaste program emphasizes that it is important to produce effective services for children, adolescents and families. The services are important for ensuring families' and children's wellbeing and for preventing social exclusion. Some strategic objectives have been selected for the second Kaste program (2012-2015) period in order to be used as guidelines for reforming the services for children and families. One of the draft measures is that services for children under school age will be concentrated at family centres in order to more effectively serve the families. Services for school children and students will also be brought together. Another emphasized goal is to put an increased focus on child welfare and especially on non-institutional care and family care. (Hastrup et al. 2013, 9-11).

Interprofessional learning

In order to collaborate effectively, professionals need to learn together. For professional education it is crucial that the curriculum identifies and develops required skills and inter-professional competences (Mann et al. 2009, 232). Novia UAS: s education for professional in social- and health care is based on specific areas where clients benefit from interprofessional support. Safe-guarding children and services for children with special needs are identified as areas where the quality of care needs to be delivered by seamless interprofessional teams.

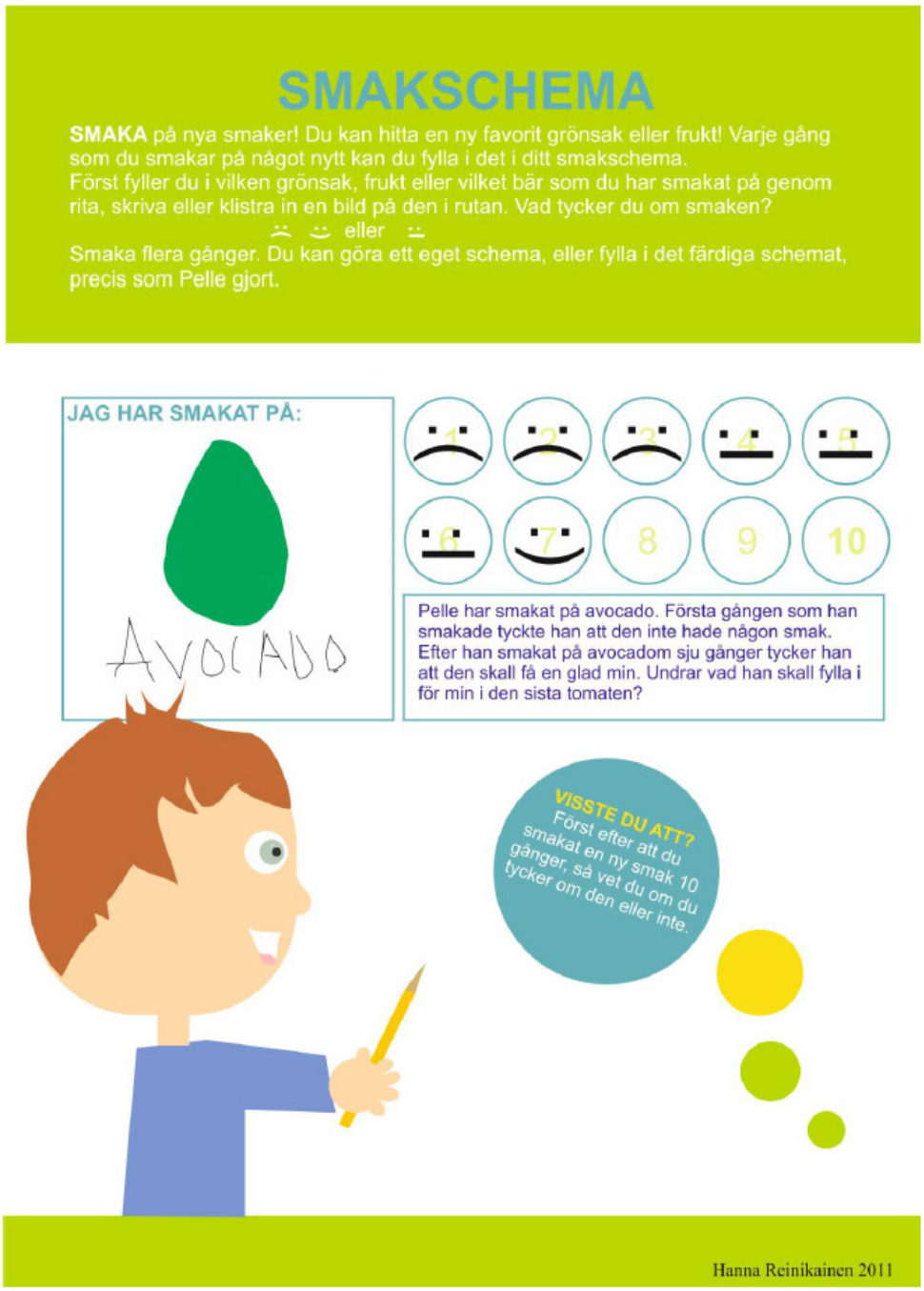
Besides the interprofessional perspective Novia UAS:s competence based curriculum also emphasizes praxis focused research and development for children and families. This means a continuous reassessment of knowledge, structures and ways of working. This approach characterizes the whole education from day one to graduation. Students are involved in projects that develop resource promoting methods. Every project collaborates with stakeholders from municipalities, organizations or other projects.

Introduction to interprofessional ways of working begins with students sharing knowledge and values. Future nurses also learn about the principles of social work and instead they share knowledge of the nursing field with students in social services. Through regular workshops during the education the students increase the skills of collaborative networking. The wellbeing of children and families is a continuous topic where the client perspective is internalized by students. Especially during the early years, children meet a lot of different professionals contributing to their upbringing. Developing services for families with small children is a core part of students learning. Novia UAS administrates two projects focusing on children´s and families wellbeing; "Det resilienta barnet" (The Resilient Child) and "Familjehuset" (The Family Centre).

The project "Det resilienta barnet" (The resilient child) aims to develop resource promoting models, methods and materials that can be used in kindergartens. The target group is 5-year-olds. The project has a child centered approach and emphasizes children's participation. Students contribute to the project for example by producing materials in their theses.

An important issue has been “body and health” in relation to the term resilience. A result of this is the material “Citron sur + banan gul = kul!” focusing on supporting and encouraging children to learn a healthy life style and to help them to extend their experiences and taste sensations in relation to fruits, vegetables and berries. The presumption is that the child is competent, curious and able to use its own resources in order to learn a healthy lifestyle in an enjoyable, fun and individually focused way. (Reinikainen 2011).

Figure 1. Example from the material “ Citron sur + banan gul = kul!”.



Another example is a game “Kalles diabetesäventyr” that is developed in order to support the resources of children with diabetes. When playing the game the child with diabetes can take the role of an expert. The child experiences a sense of coherence (Fröberg & Hållfast 2013).
The aim of the project “Familjehuset” is to develop methods and models which can be used by inter-professional teams supporting families. The main theme has been parenthood. Several issues of upbringing have been dealt with in thesis during recent years; combining working life and family life, children’s experiences of domestic violence and children’s sexual development. Students have produced cards that can contribute to reflective conversations with the purpose of supporting parenting.
The topic in the thesis *Förebyggande arbete bland gravida mödrar med riskbruk av alkohol* is alcohol consumption among pregnant mothers (Haglund 2013).The purpose of the cards is to raise questions about alcohol and pregnancy. The aim is to help mothers to reflect on the risks of consuming alcohol during pregnancy.

Figure 2. Example from the thesis
Förebyggande arbete bland gravida mödrar med riskbruk av alkohol

Realizing an interprofessional curriculum requires an interprofessional teaching team and an organization that supports collaboration. Joint values and common structures are needed. In Novia UAS the implementation of the interprofessional curriculum has been documented, evaluated and revised during the whole process by students, teachers and professionals. This orientation is a direct consequence of Novia having an integrated Management system of Quality, Environment and Safety. Methods of evaluation include feedback from teachers and students, results of evaluating and innovating workshops and concluding discussions with students. Because of the future perspective in the curriculum students often experience that the professional field is a few steps behind in values and way of working.

Future prospects and concerns
Good education for the support of children and families can only be developed by combining theoretical and practical studies. Legislation in social and healthcare makes it sometimes difficult to combine client work and education. Current structural transformation of municipalities, social- and healthcare and higher education leads to focusing on issues of external organization instead of contents. Therefore, it is at times hard to build effective partnerships and networks.

Developing a model for interprofessional education in social and health care implies the responsibility to develop the present working life. In order to use the skills of the newly graduated, working life has to acknowledge their competences. The vision is to create an Interprofessional Resource Center in co-operation with Novia UAS. The center could in interaction with practitioners provide mentoring, consulting and post-qualifying education. This could be a way for decreasing the gap between learning and professional practice – a path to redesigning service for children and families.

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Health Promotion in Slovenia towards Excellent Start: Support for mothers - Survivors of Child Sexual Abuse

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Abstract

In Slovenian public health system we are continuously working towards family, children and youth friendly services. One of our main tasks is focusing on the quality of preventive programmes right from the start, on prenatal education for health for parents-to-be and preschool children (and their parents), school children and youngsters for the whole population groups. The focus is on achieving a greater balance between aims of public health and needs of users of education for health with a special emphasis on vulnerable and disadvantage groups. At the same time we are developing approaches and practices which are interdisciplinary, innovative and user-friendly based on salutogenesis for all and especially for vulnerable groups.
Mothers and mothers-to-be who are sexual abuse survivors represent often invisible group of women with special needs. Pregnancy, birth and breastfeeding are integral part of woman's sexuality, familial experience and marked by personal her/history, health status, actual relationships and culture. In transformative life period into motherhood long term consequences of child sexual abuse can be devastating for wellbeing of woman and her baby, too.

We are going to present some contemporary findings about specific vulnerability of sexual abuse survivors in transition into motherhood. We'll present our educational material, booklet meant for pregnant women and different professionals they meet in maternity care system, offering brief information about sexual abuse in childhood and mothering and practical solutions for specific challenges survivors possibly face.
We suggest close collaboration among users and professionals to ensure opportunities for healing and transformation for survivors of sexual abuse, which contribute to the better health and life in general of women, babies, men and families; and written material can be seen as one of useful paths towards excellent start of family life.

Public health care system in Slovenia
In Slovenian public health system we are continuously working towards family, children and youth friendly services. One of our main tasks is focusing on the quality of preventive programmes right from the start, on prenatal health education for parents-to-be and preschool children (and their parents), school children and youngsters for the whole population groups. The focus is on achieving a greater balance between aims of public health and needs of users of education for health with a special emphasis on vulnerable and disadvantage groups. At the same time we are developing approaches and practices which are interdisciplinary, innovative and user-friendly based on salutogenesis for all and especially for vulnerable groups.

Health education is carrying out at different levels, settings and for different target groups. Implementation of the health education can be carried out in health care facilities, kindergartens, and schools, working organizations, local communities, wherever people live, study, eat or work. Caring for the children's health starts already when planning a pregnancy and taking care of a healthy lifestyle during pregnancy, it continues in the family, educational institutions, local communities and beyond. Health education comprises consciously constructed opportunities for learning to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and community health.

In Slovenia pregnant woman is cared for by her gynaecologist, almost all women give birth in one of 14 maternity hospitals, and they receive postpartum care by the community nurse when they return home with the newborn baby; expectant parents have opportunity to attend childbirth and parenting preparation classes for free (classes are not obligatory but desirable). The implementation of all

preventive programs and health education in the health sector is substantively and methodologically defined in the instructions for the implementation of the preventive health care at the primary level (NZPZVPN, 1998, Supplement 2003). In our work on healthcare quality improvement in maternity care the actual focus is on vulnerable/disadvantage groups of mothers- and fathers-to-be and individuals.

Maternity care – towards patient-oriented practices

First needed step is conceptual shift in maternity care in general: from »health care professional-oriented practices« into »patient-oriented practices.« In the front of contemporary theoretical approaches to maternity care in globalised world is the concept of "women and baby centred care". It is meant to promote satisfaction with the maternity care experience, to improve wellbeing of babies, women, and families in general and the wellbeing of health care professionals, too, and it is considered as an essential component of the quality of maternity care. The baseline is repeated in slightly different forms, but the core issue is the same: individual approach, which is possible only when the mother and the baby are in the centre of care is recognised as key factor for optimal maternity services. One of the basic principles of International MotherBaby Childbirth Initiative, document developed in the International MotherBaby Childbirth Organization, is formulated as individualization of maternity care: "Pregnancy, birth and postpartum/newborn care should be individualized. The needs of the MotherBaby should take precedence over the needs of caregivers, institutions, and the medical industry" (International MotherBaby Childbirth Organization, 2008, p. 2).

Sometimes concept is not explicitly introduced, but we can understand that needs of women and babies are important or considered essential, when speaking about communication between women and healthcare professionals per example in WHO guidelines they say: "The guide provides a full range of updated, evidence-based norms and standards that will enable health care providers to give high quality care during pregnancy, delivery and postpartum period, considering the needs of the mother and her newborn baby" (World Health Organization, 2006, p. 4). In another well-known document, NICE Intrapartum care there is an explicit statement about communication between women and healthcare professionals: "All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, healthcare professional and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use" (National Institute for Health and Clinical Excellence, 2007, p. 7). In the expanded Slovene version of the document Maternity Care Initiative, with the goal to initiate development towards Excellent Maternity and Newborn Care in Slovenia, we can read "Since the child's well-being is directly related to the wellbeing of women during pregnancy, childbirth and in post-natal period, key aspects of excellent maternity care are to create a loving atmosphere and circumstances where mother is heard, expression of her needs is encouraged, and her privacy is respected, in such way the best possible care is provided, summarized the expression 'woman centred care'. Good care for pregnant women and birthing women is a necessary (but not sufficient) condition for good care for the child; and it must be accompanied with specific care for the child" (Drglin & Šimnovec, 2010, p. 9). The basic of the maternity care is the quality of attitude to every individual woman - it should be respectful, and the dignity of women should be guaranteed. This means that suitable attitude is guaranteed from all the medical experts and others who take part in maternity care. How can health care worker act with humility, acknowledging his/her limitations to deliver it? What are needs of the woman and the baby?

Cultural determinants frame motherhood and fatherhood as well as processes such as pregnancy and childbirth. A woman's relation towards motherhood results from the interrelation of numerous factors. Pregnancy, birth and breastfeeding are integral part of women's sexuality, familial experience and are marked by personal her/history, health status, actual relationships she lives; culture shapes her way of mothering, her choices and opportunities in pregnancy, delivery, care of the baby. When health care professionals meet the woman in the maternity hospital for the first time, they don't know her personal or intimate history, her wounds and sorrows, hopes and visions. We need to explore the vulnerability of women with their particular and special needs in transition into motherhood, like those who are survivors of sexual abuse, who experience domestic violence, women with past traumatic birth experiences, women with mental problems, or women from socially disadvantaged groups.

Sexual abuse and motherhood

We are going to focus on maternity care for women who were sexually abused in childhood. Woman who was sexually abused as a girl can be re-traumatized per example, by routine procedures in maternity hospital, by insensitive vaginal exam, or by an order: “Just lay down, don’t fuss!” or by expression “Be a good girl, trust me,” when similar words or gestures were part of past abuse event. It is important to recognize unseen wound, pain and long term consequences of sexual abuse and find way to break the cycle of suffering. Midwives as women who are dedicated to ensure the well-being of mothers-to-be are invited to explore what skills are needed to offer safe, tender and healing care for wounded women (and men, too); how survivors can be supported and how to avoid re-traumatization in everyday practical work in health care system. Quality health care for women during pregnancy, childbirth and postpartum period must not over-look the psychical dynamics, the fears and the significance of each individual woman needs and expectations. The main question was: how to enable women with previous sexual abuse to have the best possible start, to get proper information and support during transition into motherhood?

Some themes are socially “unspeakable”. This taboo against speaking out seems to be particularly strong regarding sexual abuse. At the Institute we started with the development of theoretical knowledge from different perspectives about sexual abuse in childhood and possible influences of sexual abuse on pregnancy, birth, breastfeeding and motherhood. At the same time needs and expectations of future mothers were discussed through personal contacts. We decided to publish informative booklet about this topic on the web page of the National Institute of Public Health with free access for interested women and health care providers.

The booklet *Sexual abuse in childhood and motherhood* is the work in progress – based on practical work with women, the newest theoretical knowledge and examples of good practices (mostly from UK and USA) offers information about several important issues regarding main topic. The suggestions about possible solutions for women and health care practitioners are also included. The way booklet is designed is also important: motives, language, and main messages support each other: there is always a way for wound to be healed. Citations from women’s stories are included in the text – I would like to thank all women for their courage to reveal their wound during consulting sessions while being pregnant and to give permission to use their words from their life experiences. Such an approach offers readers to reflect their own (possible) experience while there is no pressure to reveal it.

We start with introduction about sexual abuse and consequences for women. We know sexual abuse in childhood and in later period has powerful effects on woman's whole life, and especially on childbearing and mothering. As we can learn from recent literature, some survivors function well, and develop satisfying relationships, raise families and enjoy life; it is known that this can be achieved after overcoming much psychological distress (Simkin & Klaus, 2004). In the text we focus particularly on sexual abuse and its possible influences on pregnancy, labour, birth, nursing, motherhood and parenthood. In pregnancy, labour and new motherhood women who are carrying the effects of sexual abuse face special issues that go far beyond common challenges of this transformative period; pregnancy, birth, breastfeeding can trigger abuse memories. The physical experiences of being pregnant, with foetal movements, growing body, fatigue, birth sensations with contractions, urge to push, pain, breastfeeding with suckling baby and other baby’s needs like need to be really close to the mother’s body, all this may evoke feelings of being out of control, dependent, unworthy. Some women experience psychological reactions like fear, flashbacks, withdrawal, and dissociation, panic; body memories with extreme pain and tension can be triggered. Clinical procedures and situations also bring up numerous potential triggers: vaginal exams, using intravenous fluids, forceps, episiotomy, invasion of body boundaries, exposure of intimate body parts, “victim” positions like lying down while others stand; being vulnerable, not being in control, powerlessness, helplessness (Simkin & Klaus, 2004).

Suggestions and practical solutions for different aspects of pregnancy, labour and birth, breastfeeding and care for the baby are written from women’s perspective to offer them tools for design their own experience of satisfying step into motherhood. Per example: we suggest pregnant women to inform midwife about the trigger (if she knows it) and ask her to avoid wording or gestures they activate it: “I can’t stand to be on my back. Please, support me in standing birthing position.”

Conclusion

Towards better health and life in general of women, babies, men and families
We need to pay attention to short- and long-term consequences of “women and baby centred care” on health of the mother, baby and whole family when speaking of women with special needs. In day-to-day practice we have to ask ourselves: where in this particular form of maternity care we can find opportunities to offer encouragement, support and sometimes healing and transformation for women which will contribute to the better health and life in general of women, babies, men and families? Our duty is to really listen to women and to introduce changes on different levels of maternity care. In papers, books and guidelines we can find examples of needed solutions for implementation of mother and baby centred care into practice, there are also examples of “birth models that work” from institutions, groups, individual practices or particular maternity care systems around the globe, so we can learn from them, too. It is important to recognize unseen wound, pain and long term consequences of sexual abuse and find way to break the cycle of suffering. Midwives as women who are dedicated to well being of mothers-to-be are invited to explore what skills are needed to offer safe, tender and healing care for wounded women (and men, too); how survivors can be supported and how to avoid re-traumatization in everyday practical work in health care system. With sensitive approaches, lot of knowledge and collaboration among different professionals working in health care system is possible to create opportunities for healing and transformation for survivors of sexual abuse, which will contribute to the better life of women, babies, men and families in general. The booklet *Sexual abuse in childhood and motherhood* is one of promising tools for opening communication as basic principle of health promotion in general. There are several touching responses from women who read the booklet in my archive, one of them has written: “I didn’t know why I’m so anxious while pregnant. Now I know and I’m looking for health experts who will support me during birth with as few vaginal exams as possible.”

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Dealing with diversity: Parenthood and professionalism in a Family Centre and beyond.

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Abstract

In a Family Centre, different services are co-located as a means of providing comprehensive support for families in the local community, and to facilitate comunication and collaboration between professionals (Adolfsen, Martinussen, Thyrhaug, & Vedeler, 2012:50). This paper deals with diversity in a Family Centre in two ways: Firstly, using an ethnographic case, it examines professionals' dilemmas of care and control when dealing with diverse populations. [1] Secondly, the paper examines interactions between parents of diverse backgrounds, drawing specific attention to language, and, briefly, follows these also outside of the Family Centre. Theoretically, the paper moves beyond the study of Family Centres and into the wider community, exploring the impact of Familys Houses on belonging in the community, through my explorations of belonging, values and what I term broad and narrow strategies of belonging, which takes me to my final discussion of broader issues of democracy and citizenship.

Introduction

Research is conducted in Eastern Oslo, in one of the Grorud Valley's four boroughs. Together these four boroughs total more than 127 000 inhabitants from 170 countries, 22% of Oslo's population ("The Grorud valley Action Project "; Groruddalssatsningen, 2010:7). About half of the inhabitants in Alna, the borough where this study is conducted, have an ethnic minority background (26% in Oslo as a whole) – with an even higher percentage among children. The valley has, in Norwegian terms, a high population density, with high-rise buildings and a majority of the inhabitants living in flats. Post Second World War, the Oslo municipality started large scale planning of the high rise buildings which today symbolise the Grorud Valley, and it became known as a "drabantby", a working class suburb. This paper is based on my fieldwork in the two Family Centres in Alna borough, as part of my PhD research.

Through a collaborative and interdisciplinary approach families meet integrated and supportive services, seeing the whole family as a whole rather than in bits. Public health, prevention, and early intervention are central. The different services are to be accessible for families through their physical co-location. The amount and kind of services which are located together varies from Family Centre to Family Centre. Through most of my fieldwork the two Family Centres was comprised of the following institutions:

Family Centre 1	**Family Centre 2**
Open kindergarten Parent and Child Health Services (*helsestasjon*) Antenatal care (*svangerskapsomsorg*) Pedagogical-psychological services (*Fagsenter*) (Family Centre Team)	Open kindergarten Parent and Child Health Services Antenatal care SMART kindergarten Family Centre Team, coordinator

The Family Centre Team consisting of professionals from the different services meet monthly at one of the Family Centres. In addition, there is much informal conversation within and between the Family

[1] A Family Centre is complex, inhabited by institutional spaces and professional groups with different histores. While these are central to the ways in which professionalism is exercised, I am not able to expand on these in great detail here (see Andrews & Wærness, 2011; Neumann, 2009).

Centres, either over a cup of coffee in a kitchen, or through someone running up or down the stairs, speaking to a professional, a parent or making a phone call when the need arises. Collaborative organisation based both on structures and on a case by case basis is found also by Martinussen and Adolfsen (2012). The authors, citing Thylefors and colleagues (2005), divide collaborative teams into multiprofessional teams, interprofessional teams and transprofessional teams, indicating degrees of specialisation of roles. Formally, most Family Centres use the middle form, where roles are specilised and intact, whereas tasks are interdependent and must be coordianted (Martinussen & Adolfsen, 2012:45-6).

"The inhabitants" of the Family Centres are diverse, with parents and children representing more than 30 nation states. The two open kindergartens I have based this paper on – I have also conducted research in a third one which is not located in a Family Centre– had over 3300 visits from 409 children in 2012, an average of 8 visits per child, and 13 visits pr day. Norway and Pakistan are the countries which most parents record as their country of origin, 137 and 55 respectively. Poland, Turkey, Kurditan, Somalia and countries from the previous Yugoslavia are other countries with high frequencies of participants.

My fieldwork is conducted in mainly two arenas – and between these:
1. Parent and Child Health Services: Three services are included in this service following a person from conception, through childhood and adolecence, and then again through maternity care. My main focus is on care for children. Attendance is voluntary, but about 99% in Norway. Babies and one or two parents come for consultations with professioanals for a number of times during the first year, and then more seldom after that. The service is responsible for administring the national inoculation programme.

2. Open kindergarten: Open kindergarten is a free offer for children accompanied by parents or other adults, and one can come and go as one wishes to. Parents are responsible for their own children. Open kindergarten is a social arena, and an arena for learning for both parents and children. Children develop, get new impulses and friends, and parents receive support and guidance in their parenting role. These different institutions also offer and facilitate contact with other institutions, and give parental courses (International Child Development Programme - ICDP) courses, which in this borough regularly are offered in different languages.

Theoretically, I see the state as an agent rather than a structure. For Weber and Foucault power is relational. Thus, power is empirical, integral to human actions, exercised through what Foucault terms *governance*. The state, in this sense, must be understood not as a separate institution or apparatus for dominance and control, but rather as something that has melted together with society (Foucault, 2002:9). There is an apparent paradox in governance: Through governance the state becomes individualising and reflective, where individuals govern themselves through individual truths. At the same time, the state is totalitarian in a sense that it "constitutes the conditions for action for the individual truths, thus steering these in one specific direction" (Foucault, 2002:18, my translation). With regards to child rearing and parenthood "governmentality is embodied in innumerable deliberate attempts to invent, promote, install and operate mechanisms of rule that will shape the investment decisions of managers or the child care decisions of parents in accordance with programmatic aspirations" (Miller & Rose, 1990:83, cited in Howell, 2003:201).

Criminologist Cecilie Basberg Neumann views public health nurses (*helsesøstre)* as a core tool of implementation of state policies due to their proximity to the population (Schiøtz 2003:484, in Neumann, 2009:39) and their universalistic mandate. However, they are also in a contradictory position as they depend on a trust based relationship with parents, while they at the same time are that of the welfare state professionals best positioned in relation to the family, to observe, but also to intervene (Neumann, 2009:31). The dilemma between care and control, mediated through trust, can be applied to the Family Centre more generally, making Family Centres central sites in studying governance of the family in a broader sense, connecting the state, locally through the borough, to intimate spheres of the family.

Belonging and diversity are hot topics in much social science, and take many forms: complexity (T. H. Eriksen, 2007), multiculturalism (Modood, 2007) and superdiversity (Vertovec, 2007) to mention a few. Further, there is a whole field on citizenship literature (Lazar, 2008; Yuval-Davis & Werbner, 1999), and social capital (Portes, 1998; Portes & Vickstrom, 2011; Putnam, 2000, 2007). Levitt and Glick

Schiller distinguish between ways of being and ways of belonging, where the former are the actual social relations and practices an individual engages in, and the latter are the associalted identities (2004). Space does not allow me to move into this discussion as such, but I introduce the term "strategy of belonging", a form of 'belonging work' that takes place in Family Centres. It is complex, but can be seen to take on two forms: broad and narrow strategies.

Alna borough is super-diverse in a sense that it encompasses a level and kind of complexity surpassing anything ever experienced in any society (Vertovec, 2007). This complexity is marked by a dynamic interplay of variables such as language, religious affiliation, country of origin, local and regional identities, level and kind of education, access to employment and local conditions – in addition to local governance structures and practices. Understanding and governing this complexity demands new means and new methods, which, in the Family Centres I have conducted research, is negotiated through use of broad and narrow strategies of belonging, practiced by both parents and professionals as means of negotiating belonging through diversity management.

Professionals and participants in open kindergarten use both broad and narrow strategies of belonging as a means to manage diversity. Both strategies involve management of practice and participation. Choice of strategy is often conscious, and the discourse of belonging is openly discussed, as informants are concerned with this in their everyday lives. The two strategies can also be termed management strategies, but I find strategies of belonging to, arguably, be a better term for two reasons: 1) Parents too, who do not formally at least manage institutional spaces use these strategies. 2) It is diversity that is being managed, with the aim of creating a sense of belonging and community coecion. Consequently, belonging is a more concrete and context specific term than management. Neither broad nor narrow strategies are used to exclude, but rather to enable what informants term a *balance* or *ideal mix*. Type of strategy used does not seem to be determined by whether one is a parent or professional, or have a minority or majority background.

Methods

This qualitative research draws on interviews with professionals such as midwives, public health nurses, family therapists, ICDP mentors and employees in open kindergartens, as well as parents in these sites. I did not conduct fieldwork in the Pedagogical-psychological services. Participant observation is conducted in open kindergartens, Parent and Child Health Services, ICDP parental courses as well as community beyond, and into private homes. I have known some of my informants for three years, others less. Fieldwork is conducted 2010-2012.

Results

In my results section I discuss interhouse interprofessional collaboration within a Family Centre, and, using language as an example, the negotiations of diversity among parents and professionals in an open kindergarten. Professionals working in Family Centres are particularly concerned with keeping relationships of trust with parents. The public health nurse who told me that she has a "*black belt in reporting* [to the child welfare authorities]" is an exception. Rather, professionals seek to help families through more informal channels, and place more efforts into families than what is recorded formally. On the one hand, there is much more at stake in losing touch with parents when services are co-located. On the other hand, professionals have a larger tool kit available in meeting and governing parents "*where they are*", as one public health nurse told me.

"*Finding a good balance"* is a frequent mantra among parents and professionals in balancing different forms of difference. When I follow up and ask what a good balance is - and of what - the wish for a clear Norwegian ethnic and language majority is a common response, with a "*good mix"* of other groups, "*50/50"* as some say. In the following case, I explore informal case to case collaboration between Christine (open kindergarten), Jenny (pedagogical-psychological services), Carey (Parent and Child Health Services) and Hanna (SMART kindergarten). They meet monthly to discuss formally, but this case illustrates more informal case by case collaboration.

Case 1: Saima
Saima had been coming to open kindergarten for some time with her two youngest children, girls aged 4 and 1 years old. The 4 year old is often visibly bored surrounded by children that were younger than her, and with a mother who seemed to find it difficult coping with two children during the day. Their older sister is at the SMART kindergarten. Saima has been suffering from mental and physical health problems for years, and, although she identifies herself strongly as a mother, admits to finding mothering challenging, becoming increasingly disengaged in her children. Christine had been observing Saima with her children for a long time, and realised that I was doing the same. Concerned, one afternoon she took me aside and asked me what to do.

Some other parents react negatively, or become insecure when they see Saima, her gaze, gestures, and body language, her disengagement with her children, they do not enjoy being here when Saima and the children are here, Christine says. Still, Christine emphasised that open kindergarten is a low threshold institution – everyone is welcome here and there can't be criteria that excludes people. – *What can we do, can we "force" people to accept assistance? When? When we think that it can prevent them from being contacted by child welfare?…Saima's 4 year old daughter is at the back of my mind every night before I go to bed*. Jenny came, and sat down with Christine and I, joining the discussion: - *She has been coming here since the beginning, but here she is sitting with that distant look…how far have we really gotten? Then again, what do we know of the alternative, what it would have been like had she stayed at home with her three children, probably worse…*Hanna, now arrived, seconds this opinion, and says that she is concerned about the social development of the oldest child who attends SMART kindergarten.

Christine approached Jenny, and together they encouraged Saima to apply for a place in kindergarten for her 4 year old girl. Saima was in fact planning to apply, but only the following year. In the end, she applied as Christine and Jenny had encouraged her to do, even though it was after the yearly March deadline. Christine told Saima that she could apply on special grounds because of her ill health, so that her daughter would be guaranteed a place. Saima did this with their help, and spoke to other parents in the open kindergarten with excitement about how much she thought her daughter would enjoy kindergarten. – *After this,* Christine says, *Saima has treated me with much more respect. She trusts me now, she knows that she can speak to me, and that I will take concerns seriously…(pause)…I get so frustrated when people think that it is "good enough" and a sufficient aim that people come and attend open kindergarten.*

Carey, working at the Parent and Child Health Service, separatly approached me about Saima. Where Christine was concerned about Saima and her children's well-being, Carey was concerned about her behaviour in the open kindergarten, and told me that this was disturbing for other parents. - *I have to talk to her. I will give her a warning, and say that she has a 3 week's trial period before she is not allowed to come anymore.* She then said something about child welfare authorities. I mentioned something about the importance of including everyone. – *Yes!*, Carey explaimed*, but it is not including if her behaviour is excluding.*

I met Saima outside the Family Centre the day she received the letter from the borough administration. She asked me to read it for her, as she did not quite understand the difficult phrases. Consequently, I was the one who told Saima that the borough administration had not found her to be sick enough for her daughter to qualify for a place in kindergarten. Of course, this raised frustration in Saima and the professionals she had been in touch with at the Family Centre. A borough employee who is closely linked to the Family Centre, remarked that this, again, indicated that the Family Centre logic lacks legitimacy outside of its four walls, thus collaboration ends where the building ends, which for Saima meant that her daughter did not get a place in kindergarten.

The co-location of the services encourages in-house collaboration. This enables Christine to observe Saima and other parents' reactions over time, assessing the situation and evaluating possible measures. It also caused Hanna and Jenny to coincidentally walk past Christine and I during our coffee and conversation, so that they could share experiences about the different family members they know, having observed these in different contexts. Through this form of case by case collaboration professionalities are weak in relation to each other. Co-location of services also enables Christine to see the general effect of intervention, that Saima now respects her more. There are also instances where her intervention has had the opposite effect, and parents have stopped using open kindergarten dues to Christine's attempts at intervention.

Both Carey and Christine mention the child welfare authorities: where Christine wishes to apply measures so that the family avoids contact with the child welfare authorities, Carey considers contacting them. Christine is aqutely aware of the dilemmas of governance, and continously evaluates the alternatives to and of interventions, balancing *trust* and *force*, care and control. She ends up with a *broad* approach to governing, but not so broad that nothing is done – it is not good enough that people merely attend open kindergarten, but, for Christine, this is all about finding a *balance*. Carey has a more *narrow* strategy, considering denying Saima acccess to open kindergarten if she does not change her behaviour within a specific timeframe.

Case 2: Language and diversity in open kindergarten
The issue of language is a bone of contention in the kind of diverse context I explore here, where parents commonly have a different language than Norwegian as their first language, and wish for their children to speak this too – as well as Norwegian. Often, parents speak their mother tounge with their children at home, and, commonly, in open kindergarten. Parents emphasise the importance of their children learning "*good Norwegian"* before they start school. This is sought achieved partly through attendance in open kindergarten and through sending children to normal kindergarten when they are 3 or 4 years old.

In one open kindergarten I sit on the floor playing with two children. Their mothers, sitting by us, chat, and I partly engage in the conversation. Their conversation is mainly in Norwegian, but when they speak about intimate issues or about things that happended in or is related to Pakistan, they switch to Urdu. Anna, who has recently begun working in the open kindergarten walks up to us and tells the women not to speak Urdu because it excludes other participants (she hints at me). She proceeds to walk off, and Leyla, one of the mothers turns to me: - *Who does she think that she is? She is new here. She can't tell me not to speak Urdu, I have come for many years.* Anna, 'debriefing', tells me: - *Noone translates, when they speak their language. Noone says "we were just talking about this" so that others don't think that they are talking about them behind their back. So it is excluding!*

Common language practice is seen by many parents as a prerequisite for a *sense of community*, and they express that they find it excluding when adults speak to each other in other languages than Norwegian, or when they don't switch to Norwegian when they see someone approaching who does not speak the languageof conversation. A father of Moroccoan origins tells me: - *It was once, I don't think that you were here, Ida, but I was here…with Christine and some women that were speaking Afghani (Pashto) with each other. What is the point of that? They sat there, and Christine and I were sitting here. I told them; is this a Afghani kindergarten? No, it is Norwegian. That made them angry, and they went upstairs to speak to (employees). And what did they say? They said that I was right.*

Two fathers, of South American and North African backgrounds want to put up a poster where it says that all other languages than Norwegian is forbidded to speak at the Family Centre. Christine understands their concern, but do not agree with the suggested solution. She has a broad appraoch to managing indicators of belonging, but she is not certain how to solve this challenge. She does not want to ban a language at a low threshold institution, because it may push parents away – especially those parents she wishes to reach out to the most. Anna, like these two fathers, has a more narrow approach to the management of diversity, wishing to regulate it through implementing sameness as practice – Norwegian to be spoken. Legitimacy in managing belonging is contested, but not divided along the lines of professionnl and parents: Christine, Leyla and and the other mother have similar approaces, whereas Anna and the two fathers share approaches. Leyla locates legitimacy not in professionalism, but in time spent in open kindergarten. At the level of the ideal and values, however, there is sameness, with parents aiming to make their children competent biluingualists in a superdiverse context.

Parenting is an intimate practice but through a form of communal parenthood can become a shared experience. Simon, a Norwegian/Italian father, explains what he appreciates about open kindergarten: - *It is good preparation for society…there aren't really that many places where we can meet in this way. Here, we have a common interest and a common value: our children. Here, there is room for discussion. My view, your view, my view, your view…language and culture…learn from each other.* Simon emphasises the commonalities in parenthood. He bases his broad definition of sameness as "*common interest and a common value"*, but at the same time he says that *"here, there is room for discussion".* He is well aware of the differences in parenting, but through defining parenthood itself as

a common value, he sees beyond parenting differences, and lifts the mode of belonging to the common value of having children. However, the different ways in which they are reared and parenting is practiced is not left out of the conversations. For Simon, contestations of child rearing – importantly, when they are spoken about – do not inhibit common values. Simon can be seen to practice broad strategies of belonging, seeking to define the field as diverse and based on conversations of difference. Through these conversations, the aim is not to reach agreement. Rather, it is the *disagreements themselves* which create a sense of community.
The ultimate goal of family centers is to promote a healthy childhood through the reinforcement of parenting skills (Kekkonen, Motonen, & Viitala, 2012:114). However, 'parenting skills' and 'healthy childhood" are not uncontested. Rather they concern the very morality of personhood and essence of being a human being in relation to other human beings. In open kindergarten the apporach to governing parenthoodis broad from professionals; they may help mothers finding work, or kindergarten, as in the case of Saima. One borough employee told me that open kindergarten is not an integration measure, but a measure of inclusion. In my experience, Family Centre employees have an apporach somewhere in between this. One employee tells me: - *We raise parents too…oh yes, with two lines underneath.* Another employee says that they try to help mothers with finding employment or relevant courses if they are motivated, but that this is not an aim in itself. Still, as the employee continues: - *Generally, I dont think that it is good enough…it is just as much about own development…it is not enough to «just» be a mum and «just» be at home and care for children and husband…one stagnates…*A Norwegian Pakistani mother has experience of this kind of help: - *Everything I know, I have learnt at the open kindergarten!*, she tells me, when I meet her at her job in a normal kindergarten. When she was at home with her two children, she went to open kindegarten regularly. A midwife from the Parent and Child Health Services introduced her to the kindergarten when she is now employed.

Parenthood in the local commuinity, and the Family Centre, may bring about a sense of belonging and understandings of diversity, increasing community coherence and trust, both within and beyond the Family Centre. Commonly I observe incidents such as parents taking away other's children's pacifiers if they know that the parents try to make them quit, parents coming to open kindergaten with other parents' children if the mother has to go to the doctor, or speak to teacher of older children, or if she has an appointment at the Parent and Child Health Services. Other times – but not always – parents discipline others' children, responding on conflicts among the children. Friendships between children, between parents – and to some extent between parents and professionals develop and may also move beyond the Family Centre, through birthday celebrations, play dates, daytrips to the forest or amusement park – or for an evening out for parents, without children.

Discussion

Parents report that they find the micro-public sphere of the Family Centre open and accessible, a *nærmiljøfunksjon*, or a local public sphere, serving to fascilitate local belonging through different forms of participation – participation through parenthood. This participation can be enabled through discussions and definitions of *common values* as the currency of unification, as Simon says – even when these values diverge between parents – and between professionals. Such a sphere, a culture of participatory and open-ended engagement, can constitute a 'vibrant clash of democratic political positions' (Mouffe, 2000: 104) between free and empowered citizens, respectful of each other's claims. While this kind of engagement may leave disagreements and conflicts unresolved, it may build an open and dialogical foundation for future encounters through the uncovering of misunderstandings, even resentments (Amin, 2002).

For Chantal Mouffe, democracy is about expressing conflicts in legitimate ways, which again may lead to a deeper form of democracy. This, she argues, is a prerequisite for existence (Mouffe, 2000, 2005). In Norway sociologist Lars Laird Iversen speaks of "a community of disagreement" (*uenighetsfellesskap*) (2008). These unresolved dilemmas, even disagreements – if they are subjects of conversations may in themselves lead to more understanding, more participation, more democracy, and more togetherness. Yet, in order to communicate, there must be a common language, as some parents point out. The fruitfulness of dilemmas cannot be taken for granted, nor is it something that is there once it is achieved, rather, it is a continuous and conversational process, through which active citizenship at local and national levels is both exercised and negotiated. Similarly, professionals

negotiate the dilemmas of care and control, a balance which, at times, may seem vague to parents. This form of vagueness is not exempt from control. Rather, this in itself is a form of governing, embedded in a specific form of governing rationale – broad but also deep, encompassing choice – but within given frameworks.

Belonging, inclusion and exclusion are shaped through everyday actions (Ong, 2004:55). Parents, and mothers in particular, administer their children's citizenship through managing their own and, through socialisation, shape their children's nature of citizenship in the nation-state. Thus, in addition to embody boundaries and borders, mothers also have the opportunity to cross and transcend these (Yuval-Davis & Stoetzler, 2002:342). For the parents and professionals in my study, diversity and difference are intrinsic to the locality in which they live and work, and shape their own and their children's values.

Through my exploration of parents' and professionals' applications of broad and narrow strategies of belonging, I have sought to highlight ways in which parenthood and parenting are managed and negotiated in a Family Centre, located in a super-diverse area. I have shown that moral contestations of parenthood, when unified at a broader notion of values serve as a unifying function in the community – despite, or because of – disagreements. In fact, it is these contestations in themselves that - through parenthood - build inclusive communities.

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Family Centers in Finland

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Abstract

Early promotion of children's and families' well-being is a fundamental precondition in the prevention of social marginalization. In family centers parents' needs for support are met at an early stage. Family centre work has been implemented in Finland since the early 2000s, but empirical knowledge about the services on the national level has not been available. The National Institute for Health and Welfare (THL) carried out in 2012 a study about the services, cooperation, management and early support in family centers in Finland. There was considerable variation between municipalities with regard to services included in family centers. The study identified four service concepts; a multidisciplinary family centre, a welfare advice centre, an open early childhood education and care (ECEC) –centre, and a specialized family support centre. There were also differencies between municipalities regarding ways in which early support and special services were included in the family centre service concept. Strong evidence was found that the multidisciplinary service concept should be strengthened. Family centre is most likely to succeed when services are coordinated on a broader strategic management level. Furthermore, family centers with coordination, established cooperation practices and a low-threshold meeting place for families were more successful in providing parental peer support, targeted early support and information about services to families. NGOs'role in the family centre seems to have a strong linkage with involvement of parents, peer support activities and low treshold services. In Finland the family centre service concept is part of The National Development Plan for Social Welfare and Health Care, i.e. Kaste Programme 2012-2015. The Family centre concept is one of the leading themes in Kaste Programme concerning the development of child and family services.

Introduction

Development of family centres began in the early 2000s. Three phases can be separated in the rapid growth of the family centre service model. During the first phase family centres arrived in Finland through small, local projects which were carried out in single municipalities. The approach of promotion and prevention started to form. The second phase started in 2005 when The Ministry of Social Affairs and Health established the national FAMILY -project (2005 - 2007). The FAMILY-project was anchored in the national goals of social and health care services. The project was implemented over the whole country and covered up to 100 municipalities. During the project a shared vision of the family centre concept began to take shape. In the third phase, family centre was included in The National Developmental Plan for Social and Health Care by name Kaste Programme I (2008 - 2011). Kaste -programme I (2008 - 2011) was the national development programme for development of child, adolescent and family services. KASTE -programme I (2008-2011) emphasized strongly crossectoral services, multiprofessional cooperation, early support and involvement of children and families. Sector specific reforms not seem to be sufficient.

The fourth period started alongside the second period of Kaste -programme II (2012-2015). Family centre work was foregrounded as one of the main strategic goals and development themes in child and family services. Motivation for the development of family centre rises from the fact that in Finland the demand for specialized services among children and adolescents has been steadily growing. Both the amount of child welfare services and child psychiatry services have been increasing. There exist wide consensus about the urgent need for early prevention and timely interventions both in universal services, in selective early support services and in indicative interventions and specialized services. Family centres can offer one solution to this demand.

In spite of the relatively long history of family centers a national survey has not been conducted. The report of Family centres in Finland. Services, cooperation and management fulfils this gap. The first national survey of family centres offers interesting information about the Finnish family centres.

Methods

The survey was sent to 97 municipalities. Respondents were leading municipal officials, service managers and child and family professionals. Families were not included. It should be pointed out that survey was not sent to all Finnish municipalities (N=320). Selection of the municipalities was based on the information collected during the previous survey and Family project, in which municipalities had informed to have a family center type of services (Perälä et al. 2011; Viitala et al. 2008). A total of 52 municipalities returned the Webropol –questionnaire, but up to 20 municipalities replied not having family center. The final sample comprised 32 local authorities and municipalities.

The aim of the study was to compile information about services, cooperation and management of the family centers in Finland. The study was commissioned by the Ministry of Social Affairs and Health and National Institute for Health and Welfare carried it out during 2011-2012.The aim of the study was to find out:

- How many and what kind of family centres there are in Finland?
- How management and coordination of family centre services are organized?
- What kind of cooperation with NGOs is there in the family centres?
- How participation and early support is provided to families and children?
- What kind of knowledge and expertise is needed in family centers?

Results

Number of family centers in Finland
There are totally 320 municipalities in Finland. The number of municipalities has steadily decreased from 448 municipalities in 2002 to 320 municipalities in 2013. Results of the study indicate that there were 32 municipalities which provide family centre services in Finland in 2011. However, the number of family centers may be higher on the basis of other research results. According to Perälä et al. (2011) there were 51 local authorities, which had organized child and family services according to the family center service concept. In addition, NGOs were not included in this study, although they provide a low threshold meeting places for families (Kalliomaa 2012, 83).

Four family center models in Finland
There was a considerable variation between municipalities in regard to the services they provided under concept 'family centre'. Municipalities provided a wide range of services under the headline of family center. The concept of the family center was based on the family centre definition made by The Swedish National Board of Welfare and Health from 2008: “Family center has been defined as a complete range of services which are fully co-located and cover maternal healthcare, child healthcare, open early childhood education and care services and at least the preventive work of social services. (Familjecentraler -kartläggningen, 2008).

We applied the above mentioned definition when analyzing the data. There could be identified four service concepts:
1. Multidisciplinary family centre
2. Welfare advice centre
3. Open early childhood and education (ECEC) -centre
4. Specialized family support centre.

Of all municipalities 47 % informed to have the multidisciplinary family center, in which services may locate at least partly in different premises and buildings. These centers were network -based multidisciplinary family centers. One municipality (3 %) answered to have multidisciplinary family

centre in which all the four core universal services were co-located in same premises. Totally half of all family centers in this study were multidisciplinary family centers, of which major part had services located in different service premises.

Welfare advice centers accounted for 22 % of the municipalities. Open ECEC -centers covered 9 % of the municipalities and specialized family support centre existed in 19 % of municipalities.

Service structures of different family centre models varied. Multidisciplinary family center included all four core universal services; maternity health care clinics, child health care clinics, open ECEC -services and at least preventive social services. Welfare advice centers did include maternity health care clinics, child health care clinics and preventive social services, but they did not have link to open ECEC -services. The idea of multidisciplinary service model was not fullfilled. ECEC-center covered day care services and preventive social services, but there was no link to maternity or child health care clinics. Specialized family support centers were quite distinct from the three first mentioned models. In specialized service centers there were located child welfare services, child or adolescent mental health services, substance abuse services and other specialized services. There was no clear link to the universal services.

Results of Finnish family centers are strikingly similar to Norwegian family center survey conducted by RKBU Nord in Tromsø in 2008. In the Norwegian national survey four family center types were categorized: The Family's House (24%), Resource health clinics, (27%), Open kindergarten with extra resources (16%) and Specialized referral centers or teams, (17%).

Results from Finland and Norway indicate that in Nordic countries both child health care services and ECEC -services have been strengthened with preventive social services, but independently from each other. At present coordination of child health care services, early childhood education and care services and social services is seen as an essential precondition in order to provide children and parents universal, selective and indicative support close to them, at low threshold and timely.

There could be found positive relation between multidisciplinary family centers and supply of universal support and early interventions to families and children. In contrast, the welfare advice center had no links to ECEC -services and vice versa; ECEC-based family center did not have functional links to primary child health care services. In these family center models support of families was based on more narrow service supply. In conclusion, welfare advice centers and Open ECEC –centers are on their way to fully functioning multidisciplinary family centers. Furthermore, specialized family support centers without any connection to universal services differ from the classical definition of the family centre.

Over half (53%) of all family centers provided universal and selected support to children and families, while 47% of all family centers provided specialized, indicative support. The forms of selective services were counseling and guidance, family work, social work, home visits and home help and speech therapy. However, more information is needed to find out more precisely how both selective early support and indicative, specialized services are organized and coordinated with universal services in different family center models.

Local administration, integrative management and coordination

It is of vital interest how administration, management and coordination of family centre services are organized. In the Finnish study our main interest was how the local administration of family centre was carried out. Of the all family centers 71% were administrated by social, health or combined social- and health care administration, 23 % by educational local administration and rest by NGOs.

When we looked whether there was correlation between the administration of family centers in municipalities and family center models presented previously, we found out that multidisciplinary family centers were most often administered by educational local authorities, whereas family centers administered by local social- and health care authorities were of all types. In addition, some family centers were run by NGOs providing parents low threshold meeting places and peer group activities in the form of family-cafes.

Municipalities were asked how the management and coordination of services was organized in family centers. The results implicate that integrative management and coordination is necessary in steering family center services. Of all family centers included in the study one third had a family center coordinator (32%),a family center manager or steering group (34%) or family center teams (30%). There was a positive link between efficient coordination and cooperation; cooperation was more common in local authorities that had a designated family center coordinator or steering group.

Development of coordination requires agreed principles of cooperation. Of all the family centers 80 % had agreed upon principles which concerned support provided to families in minor concerns of everyday life, principles of early interventions in case families or children are at risk. Up to 70 % of family centers had agreed upon principles concerning evaluation of family centers, services prioritized, service processes and multiprofessional cooperation. In addition, four family centers out of five had operative goals or an action plan.

However, family centers had seldom agreed upon principles concerning strategic development of family center, cooperation with NGOs and other partners. In addition, family centers had seldom agreed on practices and approaches of involvement of families and children.

The findings indicate that construction of family center service model requires overall crossectoral coordination, more systematic steering structures and more integrative management of services. Also negotiated agreements and more coordinated cooperation with NGOs and other partners are needed. Results are in line with findings from European family centers. Both Germany and The Netherlands argue that multiprofessional working model brings new challenges for the leadership and working practices. Therefore, it is of primary concern to put effort on integration of different services and activities and improve integrative management (Compendium of inspiring practices 2012, 18, 28). Integration of services as well as integration of management is a current challenge also in Finland.

Support and interventions provided to families

All family centers provided services for children under six (6) years of age, i.e. under school age children. What's more, all family centers offered services also for children under 12 years of age. In addition, over half of the centers provided services also for elder children up to 16 years. In Sweden family centers started to develope around the families with newborn and small children. Family centers were designed to give unborn, newborn and small chidren a healthy start (Bing 2012, 15; Johansson 2012, 69). In Finland the target group seems to be broader. One explanation might be that in Finland also municipalities with specialized family support centers were included. These centers provide selective interventions for children and adolescents independent of child’s age.

One of the central ideas in family centers has been to create local meeting places for families and parents, where adults can meet and play together with their children (Bing 2012, 17). We were curious about whether Finnish family centers provided low threshold meeting places and early support for families. On the basis of the study results the goal had been achieved well. Family centers were in general effective in providing early support for parenthood by:

- supporting parents’ strengths in everyday life
- helping parents to create social networks
- ensuring peer group activities
- promoting early interaction between child and parent
- arranging low threwshold meeting places for families.

Family centers could also provide indicated interventions in form of counseling and guidance in the issues of upbringing, parenting and relationship. There could also be found positive relation between well functioning coordination and early support of parents. Common agreements, coordination and shared practices in family centers were positively correlated with peer support, support of early interaction and early support provided to families. All in all; family centers seem to need well organized steering structures, functional coordination practices and joint, integrated management in order to meet the needs of parents and children.

Competence and knowledge of family center personnel was perceived as good. Personnel's skills were evaluated as good concerning group leading, dialogicals methods, partnership based cooperation between parents and practitioners, supporting early interaction between child and parent, early interventions and multiprofessional cooperation. However, there is a need for improvement of professional competence concerning structured parent support programmes and preventive relationship counseling.

Role of NGOs
It has been stated that NGOs have a crucial role in the family centers (Kalliomaa 2012, 79). In the Finnish family center study we wanted to find out whether different family centers (multidisciplinary, welfare health clinics, Open ECEC -center and specialized family support centers) were cooperating with NGOs and other partners. When comparing cooperation between NGOs and different family center models, significant differences were found.

Of four different family center concepts multidisciplinary family centers had most often agreed on cooperation with partners like NGOs, church and private partners. Also majority of open ECEC -family centers cooperated with NGOs and church. In contrast, neither welfare health clinics nor specialized family support centers had cooperation with NGOs. Family centers having cooperation with NGOs' could more often provide:

- early support and peer group activities
- low threshold meeting places
- involvement and participation of parents.

These findings are not insignificant. It seems that not only crossectoral cooperation among municipal, public services plays a crucial role in the success of family centre. Apart from that, NGOs and other partners have an essential role in providing informal meeting places, peer group support and opportunities for involvement and participation for parents and children.

Lessons learned and conclusions

The future development of family centers in Finland will be based on the national strategy, which is steered through The National Development Plan for Social Welfare and Health Care, i.e. Kaste-programme II (2012 - 2015). Kaste -programme aims to convert the provision of universal services and more targeted specialized services in order to supply support for children, young people and families near in their everyday environments. One of the main principles is to strengthen the promoting and preventive approach and early intervention. Family center service model is prioritized as one of the major strategic themes in Kaste- programme (2012-2015). The National Institute for Health and Welfare (THL) will be responsible for coordinating and networking all players and partners around family center work; municipalities, educational institutions, universities of applied sciences, NGOs, churches and voluntary organizations as well as managers, professionals and families themselves. This work has started.

On the basis of the research results presented above it can be concluded that there is a need for national guidelines for steering family center management, coordination of services, co-operation of partners and improvement of professional competence. On the basis of the study the following conclusions can be drawn:
Of all family center models, multidisciplinary family centre is the most effective in combining all four universal services and providing promoting, preventive support.
Universal services form the basis for the family center. However, integration and cooperation of universal services and selective and indicative interventions must be further specified and elaborated.
NGOs, church and other partners compose a vital part of the multidisciplinary family centre.
Parental involvement, peer support, low threshold meeting places and social networks can be best promoted in multidisplinary family centres in which NGOs and other partners are involved.
Integrative, joint management and broader steering structures of child and family services in municipalites are needed in order to coordinate family center services specifically.
Crossectoral cooperation of family center services requires coordination structures; family center coordinators and family center teams.
Competence of professionals should be improved by structured parent support programmes.

The role of parents, families and children needs to be strengthened and involvement enhanced.

Source: Family Centres in Finland. Services, cooperation and management. National Institute for Health and Welfare (THL). Report 62/2012.

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More effective services for children, young people and families with children

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Abstract

The National Development Plan for Social Welfare and Health Care (Kaste programme) is a strategic steering tool for management and reform of social and health policy in Finland. The first period of Kaste programme was 2008-2011 and the duration of the current period is 2012–2015.The purpose is that national, regional and local actors cooperate with each other to implement the reforms. During the first period one of the objectives was to achieve a reform of services for children, adolescents and families with children.

During the second Kaste period there are two key targets:1) inequalities in well-being and health will be reduced and 2) social welfare and health care structures and services will be organized in a client-oriented way. The Kaste subprogramme for reforming of services for children, adolescent and families targets on three thematic and operational areas: 1) the family centre service concept, 2) services for schoolchildren and students will be improved under the umbrella of pupil and student welfare services and 3) child welfare. One of the main principles in all of them is to strengthen the promotive and preventive approach and early intervention.

There are now efforts to actively discourage the practice of referrals and instead to bring the expertise of specialists into children's developmental environments to support basic services. From the perspective of children and their families, this is a radical change: instead of the children transferring elsewhere they are provided support in their everyday lives in a familiar environment with familiar people.

The Finnish cohort study of children born in 1987 confirms the policies and practices adopted: children, adolescents and their parents must be provided with early and sufficiently intensive support.

Introduction

According to Statistics Finland the total population of Finland was 5 426 674, the number of families with children 578 000, the amount of children aged under 15 being 891 392 and live births 59 493 at the end of 2012. Forty percent of the total population belonged to the families with children. Of the families with children, a little over 20 % were single parent families.

In the 1990's after the depression, there were big cuts in the services for children, adolescents and families (maternity and child health clinics, school and student health care and child welfare). No corrective moves were made during the good economic years at the beginning of the 2000's. These services were seen more as costs instead of investment.

Several surveys demonstrated that there were major differences in the quantity and quality of universal services between municipalities and many services did not meet the national recommendations. In addition, there were deep divisions between all sectors including old boundaries between health and social services and between basic and specialized services. The situation was considered highly problematic as these scattered services could not meet the comprehensive needs of families. Disorder-focused theory was prevailing and mental health service was seen as a specialty service. Due to the cuts, the proportion of preventive services was diminishing and that of corrective services was increasing meaning remarkably higher costs.

In the 2000's the professionals in promotive, preventive and corrective services had recognised the importance of finding a new way to co-operate together. Also a new paradigm of co-operating with parents in primary health care, in day-care and in schools was emerging. There were several projects in primary health care aiming at changing the nature of services, especially towards to more client-centred direction. They greatly facilitated the change process. Among the positive examples was the European Early Promotion (EEP) project. The EEP project was a development and research project that aimed to develop a service concerned with the promotion of child mental health, the primary prevention of emotional and behavioural problems and early intervention based on the needs of the children and their families. The objectives of the EEP project were to develop a training and supervision programme for primary health care professionals to enable them to implement promotional, preventive and early intervention strategies appropriate to the level of need for services, for all families within primary health care. The role of the primary health care professionals was to establish a supportive partnership and to empower parents to explore, clarify and resolve any issues they found problematic. The project increased support to parents in universal services.

It became evident that a radical reform of services was needed. This reform was carried out through the National Development Plan for Social Welfare and Health Care (Kaste programme). Kaste programme is a strategic steering tool for management and reform of social and health policy in Finland. The first period of Kaste programme was 2008-2011 and the duration of the current period is 2012–2015. The programme defines the key social and health policy targets, priority action areas for development activities and monitoring as well as essential legislation projects, guidelines and recommendations that enhance the realisation of the programme. The purpose is that national, regional and local actors cooperate with each other to implement the reforms. During the second period the key targets are:1) inequalities in well-being and health will be reduced and 2) social welfare and health care structures and services will be organized in a client-oriented way. The targets will be met through six sub-programmes, and one of them is "More effective services for children, young and families with children". The original idea was to develop and pilot services in a specific region. However, right at the beginning the reform was extended to cover the entire country which brought an added challenge.

Purpose

The purpose of the reform of services was

- to develop and integrate services to support child development
- to develop and integrate promotive, preventive and curative services at the basic level and across sector boundaries
- to organize services in a client-oriented way and to strengthen the role of parents, families and children
- to change the ratio of preventive and curative services, the focus on preventive services

The vision is that children and young people and their families receive support as needed and aid for healthy development in the environments they live in. When there are problems and disturbances the whole environment is supported so that young people do not have to be separated from their natural relationships and normal daily activities and adults learn new skills how to support children and young people.

Methods

Two major methods were used when reforming the services of children and families. They were projects and active support provided to projects.

Five large development Lasten Kaste (Childrens' Kaste) projects started almost at the same time: Voice of children project in southern Finland, Remontti project in western Finland, Kasperi project in intermediate Finland, Children and families Kaste project in middle and eastern Finland and Tukeva

project in northern Finland. The five projects took care that on the local level in developing community based services the promotive, preventive and corrective services were coupled over existing sector boundaries (health, social, youth, school, and police services). Projects contributed to the development of specialized and intensive support services, to their adoption in strategies and to their functioning through and with local services. During the process the supportive potential and needs of the developmental environments (home, day-care, school, hobbies, the net) became clear.

The most important support was provided by the National Institute for Health and Welfare. Its responsibility for supporting the projects and networking with them was officially agreed and documented. In the first Kaste subprogramme (2008-2011) networks were built along developmental lines: home and day-care, school, child participation. In the second period of Kaste programme 2012-2015 networks are built along the three strategic targets:

- the family center service concept
- services for pupils and students will be improved under the umbrella of pupil and student welfare services and
- child welfare

In addition, new health and social care legislation has provided support for the reform. These include Health Care Act (1326/2010) and the Government Decree (338/2011) on the maternity and child health clinics, school and student health care and preventive oral health care. Both of them emphasize health promotion and prevention, well-being of the whole family and regular and comprehensive monitoring of health. In addition, they give guidance for the identification of needs, especially special needs, and for being active in searching those not attending the health examinations. A special innovation are the so called extensive examination to which both parents are invited and in which the well-being of the whole family (parents included) is being assessed and promoted. Problems of children and parents should be identified and support organized.

Results

A large number of models and methods were available from the first Kaste programme period, along with the overall conception of the services involved and how they should be organized. These models and methods were analyzed and synthesized.

1 A comprehensive promotive and preventive service model for children and families

The most important result of the subprogramme is the conceptualization of a comprehensive service model (and its elements) for the promotive and preventive work with children and families. The model facilitates the change from curative to preventive services. In addition, it provides a means for evaluating the current state of municipal services and for the identification of the changes needed. The model comprises of elements complementary to each other. They are universal services and services giving early and intensive support and a new way to make specialists's know-how available. The main idea in organizing the services is to take account the nature of client's difficulty or problem and the length and intensity of the support needed.
Universal services establish the basis of the service renovation. They have to be of good quality, available close to families and adequately staffed. Examples of these services are maternity and child health clinics, early education, schools, school and student health care as well as pupil and student welfare. In universal services it is essential that children and families needing additional support are timely identified.
As a problem is still small and fairly simple the help can be obtained quickly through focused and supportive counseling. These methods and models are called early support models. Examples are peer groups, preventive family work and early support in child-rearing issues. It is assumed that if these early support and universal services are not adequate or sufficient many problems get worse. For children and families needing stronger and more long-lasting supports there are models available providing intensive and special support. The client can meet a professional often and explore the issue profoundly. It is essential that the support is provided without delay and that it lasts long enough.

Examples are intensive family work implemented in homes, group-shaped rehabilitation and divorce groups for children.

One of the key outcomes has to do with changing the relationship between basic and specialist services. Traditionally, when additional support was required in basic services for children, the children in question were referred to specialist medical care. There are now efforts to actively discourage this practice of passing the buck and instead to bring the expertise of specialists into children's developmental environments to support basic services. From the perspective of children and their families, this is a radical change: instead of the children being taken elsewhere, e.g. to hospital, they can continue their everyday lives in a familiar environment with familiar people. The adults in this environment are provided with instructions and support in understanding and helping the children. Previously, children were isolated for treatment, and the adults carried on as before. This meant that when the children were discharged from hospital, they did not necessarily receive the support they needed. The reform produces a win-win situation. To achieve the above described reform, special efforts are needed in the service structure and in the attitudes of professionals.

Partnership in parenting approach. Essential principles guiding the implementations of the above models include participation and partnership. We have become aware of the importance of children, adolescents and families participating in the life of a community, both for the community and for the family's handling of its own affairs. Real professional-parent partnership is built from active listening and dialogue, mutual respect and interdependent trust.

2 Essential elements for developing/introducing and implementing the service model

The above models don't arise by itself. The reform work has needed sustained efforts and new structures. A great deal of useful information and experiences concerning how to establish new practices had been obtained and synthesized during the projects. They concern for instance the importance of strategy work, management commitment, decision-making support and enhancement of expertise.

Support from municipal decision-making bodies is necessary: clearly stated goals, introduced into the municipal strategy, are needed. Welfare plans for children and families and welfare reporting system have been utilised as useful tools. They both bring together municipal actors across sectoral and management boundaries. In addition, extensive network models and multiprofessional collaboration across municipal and management boundaries, good leadership and management system are essential.

Many of the models developed in extensive collaboration have remained and they are expanding from pilot areas to near-by municipalities. Collecting services for families with children at family centres and improving their management systems is an example of a regional service model. Valuable experiences and information facilitating the implementation has been received during the project period. These include support from management and decision-making bodies, continuous evaluation and strengthening the skills of professionals.

Conclusions

The reform of services for children, adolescent and families has been on the right track and it will continue.
Many research studies such as the cohort study of all children born in 1987 confirms the correctness of the policies and practices adopted: children, adolescents and their parents must be provided with early and sufficiently intensive support. Extensive health examinations regulated by the Government Decree 338/2011 enable reinforcing of the well-being of children and families, recognising needs for early support and enhancing prevention of social exclusion, beginning as early as during pregnancy. Any behavioural disorders and other predictors of long-term problems and difficulties of children and parents must be identified as early as possible, preferably long before the school age. It is vital to invest in this stage of life, intensely if necessary.

The Kaste 2012-2015 subprogramme for reforming of services for children, adolescent and families' targets on three thematic and operational areas: 1) the family centre service concept, 2) services for schoolchildren and students will be improved under the umbrella of pupil and student welfare services and 3) child welfare. One of the main principles in all of them is to strengthen the promotive and preventive approach and early intervention.

Family centres are potential places to provide low threshold meeting places and early support for families. According to civil servants and professionals of municipalities, the goal had been achieved well (Halme et.al 2012). Family centres were in general effective in providing early support for parenthood by

- supporting parents' strengths in everyday life
- helping parents to create social networks
- ensuring peer group activities
- promoting early interaction between child and parent
- providing low threwshold meeting places for families.

Future challenges have been identified in the overall analysis of the project work and in the identification of focus areas. Future investments must involve intensive support for small children and their families and early support across the board. It would be particularly important that services for adolescents would be available on the one-stop-shop principle. The policies in the Kaste programme are intended to govern development in social welfare and health care services. These efforts must therefore be continued nationwide. Operating models that have already been developed and proven must be distributed to every municipality, and to every child health clinic, daycare centre and school in each one of them. Services for children, adolescents and families are of great importance in ensuring the well-being of this population group and in preventing transgenerational social exclusion. Because the costs of providing these services constitute a large portion of local government expenditure, the services must be efficient and effective. Priority must be given to preventive services which are far cheaper than the corrective services. They are also justified from the perspective of children's rights.

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To meet or not to meet: The crucial role of the staff in integrated family centres in Flanders

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Abstract

The Government of Flanders is preparing an act on preventive family support. One of the key points in this future act is the development of integrated family centres (i.e. “Huizen van het Kind” - “Children’s houses”). Next to promoting partnerships, these integrated family centres are aimed to promote informal social networks and social cohesion among (future) families with children, which can be an important source of parental support.
Currently, there are several pilot projects exploring how these integrated family centres can be developed, and how the informal social network around families can be facilitated. In order to support the pilot projects, we set up a learning community composed of practitioners from the projects. The pilot projects revealed that the development of meeting opportunities for children and parents in the integrated family centres has many implications, especially for the staff (professionals and volunteers). The staff plays a crucial role in facilitating social contacts between children and parents. This role demands specific competences, at the individual level, as well as at the institutional level.

Introduction

Family centres in Flanders

In Flanders (Belgium), there are many services or actors focussing on preventive family support. These services can be organised by the government or civil society organisations or they can be private projects. This multitude of services and actors can only be applauded. However, not all services or actors are currently working together and often parents can’t find their way to or in the ‘jungle’ of preventive family support. Therefore, the Government of Flanders is developing a new legislative act on preventive family support.
One of the key points in this act is the development of integrated family centres (i.e. “Huizen van het Kind” - “Children’s houses”). These family centres aim to integrate the multiplicity of the existing preventive family services and focus on collaboration between existing services and organisations. This collaboration in the field of preventive family support should promote the wellbeing of all (future) parents and families by supporting them in the field of welfare and health, in order to realise maximum health and welfare gains for every child.
Next to promoting partnerships, the family centres should promote informal social networks, encountering and social cohesion among families with children, which can be experienced as social support. This is the focus of our research project. In the present article, we explore how informal social networks are set up, and we focus on the role of the staff in facilitating encountering in the family centres. For more information concerning the background, the goals and the building blocks of the new Flemish act on preventive family support we refer to Blondeel, De Schuymer, Strynckx, and Travers (2013).

Focus on informal social networks around families?

Previous research (e.g., Buysse, 2008; Nys & Van den Bruel, 2009) revealed that in most cases raising children is not perceived as something problematic. Nevertheless, often parents feel insecure and have questions concerning parenting and bringing up their children. Currently, in Flanders there are many services supporting parents in their parenting role. Parents can take courses on countless different topics; they can find information on the internet, on online forums, in books or magazines, or individual meetings with professionals. Also, on television parents are overwhelmed with information on how they should or should not raise their children.

But what is supportive for one parent is not by definition a source of support for another parent. There is only one exception: the informal social network. All parents feel supported by their informal social networks (Buysse, 2008; Nys & Van den Bruel, 2009). Often this informal social network is composed of tide, close relations such as friends and family (Buysse, 2008). But also lose, ad hoc relations can be supportive. As Rullo and Musatti (2005) stated: "Interactions with persons that share the same intense life experience is considered to be potentially supportive for young children's parents (as it provides the opportunity to observe a variety of parenting models)". They (Rullo & Musatti, 2005) believe it is not necessary to establish a continuous and committed relationship. Social contacts among parents, who are not necessarily involved in any close relationships, could assume a specific and positive value and become significant on the basis of the life experience that parents share. Hence, providing the opportunity for social intercourse among parents, who share the same life experience, can be an important resource in raising children (Rullo & Musatti, 2005). Also, Soenen (2006) argues that lose interactions and small talk, which is characterized by anonymity and informality, can be supportive. These arguments, revealing the importance of not only bonding, but also bridging relations in family support, inspired us in examining how the encountering or the informal social networks could be set up in the family centres.

A learning community as a source of inspiration

Currently, there are several pilot projects in Flanders proactively exploring how family centres can be developed, and more specifically how they can facilitate informal social networks, encountering and social cohesion around families. VBJK[2] supports these pilot projects by setting up a learning community composed of practitioners from the different pilot projects (i.e., 7 pilot projects in 2012).
Learning communities can be defined as "*an example of collaborative learning where a group of practitioners regularly meet and discuss a chosen topic. During these meetings the members share practices and reflect on these practices in order to develop their professional competences (based on ONS, 2013).* For 1,5 year the members of the learning community gathered each 6 to 8 weeks and visited the different pilot projects. In the learning community issues were discussed which are important for facilitating social contacts between parents and children. The members of the learning community all agreed that the development of meeting opportunities for children and parents in family centres is not self-evident and can differ extensively concerning the context. Also, the role of the staff (professionals and volunteers) was defined as a main discussion point during the meetings of the learning community. The staff plays a crucial role in facilitating social contacts between children and parents. This role demands specific individual competences and systemic conditions. In the following part we first elaborate on how informal social networks were facilitated in the pilot projects. Next, we focus on the complex, but crucial role of the staff in facilitating encounters between parents and children.

Meeting and encountering in family centres

As discussed above, there is an explicit focus on informal social networks, encountering and social cohesion in the new Flemish legislative act on preventive family support. However, how services should translate this act into practice is not (yet) defined by the Flemish Government. Hence, the different pilot projects translated this in a distinctive way. Some services try to facilitate encountering by organizing sewing or knitting ateliers; other organizations set up supporting groups for mothers, others for fathers; some organize crafting activities for children others for children and parents. Some services organized baby massage or singing sessions for parents with their child in order to facilitate social contact and informal social support. Or some organizations facilitate encountering in child health centres. Or there are gaming afternoons in toy libraries in order to stimulate social contacts between parents and/or children. Other organizations started meeting places for children and parents[3]. These examples clearly show that there are currently many different translations of the focus on informal social networks in family centres. Probably, all these different examples can stimulate contacts and small talk between parents and/or children. And, probably the different examples are valuable for certain parents and certain children. But through this multitude of examples it is crystal clear that each service defines 'meeting and encountering' in a different way. Meeting and encountering has become a container concept which has many different meanings to different actors. This can be confusing:

[2] This project 'Meeting function for children and parents in family centers" was performed by VBJK, and subsidized by Kind en Gezin (Child and Family, the Flemish Agency in the Public Health, Welfare and Family).

[3] Meeting places for children and parents or centre for children and parents (CCP) can be defined as places where young children can stay with their parents (or other persons responsible for the child) in the attendance of professional staff: hosts who facilitates encounters between children and parents. In the meeting place, children can meet other children and parents have the opportunity to meet other parents and discuss the raising of children (based on Van der Mespel, 2008). CCP's are not problem oriented, nor are they targeted at a specific group.

confusing for the services and the staff (e.g., The concept is unclear and facilitating meeting and encountering puts extra pressure on the staff). But also confusing for parents and children (e.g., What can they expect when they visit different services? Are they obliged to meet with other parents or children?). This confusion calls for more clarity. And, in order to unravel the complexity of 'encountering or meeting in family centres" a clear conceptualization is needed. We suggest the following conceptualization of encounters in family centres: "*an open 'place' where everybody feels welcome and where children and/or parents from the neighbourhood can be together, they can freely encounter and/or play, and where the community can be build*." Again, this conceptualization is open for interpretation and the unravelling should be extended. A central question that can be helpful for services in this unravelling process is: "*What are we doing for whom?"* A simple question, examining the target group and the aims of encountering in family centres. But the above-mentioned examples show that, although many services aim to facilitate encountering between children and parents, they actually only enable social contacts between parents (mostly mothers). So, if the service aims to facilitate play and interaction between the child and his or her mother and father, than sewing or knitting ateliers, support groups for mothers, encountering in second hand shops are probably not the best option?

Also, the aims can differ considerably (i.e., *what* are we doing?). For example, in the second hand shop parents come to buy or trade clothes, additionally they go there for the social part. Or in the toy library, children and parents go there to borrow toys or to play games. Additionally, they can visit the toy library for the social part. Or in child health centres: parents go there for the medical part: to measure and weigh their child, but some parents enjoy the small talk with other parents during the waiting time. In these examples encountering and meeting parents and children, will not be the main reason to visit the services (for most parents).
Another example are the meeting places for children and parents: parents visit this place intentionally in order to play with their child, and/or to meet other parents. There can be many more reasons for parents to visit a meeting place with their child, and these reasons can differ from parent to parents. Meeting places for children and parents have 3 main functions parental support, challenging development of children and community building. It is this combination of functions that makes these services so valuable.

Concerning the encountering in the family centres, all the different examples named above, can stimulate social contacts between parents and/or children, and a multitude of different services focusing on encountering between parents and / or children should be commended. There should be something for everyone. But … some important remarks must be made.
First, in the family centre not only social contacts between parents should be focussed on. In family centres - in Flanders called Huizen van het Kind [Houses of the Child] - we plea for an open place for parents and children together. In the pilot projects, the latter were sometimes forgotten.
Second, special attention should be given to meeting places for children and parents in family centres. So meeting and encountering is not something additional or a side effect. Here the Nordic family centres can inspire the Flemish 'Huizen van het Kind', because the open preschools, which are comparable to meeting places for children and parents, are perceived as the beating heart of the family centre.

The role of the staff
In the previous part we discussed some interesting examples of how the social cohesion and encountering was translated from policy to practice by different pilot projects in the learning community. Although meeting and encountering was a (main or side) goal of the services, the pilot projects came to the conclusion that social contact between parents, between children or between parents and children does not by definition lead to social support? Putting people together does not mean that it becomes directly a supportive environment. There are many preconditions for social contacts to become social support[4] and one of these preconditions is the staff: the role of the staff, the competences of the staff.
We will discuss 2 examples in order to explain the crucial role and the competences of the staff: encountering in the waiting room of the health care centres and encountering in meeting places for children and parents.

[4] Other examples of preconditions are the location, furnish, communication language, collaboration with other services, opening hours, evaluation, …

Example 1: The role of the staff to facilitate encountering in the waiting room of the child health centre

Previous research revealed that the waiting room in child health centres can be a forum where parents talk about the upbringing of their child, where they exchange experiences and ask questions to other parents (Van de Walle, 2009). There are different types of staff in the child health centres: volunteers, doctors, nurses, and sometimes family supporters (which are bridging figures for parents in vulnerable positions). Especially, the volunteers are currently assumed to play an important role in stimulating and facilitating the 'meeting' between children and parents. However, this 'new' role is not self-evident for the volunteers. Some volunteers feel reluctant to perform other tasks than measuring or weighing children. Others don't know what the difference is with the current tasks they perform: they already take care of a warm welcome, they already talk to parents and children, what else should they do? Many questions arise for the volunteers: how can they facilitate these social contacts? Some pilot projects, who were part of the learning community, decided to add a volunteer especially for the social contact. This implies, that in the waiting rooms 'good cop bad cup' scenes can become a reality: the good cop (volunteer for the social part) welcomes parents and children, chat with parents, plays with children, serves coffee or tea, ..., while the bad cop (volunteer for the medical part) only measures and weighs the child, and performs administrative tasks. We believe that this is not the right solution. Instead, all volunteers (and all other staff members) of the child health centre should play a role in creating *an open 'place' where everybody feels welcome and where children and/or parents from the neighbourhood can be together, they can freely encounter and/or play, and where the community can be build*." Hence, a main competence of all staff members is to welcome everyone and to be able to work in a context of diversity.

Example 2: The role of the staff in meeting places for children and parents

The staff in meeting places for children and parents play a crucial role. However, what this role exactly is remains rather vague. Often they are seen as hosts (in French they are called accueillant): taking care of a friendly and warm welcome of children and parents. Also they are facilitators of social interactions between children and/or parents, initiating conversations and play (Adolfsen, Martinussen, Thyrhaug & Vedeler, 2012). Furthermore, they should be experts in not being expert. Or as Hoshi-Watanabe and colleagues (2012) stated "they are conveyors, hosts or facilitators, rather than having the educational or psychological expertise deemed necessary to advise parents on their parenting role". Instead they should be sensitive practitioners who can cope with the different expectations of parents and children visiting the meeting place and coping the unpredictability of the here and now in the meeting places. Adolfsen et al. (2012) correctly conclude that this is a challenging role, where strong social competences are required. In line with the CORE-report (2011) competences at the individual level of staff members can be defined as well as competences at the institutional level. In Table 1 some crucial competences at both levels are enumerated.

Table 1. Domains of competences of the staff in meeting places for children and parents (based on CoRE-report, 2011).

Domains of individual competences	Domains of institutional competences
• Developmental aspects of children from a holistic perspective • Communication with children and participation of children • Stimulating parent-child relationship • Working with parents and local communities • Team working • Networking with other services • Working in a context of diversity • Health and care, provide safe environment • Strong attitude in self-reflection …	• Learning organization • Shared vision • HRM, diverse team • Leadership, coaching • Professional development • Team reflection …

These domains of competences reveal the complexity of the role of the staff in meeting places for children and parents. In order to reach these competences at individual and institutional level, regular peer review (in team) and supervision (with an external 'critical friend') at team level, where daily cases are discussed, are a prerequisite.

Conclusion

Facilitating informal social support and social cohesion around families with children is defined as an important aspect in the new Flemish act on preventive family support. But how this act is currently translated in some pilot projects differs considerably: it differs in the aims and in the target groups. We plead, that in the family centres, called 'Huizen van het Kind' (Houses of the Child) it is important that not only encountering between parents (mostly restricted to mothers) is facilitated. The 'Huizen van het Kind' should be a place for children too, with activities and services for children and parents together. Hence, we advocate the presence of a meeting place for children and parents as one of the services in the family centres.
It is clear that the current focus on social cohesion, encountering, informal social contact has implications for the role and the competences of the staff.
Although the legislative act on preventive family support is not yet operational (probably in 2014), some pilot projects proactively started with developing family centres and exploring the possibilities of informal social networks between families. But how the encountering in family centres will evolve and which influence this has on the staff, is still a question mark. More food for taught is coming up (when the new act is in action).

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Family Group Conference as an innovative method for working with families in crisis situations - experience the cooperative program "Children and Youth at Risk in the Barents region 2008-2015"

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"The Children and Youth At Risk in the Barents region" (CYAR 2008 - 2015) is a co-operation program within the framework of the Barents Euro-Arctic Council. It has been developed as a result of growing concern regarding marginalized youth and children in the region. The CYAR programme emphasizes that all efforts should aim to strengthen the public services and their ability to adequately assist and support children and youth on the individual level. The programme aims to improve life conditions for the youth and children at risk through cooperative actions in general (creating frameworks for exchange of information) and project activities in particular (building partnerships between public institutions at all levels and non-governmental organizations in the Barents region with responsibility for the well-being of youth and children).

In the work of the CYAR programme, *family* is the key word. All efforts should promote the sustainment, strengthening, recreation, or – as a last resort – substitution of the family. The following fields of competence will therefore receive special attention: strengthening of parental resources, development of foster care services, social skill training for children and youth, monitoring of the rights of the child.

In order to fulfill the objectives of the CYAR programme, several activities take place throughout the period, involving all Barents partners. The CYAR's core activity is dissemination of the research-based methods/programmes, where the Family Group Conferences is one of them.

Family Group Conferences (FGCs)

FGC is an innovative method for working with children and families in crisis situations. This method appeared in New Zealand in 1989 when a law "On Children, Youth and Family" was passed, which emphasized the importance of family and cultural heritage in the upbringing of children. According to this law, responsibility for education rests with the family, and professionals should involve the closest network in the process of decision-making when the child is in a problem situation.

The appearance of the low was caused, on the one hand by the crisis in social work during this period in the country, on the other hand by the Maori traditions. Maori believe that the closest network plays an important role in the life of a child. The family consisting of several generations knows their children better than any specialist; the family is the best place to raise a child, here children will receive necessary care. The family's responsibility form the upbringing of the younger generation can not be transferred onto the shoulders of social services.

Application of this method is closely related to the ethical principle, which states that individual responsibility is the most important responsibility. The method underlines, above all, the need to respect the central role of individuals in solving their problems, which have been identified and defined. The people themselves cope with their problems; you must give them the opportunity to propose solutions. This is the meaning of a new method of decision-making.

FGC is a sort of family council, a meeting of all family members to discuss the situation and make their own decisions. This method is used in various crisis situations, such as family conflicts, adolescent drug use, juvenile delinquency, lack of understanding between parents and children, as well as in cases of domestic violence. FGC can be easily adapted to different areas, such as conflict resolution at work, at school, at home.

FGC is a structured decision making meeting made up of 'family' members. 'Family' is determined broadly, to include the children, parents, extended family and even significant friends and neighbours to the family who may not actually be blood related. This group of people are given 'private' time to reach a plan to facilitate the safe care and protection of a child or children in need. The idea of family group conference is associated with a desire to strengthen the family's right to self-determination in matters of concern for their own children. Family group conference depends to a large extent on the

cultural traditions than on scientific theory. The professional is involved in information giving at the beginning of the process and in the assessment of the plan following a decision. It is a formal meeting in which the family and whanau of the child and professional practitioners closely work together to make a decision that best meet the needs of the child. It is based on the development of the child's abilities to overcome the crisis through interaction with the nearest environment, i.e. family. FGC are used to make plans for children in a number of different contexts: Child Welfare, Youth Offending, Education, Welfare, Domestic Violence, Children as Young Carers, Foster Breakdown, Adoption etc. The meetings are facilitated and co-ordinated by people independent of casework decisions in the agency working with the family.

Goals and target groups
The goal of the method is the prevention of marital distress, social orphanhood, neglect and juvenile delinquency, as well as support for families and children in difficult situations.

The main characteristics of the method
Rob van Paage (2006) points out four main characteristics inherent in family group conferences:
1. This is an innovative method of decision-making based on the strength and capabilities of the family itself.
2. The full and sole owner of the meeting is the family and close associates (family members determine the time and place of meetings, organizes tea party, develops its plan, doing everything according to its prevailing culture and traditions).
3. The conference is conducted by an independent leader, a neutral person who is not related to this family and does not affect the adoption of family decisions and the development plan.
4. The family shall be entitled to obtain information, necessary personal time, the unconditional acceptance of the plan, if it is safe.

How and where is FGC implemented?
New Zealand's bold experiment to transfer authority and responsibility for their own children to the family influenced the philosophical outlook and practice of professionals working with the family around the world. Use of "Family Group Conference" is enshrined in law in countries such as New Zealand, in some states of Australia (South Australia, New South Wales and Queensland), in the Republic of Ireland. Family group conferences are designated as international best practice in the UK, Scandinavia, the Netherlands, many states in the United States of America, in Israel. The method is actively used in Spain, Slovakia, Poland, South Africa and other countries on all continents (Doolan 2002).

In spite of all the variations in the different countries there are some principles seen as: the family-only-time is the key issue. There is a strict separation of functions in the different roles of the social worker, the coordinator and the family. The coordinators have to maintain a dual independence, of the social administration as well as of the families' problems. Social workers have to act neutrally in regard to solutions and to shift the relation of power in favor of the families. The participation of children/ young people and their needs demands a special consideration. Enough time for the preparation and organisation of the conference has to be provided.

There are quite some differences but also communities, concerning the level of standardisation, the areas of implementation and the background of coordinators (professionals or lay persons) and the form of their training. One crucial difference is whether FGC is implemented bottom-up by NGOs (in the Netherlands and most Eastern European countries) or top-down by a governmental initiative (like in Norway). In between there are models where FGC was initially promoted by NGOs and then became more and more influenced by local authorities (like in Northern Ireland).

In some European countries FGC has a long tradition: In Scandinavia FGC was implemented between 1995 and 2003 (Vik 2008). Norway decided to introduce a nationwide centralistic system driven by state institutions, which are responsible as well for the standards as for the recruitment and training of coordinators. The Directorate for Children, Youth and Family Affairs, which is the governmental office under the Ministry of Children and family Affairs that is responsible for child welfare, has been given the responsibility to implement FGC in the whole country since 2007. Subordinate there are five regional offices and 27 teams who do the training in the municipalities, coach social workers in method fidelity and are in charge of the approximately 300 coordinators in Norway. By now nearly two thirds of

all communities in Norway are trained in FGC, but since there is no obligation, the implementation quote in relation to the means is rather low. It is interesting to see that the top-down approach at one hand leads to a widespread knowledge about FGC on the professional level but not necessarily to a growing demand if families are not motivated enough to do a FGC. As a consequence a communication strategy for mass media is being developed (Straub 2012).

Family Group Conference in Russia
FGC in Russia has been implemented by the Representative office of the humanitarian organization "SOS – Children's Villages Norway" in the Russian Federation. Since 2000, the activity of the Representative office in the Murmansk region has emphasized strengthening the family as its goal by means of new strategies in family support and child upbringing in a difficult life situation. The Russian-Norwegian FGC project was introduced in 2004 for the first time. Initially the project was implemented only in the Murmansk region, but in 2006 it became a basis for enhanced cooperation between authorities, institutions, civil society and individuals in St. Petersburg, Leningrad and Pskov regions, the Republic of Karelia.

The difficulties are that there is no governmental support and that Russian families seem to be very suspicious of any form of intervention – possibly a consequence of communist times. The solution is that the coordinators work closely together with schools, because the families trust teachers and there is a bigger chance for an FGC if a teacher does the referral. The Norwegian SOS Children's village association supports the Russian initiative.

Undoubtedly, new knowledge positively affected the lives of the families and by introducing new technologies it contributes to broader personal horizons, changing public opinion. Despite the positive reaction of Russian families participating in the program, certain difficulties arise on the way of the successful application of the method. For example, when a decision is taken by the family, experts have expressed their concern about the safety of the child, because in such situations, they lose control. This method requires a belief in the power and possibilities of the family and its closest environment.

Other weaknesses include financial cost related to implementation of the method, relatively high cost of doing temporary work for practitioners and experts from the municipal level, low degree of confidence in the strength of the family by experts, reluctance to transfer to family the responsibility about decision-making, fear of the family to openly discuss their problems with people. Systematical analysis of the strengths and a weakness of the program implementation is thus required in order to overcome the difficulties in time.

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How smart parents become clever

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Introduction

In Norway, there are few standardized strategies to help the parents of children with anxiety and depression. When children are treated at community child mental health clinics (BUPs), therapists and other qualified personnel are generally concerned with involving parents. Norwegian patient registers from 2002 show that within treatment in BUPs, mothers participated on average 6-7 hours, and fathers 4-5 hours (Israel, Thomsen, Langeveld, & Stormark, 2007). However, the degree to which parents are involved vary significantly as a function of their child´s problem types. Parents of children with externalizing disorders such as hyperactivity or conduct disorders are more involved (in terms of hours spent at the BUP) than parents of children with internalizing disorders such as anxiety and depression.

Research has demonstrated that a large proportion of parents of children with anxiety and depression suffer from similar conditions. Children with anxiety disorders have a higher probability than non-anxious children of having anxious parents (Beidel & Turner, 1997; Hudson & Rapee, 2004; Martin et al., 2004; Stein et al., 2002). Similarly, half or more than half of parents of depressed youth appear to have or have had depressive disorders (Essau, 2004; Kovacs et al., 1997).

Several theories and empirical findings suggest that parents play an important role in the development and maintenance of anxiety and depression in children. Overprotective or controlling parenting behaviors may communicate to the child that the world is a dangerous place, which they cannot cope with themselves but only with their parents' help. It may reinforce avoidance behaviors and prevent the child from learning important coping strategies (Manassis & Bradley, 1994, McLeod et al., 2007, Shortt, Barrett, Dadds & Fox, 2001). Anxious parents may also transfer anxious cognitive schemes and avoidance behaviour to their children through role-learning (Moore et al. 2004). With regards to depression, relationships have been found between insecure attachment and depression in children (Sund & Wichström, 2002; Essau, 2004), as well as between negativity in parents' communication and their children's negative cognitive schemes (Stark, Schmidt & Joiner, 1996).

The direction of these relationships is still unclear. Most likely the relationship is bi-directional, where parental factors and children's anxiety and depressive symptoms influence each other equally. A high degree of parental control could, for example, reinforce a child's anxiety. However, this parental control might also be a reaction to the child's symptoms, or even an expression of the parent's own anxiety, independent of their children (Fox et al., 2005).

Based on this research, involving parents in the treatment of their children seems important, especially when children are younger. Involving parents has several advantages. First, it is likely to evoke constructive attitudes among the parents towards the child's problems and treatment. Second, it can positively influence communication patterns and problem solving strategies in the family. Finally, it can enable the parents to deal more constructively with their own challenges.

For these reasons, a support group for parents of anxious or depressed children was developed on the initiative of the organization Voksne for Barn (VfB – an charitable organization for children's mental health), in collaboration with the Center for Child and Adolescent Mental Health, Eastern and Southern Norway (RBUP Øst og Sør). The main goals of the group are to provide parents with empirically informed knowledge, and the opportunity to meet other parents in the same situation. This resulted in the concept "CLEVER PARENTS" (Smarte Foreldre)[5], which was run through RBUP Øst og Sør and

BUP Vestfold in 2007 and 2008. The project received support from the Norwegian directorate of health and social issues.

Aims
The primary goals of the current study were to evaluate the feasibility and user satisfaction of the CLEVER PARENTS program. Secondary goals were to find out whether parents' knowledge about anxiety and depression improved throughout the psycho-educative part of the program, and whether parents' symptoms of anxiety, depression and stress declined and parents' resilience increased during the program.

Program
"Clever parents" (Neumer & Gere, in prep.) is a twelve-week program with one meeting per week. The first 6 weeks are spent on psycho-education, including relevant knowledge and principles/theories. The latter part is intended as a forum for the parents to mutually support each other and exchange experiences. It is designed as a self-help group and based on the equal contributions and status of all the participants.

In the psycho-educational part, the parents learn about childhood anxiety and depression, and about strategies they and their children can use to cope with it. This part is funded on the principles on cognitive behavioral therapy (CBT), which are well supported as an effective method for treating anxiety and depression. Included strategies are for example model learning, exposure, reinforcement principles and relaxation techniques. Parents practice these coping strategies both alone and with their children, through participation in group exercises and homework suggestions.

In CBT for depression, the first symptom reduction is achieved through behavior observation and planning of positive activities. Once this first goal is attained, further work is directed towards replacing maladaptive and negative thought patterns. CBT on anxiety focuses on correcting misinterpretations of cues in situations and bodily symptoms as signaling danger. A realistic reinterpretation also enables the patient to challenge his or her avoidance behaviors.Method
"Clever parents" is in its early stages. A pilot study has been run, involving three parents (mothers) and having a simple one group-pre test-post test design.

Sample
Inclusions criteria for parents were 1) having a child referred to a child mental health clinic aged 7 to 15 years and 2) this child having an anxiety (separation anxiety, generalized anxiety, social phobia, specific phobia, OCD, PTSD, panic disorder) or depressive (MDD, dysthymia) disorder.

The sample started up with four mothers aged 38-55 (M = 38.5, SD = 7.85), of which all had several children. Due to lack of time, one mother withdrew from the program after two meetings. Results thus refer to the three mothers who completed the program.

Instruments
The *Content evaluation questionnaire* was developed specifically for the program, to evaluate parent´s satisfaction with specific content components as well as the program as a whole.

The *Questionnaire for evaluation of the Group* is an adaption of the Norwegian Questionnaire for evaluation of the treatment – for both patient and therapist (SBB-P, SBB-T) (Neumer, 2002). SBB is an instrument developed to evaluate psychiatric and psychotherapeutic treatments, which has good psychometric properties. In the adapted versions of SBB used in this study, participating parents and the group leader assess group quality, progress and results of the program.

An unstructured group interview was done after the program was completed, and inquired about the user satisfaction of the parents with both the psycho-educational and the self-help group part of the program.

The evaluation of supervision and manual by the group leader was assessed through an unstructured interview as well.

A *knowledge test* was developed and conducted before and after the program in order to assess the parents' increase in knowledge. The test consisted of questions about anxiety and depression as well as other essential information the parents received during the program.

The *Depression, anxiety and stress scale (DASS)* (Lovibond and Lovibond, 1995) is a self-report form for symptoms of depression, anxiety and stress in adults. It consists of 42 items and has good psychometric properties. DASS was administered before and after the program to assess the change in parent´s psychopathology.

Resilience Scale (Wagnhild & Young, 1993) is a 25-item self-report form used to examine parents' individual resources and coping in difficult life-situations before and after the program. It correlates with other positive measures such as the Life Satisfaction Index (LSI).

Procedures
Participants were recruited from two child mental health clinics: BUPA Tønsberg and BUPA Holmestrand. All parents in the target population were invited to participate. The group leader was a trained professional from one of the clinics who went through two days of training in the CLEVER PARENTS program, as well as supervision in the use of the manual ahead of every meeting. The knowledge test, DASS and the Resilience Scale were completed at the beginning of the first meeting. The Content evaluation form was completed after the 2nd, 4th and 6th meeting. After completing the psycho-educational section (in the 7th meeting), DASS, knowledge quiz and resilience scale were again answered. At this point, the Questionnaire for evaluation of the group was also completed. After completion of the program, in the 12th meeting, the group interview of the parents and the group leader's evaluation of supervision and manual were conducted.

Results

Psycho-educational part
Knowledge. The parents' performance on the knowledge test increased from an average of 20 points to an average of 39 points from before to after the psycho-educational part. As the test has a maximum score of 55, this average 19 (16-22) point increase constitutes a knowledge increase of 35 percentage points, from 36% to 71% correct answers.

Evaluation of the psycho-educational part as a whole and its specific content. The SBB uses a scale from 0 (not good) to 4 (very good). Table 1 gives an overview of the parents' evaluation, which was overall very good.

Table 1: parents' appraisal of the psychoeducational part

Evaluation of the psychoeducational part as a whole	Relation to group leader	Framework and conditions	Sucess of the group	Own progress	Progess in family relation
3,5	3,8	3,5	3,1	3,2	2,3
Very good	Good- very good	Good- very good	Predominantly sucessfull (notable progress)	Predominantly sucessfull	Somewhat sucessfull (some progress)

The parents' evaluation of the psycho-educational part as a whole was very good, and the framework conditions and relation to the group leader quite good. Parents further indicated that the information about anxiety, depression and the role of the parent was interesting and helpful, and that the program was useful on a personal level. Of particular interest is a comment from one of the mothers emphasizing the usefulness of the psycho-education for coping with difficult situations with the children. The parents would recommend the program to others because "it is good to meet others in the same situation, who understand my experiences" and "one must work with one self and one's self insight to achieve progress".

Parents' psychopathology
Parents reported somewhat elevated level of psychopathology at the start of the program compared to normative samples of the normal adult population. Following the clinical thresholds as recommended in the DASS manual, one mother reports depression (moderate), two report stress (mild, moderate) and two anxiety (mild, severe) (see Figure 1).

Figure 1: Change in parents' psychopathology before (grey) and after (white) the program

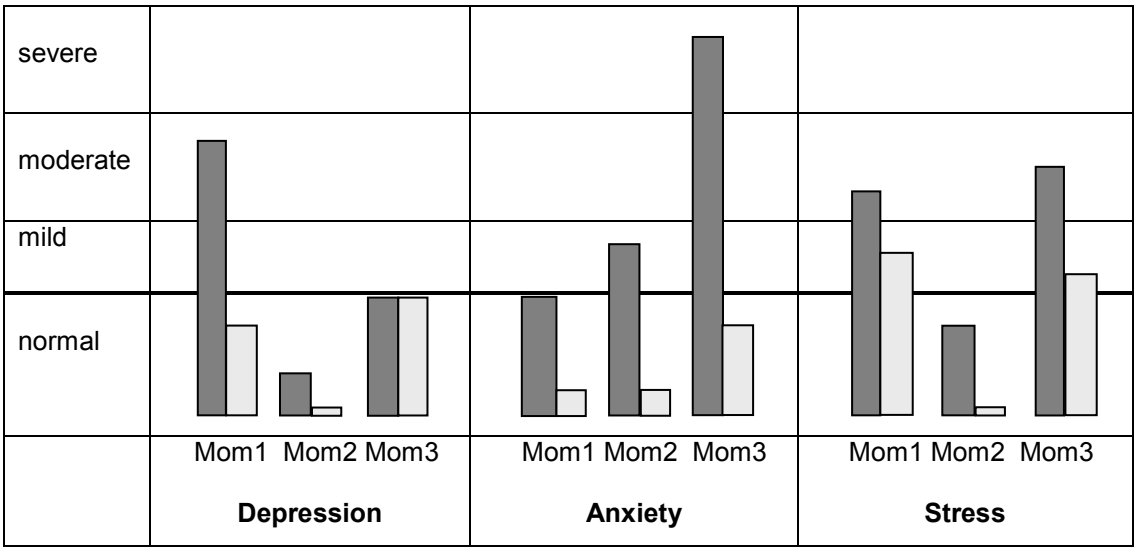

Figure 1 shows the change in parents' psychopathology throughout the program. It is worth noting that despite elevated levels of psychopathology before the program, all parents reported normal levels of psychopathology after completing the program. The statistical significance of this change was tested using the Reliable Change Index (RCI) from Jacobson and Truax (1991), which includes the measure's reliability in the formula. RCIs of 1.96 or more indicate statistical significance, with positive numbers indicating symptom increase and negative numbers symptom reduction.

Table 2: RCI for the individual scales of DASS (anxiety, depression and stress)

Person	**Depression**	**Anxiety**	**Stress**
1	**-4.76***	-1.49	-1.73
2	-0.95	**-2.23***	**-2.16***
3	0.48	**-4.09***	**-2.16***
group	-1.75	**-2.61***	**-2.01***

**= RCI ≥ 1.96*

Table 2 shows a statistically significant symptom reduction in anxiety and stress after completed program, according to parents' self-reports. As for depression, the mother who scored at moderate levels on this scale before the program also reported significant symptom reduction.

Parents' resilience was examined similar to the DASS and changes tested for statistical significance using RCI. No significant changes were found.

Parents' satisfaction. The parents' expressed satisfaction with the psycho-educational part of the program both in the self-report measures (Content evaluation form) and in the interview. They emphasized the utility and value of receiving empirically informed knowledge as well as tangible, practical advice for each individual parent in a small group. They further expressed satisfaction with the self-help group section, emphasizing the benefits of meeting parents of children encountering the same difficulties and challenges as their own. They all agreed that "more parents should be offered the opportunity to participate in a program like this."

Discussion

The program was operationally deliverable. Parents and group leaders were satisfied with the content of the program and the parents' knowledge increased. Parents' knowledge about anxiety and depression increased, on average, from 36% to 71% correct answers during the psycho-educative part of the program. This implies that all three parents doubled their knowledge on these topics. Considering that two out of three parents had attended previous meetings aimed at involving parents in their child's treatment, this is a remarkable result.

Parents' report of own stress, anxiety and depression symptoms decreased. Parents reported significantly fewer symptoms on all three scales. This suggests that the parents had a personal benefit of participating in the Clever Parents program. By learning strategies for coping with their own stress, anxiousness and sadness, the parents may have become better equipped to help their children do the same.

Limitations
Being a pilot study, there are of course a number of limitations and threats to the external and internal validity of the results. First, due to the small number of participants it is difficult to generalize the findings. A further study with a larger number of participants and a control group is therefore needed to gain more confidence that the positive results are indeed caused by the programme. Second, two of the authors were directly involved in the training and supervision of the group leader, and are thus invested in the programme. However, in other adaptions of the programme, similar positive results have been found. Finally, the question of whether and how much the children benefited from the programme remains unanswered. Future studies should therefore involve assessment of the children parallel to the CLEVER PARENTS programme. In particular, a study comparing groups of children receiving or not receiving the CLEVER PARENTS programme in addition to otherwise identical treamtment should be implemented.

Clinical implications
Beyond the above-mentioned question of the childrens' benefits of CLEVER PARENTS, the positive effect observed on the parents is an achievement in itself. This is especially true for this target group, as we know that parents of children with anxiety and depression often suffer from similar problems themselves.

The parents participating in this study clearly benefited from it. The short duration of the group leader training, the opportunity for one clinician to reach several parents at once and the fact that the parents run the second half of the programme themselves, makes CLEVER PARENTS an efficient and cost-effective alternative to current practices in family centers and outpatient clinics. The use of workbooks for the parents and a manual for the group leader assures the treatment integrity and guarantees that all participating parents get the same knowledge and training with the help of exercises and lectures. The duration of this parental program (12 hours) is compatible with existing treatment programs for children with anxiety (Kendall, Martinsen & Neumer, 2006) and should therefore be straightforward to combine

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The Family Service Center in the multicultural suburb – an appropriate health and social care for the poorest refugee families

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& Marcela Puga, Vårby Family Centre, Sweden

The Family Service Center – prevention on double organizational feet
This seminar is about health care and social work with refugee families with the youngest children, and during pregnancy, at a *Family Service Center* operated by the social services and health care in a preventive collaboration.
The center is located to one of the big multicultural areas south of Stockholm. With the world wide refugee situation, with a harder attitude against foreigners and continuously harder criteria to get a residence permit, we see a growing amount of families with small children who live without identification documents, or "paperless refugees" as they are called in Sweden.

The refugees without papers – a new and growing group among the poorest
Before becoming "paperless" the family has been asylum seekers in a long legal process, sometimes up to five years. We have children who have lived in the asylum process from birth to their school start. So when these families get their last decision from the migration authorities, deportation becomes a real threat and they change to a life of hiding, their mental status is very bad. This transition makes the children´s ordinary life even more different from that of other children in the community. These families are the poorest in Sweden today and it is mainly in the multicultural suburbs where they try to survive, hiding from executing their deportation.
This group of refugees without identification documents is growing in several European countries and in everywhere there seems to be a hope that they will move on. A growing part of the group is unaccompanied children.
Probably the refugee children without documents, with or without parents present, will increase in Sweden. The country has an earlier tradition of receiving a great number of people in ethnic and political trouble. And the expectations on Sweden to offer a good life have been widely spread for a long time.
Until the problem with these refugees whose settlement no country accept is solved in a political level, we need to develop care and support in the local community. The local employees in the service for children have to develop their professional role to meet the needs of these children – medical, social, pedagogical.

Family Service Center – appropriate in the multicultural suburb
Both studies and proven experience show that the Family Service Center (FSC) is an appropriate form for preventive health and social care in the multicultural area (Lundström Mattsson, 2004). The interdisciplinary collaboration between four kinds of professionals. the midwife, the pediatric nurse, the social worker and the preschool teachers in the open preschool work together as a team, with a holistic view on the families. Situated under the same roof, in a house in the center of the suburb is an adequate organization of the care for the marginalized family. The professionals can refer to each other when a family needs more specialized help. This intern referral, followed by continuous collaboration over as long period as is needed, we call *linking.* Linking is the special power of the FSC and crucial in the sense of safety and support of the family with extensive needs.

A study was conducted at this Family Service Center in a suburb south of Stockholm with about 10000 inhabitants, 1000 are children 0-5 years old and 250 women are pregnant. Very few persons are born and grew up in Sweden by Swedish parents. The target group of the study were families with small children, and couples expecting a baby, who were in contact with the two social workers of the center during the first half of 2010. The study is a summary of the life situation for the 85 families and a description of the support they were offered. The summary showed that 20 of them were families in a long asylum process or without documents after such a process. It also showed that most of the families live with mental problems descendent from a life in exile.

The initiative to the study of the social family work at the center was taken by the staff team at the FSC, inviting their Research & Development Unit to talk about evaluation, with special focus on the

social work of the center. Their motive was that the staff felt more and more invisible in their efforts to help and support the families who are most excluded in relation to the ethnic majority society.

Life and work in the multicultural suburb

With the ongoing refugee immigration in the multicultural area the densification of personal experiences of war and persecution gives the neighborhood a special atmosphere. It creates a sense of belonging around the notion that "we are those who lost everything and must start over." But no truth without the reverse is equally true. Although feelings of “we and them” exist towards Swedes, "they" can also be neighbors belonging to an oppressive religion, or ethnic group, in the home country who also are refugees in this western country. In the multicultural suburb contradictions are the usual. Unemployment is high, but the examples of success in working life are parallel. The traumatic experience can become a long-term disability, as well as it might not interfere so much with the everyday life. Some people are severely affected by structural racism, while others never notice such barriers.

In a parallel to the growing negativism against people of foreign origin the interest for cultural perspectives, trauma perspective, multilingualism issues and other migration-related topics is reduced. Immigration is transformed into a problem for the receiving society. The declining interest in the issue of migration, exile and ethnic relations results in less resources in the work on these issues, at all levels, within administration as well as health and social care as well as education. Migration is no longer a knowledge-and experience-based specialty.

What happens to the staff in health and social services in the multicultural suburb, viewed in the light of this development? The *integration policy* replaced during the 90s the earlier *immigration policy* with equality, personal choice and cultural collaboration as goals. But the integration policy has overlooked migration and trauma experiences as implications for future life in a new country. Everyone shall be treated equally and the standard of this treatment do not involve reflection over and support in migration-related problems. This means that staff with ambition in the multicultural suburbs fights an uphill battle. When they report that their clients, the refugee families, do not get a good service, the perception of these people as a problem in the community increases. The refugee parent is criticized for not living up to the requirements of a Swedish citizen. In this era of globalization, quite contradictory, “the Swedish way” is the standard. To make the migrant responsible for his or her problems justifies the migration-related resource allocation.

Marginalization of refugee families - and of the staff who works with them?

Decreased interest in work with refugees, with cultural encounters and with traumatized children and their parents also results in a growing acceptance of negative attitudes towards the staff that represent this work. It seems as the staff in health and social care become marginalized, in society as well as in their organization, in a parallel process with their clients, the refugee families. This marginalization is reinforced by the segregated settlements, the people who work with refugees are concentrated to the multicultural areas and they are few in every profession. They are a well defined group in a certain place. The issue of the lost status of social and psychotherapeutic work with refugees was also on the conference program at the Red Cross Center for Tortured Refugees in Stockholm, held in September 2010 in connection with the 20th anniversary of the centre. Participants in the conference were staff with duties relating to rehabilitation of torture and war injured people.

The method of the study – an interaction between practice and research

In an agreement between the staff of the Family Service Center and our Research Center we decided to map the families who had contact with the social workers of the center during the spring 2010. This mapping gives, at the same time, a picture of the social worker´s task in the center.

The material of the study has been constructed in a dialogue between the two social workers and the researcher. It consists of a story about the work with each family. The story told by the staff is reported in a document for every family, with focus on the following aspects of family life reported:

- factual information about the family (children´s age, origin country, migration year etc.),
- motive for seeking help from a social worker,
- type of support offered and given,
- collaboration between the professionals in the FSC around the family (linking),
- referrals to other care and treatment not possible to offer in the FSC.

In continuous meetings we worked together, social workers and researcher, with the analysis of the material, as well as with the report.

The researcher did the writing and continuously left the text to the practitioners for comments. The whole staff group at the FSC had also the possibility to comment the report in its different versions of the writing process, during the monthly staff conference.

Interactive method in a collaboration between field worker and researcher is a special trademark in evaluation and other studies in our research unit. The research center is own by nine communities south of Stockholm and is associated to the academy with a contract (with an institution for social work at the university). This evaluation project in the Family Service Center became a good example of mutual learning between practice and research, which is the aim of this type of collaborative research method (Jason et. al., 2002).

In a complementary collection of material for the study one of the social workers interviewed midwifes and nurses in prenatal care and child health care in other multicultural suburbs. This medical staff don´t work within the frame of a Family Service Center. We were interested in comparing the social support to families with and without this organizational frame.

The research questions
When the staff of the FSC wants a systematic documentation of their work, they intend to use it in the communication with their superiors. But they also want to use it in their own professional development. They were especially anxious to get more knowledge about:

1 / Linking - a special form of referral
In a first systematization of the work in the FSC we decided to illustrate the collaboration between the professionals, to illustrate the *linking* in the material. We wanted to paint a picture of the internal linking *to the social workers from the other professionals of the center*.

2 / The families not linked to social services from the other professionals, how do they find the social worker?
The families who seek help directly from the social worker, did they differ in some respect from those whose problems are discovered in the medical or pedagogical arena of the center?

3 / Collaboration between health care and social services without the FSC frame in a comparison
How are the possibilities to refer refugee families to support and treatment outside the own organization when you don´t have a FSC?

4 / The multicultural suburb – life conditions promoting child poverty?
The national statistics for Sweden shows, year after year, that the material resources of families in the multicultural suburb are less than those of families in other neighborhoods. To wait for a residence permit for a long time increases poverty.
In the family material of this study the poverty was more a rule than an exception. One question in the study was to investigate the meaning of poverty for the everyday life of a child.

Results

Only 3 of the 85 families in the study were Swedish. That makes the social worker´s profession a special one compared with the conditions of colleagues in areas with a Swedish population. The social worker´s profession in the multicultural area is *international social work*, but in a Swedish context.

Linking in the Family Service Center

There was an idea among the staff about differences between linked and not linked families seeking support from the social worker. But the results showed that most of them were linked, in fact. Those who now came on their own initiative had had a social worker contact some years ago. This means that the problem picture of the families was the same between the linked and not linked. Instead it focus linking as possibility to reach the marginalized families in preventive work.

More interesting was that the midwives were the most frequent ”linkers”, meaning that the a family with need of social support in parenthood is usually found as early as during the pregnancy. It also means

that midwives working in the FSC are good in outreach. Because we can also see that the linkage activity is high from the pre-natal care, about 70 % of the pregnant women are linked to the social worker. So the FSC is an excellent frame for conducting preventive social work with the youngest – however, we shall see, this opportunity is not caught in flight. If the midwife don´t discover the need for help in a family, there are more chances after the childbirth, to be linked to the social worker by the child nurse or the educator.

The migration and asylum related problem picture
Many of the families in the health care are linked to the social worker. From the material we can see that many of these families also have a *long* contact with the social worker, 4-5 years is not unusual. The analysis shows that they are big families with many children. Both parents and children are affected by severe problems that threaten their mental health.

20 of the families who met the social worker in the FSC during this study had problems with their residential permit. But half of the 85 families show other migration and asylum related problems that affect their competence as parents. Most often these problems are existential. You have severe difficulties finding a meaning in your life in exile.

Difficulties to attend to the children and their needs always follow problems in the world of the parents. Elena is a good example of a mother whose parenthood is severely affected by migration related factors:

Elena is a single mother from a country in the former Soviet Union. She has two children, a boy of 7 and a girl of 3 years, both born in Sweden. Elena has no contact with the children's father. She was linked to the social worker of the FSC 5 years ago when she felt depressed due to a long-term asylum seeking period. The whole family's health has been affected by the life situation of being a constant asylum seeker and the health care contacts are many. The social worker helps Elena

- *with an long-term individual contact,*
- *with her health care contacts in different receptions and hospitals for herself and for the children,*
- *with contact with the immigration authority,*
- *with a place in the day nursery for her son,*
- *with contact with the social services that handle money, etc.*

In addition, Elena has been linked to the child health care and to the open preschool in the FSC. When this mother gets her residential permit she has waited for it for 7 years.

Relation problems between the parents
Relation problems between the parents is, in this material, as common as migration related problems. Most often the two kinds of problems exist in the same families. A development of violent behavior is also a common pattern. After some years many of the couples are divorced. Not many marriages survive a more than 5 year asylum seeking process. An underground life is also disastrous for the family life.
A typical family with relation problems between the parents is the following:

Isra has in previous marriage two boys aged 10 and 7. With her current husband who is, as Isra herself, from a country in West Asia, she has two boys, one is 1 year old and the other a baby of a few months. During the first pregnancy 10 years ago the midwife linked Isra to the social worker at the FSC. The midwife was concerned about this mother's health and relation with the (first) husband, who Isra described as violent. The contact between Isra and the social worker lasted for 7 years.
After some time the educator at the open preschool linked Isra to a social worker again. The educator assessed a need for child psychiatric treatment for one of the older boys. But Isra herself is more concerned of her newborn baby who cries a lot. When she wants to stop breastfeeding, now pregnant again, the staff at the FSC is worried about her coping with the child to come. During her pregnancy with child number 4, she also divorces her husband in a quite dramatic separation.

This second period of contact with the social worker at the FSC lasts about two years with a lot of support. It closes with the family moving to another area and Isra gets a new social worker at a new FSC.

Referrals to other institutions for support and treatment
The social worker of the FSC is above all a family relation specialist. Her primary task is to work with communication between parent and child during the first years of life. But most of the families here described show a multiproblematic picture and demand a flexible here-and-now-focus, meaning to start with the support what the family expresses. If the need for support don´t fit her qualifications the social worker use own consultation or external referral of the family to an institution with this competence. Some examples of referrals:

- To a physician, a psychiatrist or a counselor for the mother or father in the medical center in the neighborhood
- To the day nursery organization when a child need nursery care, or when a child is not doing well in the nursery group
- To the Child Welfare Unit for investigation of children at risk, with respect to the child´s risk of harm
- To Women´s Team when there is violence in the family
- To a treatment program for children who have experienced domestic violence
- To family counseling
- To the adult education in the neighborhood especially for mothers without school attendance because of war during their childhood
- To a program for mother-child-attachment if the open pre-school is not able to offer that for the moment

But mostly the social worker has to rely on her own competence and the resources in the FSC.

Collaboration between health care and social services without the Family Service Center frame: a comparison
Because limited resources often make it impossible to offer families help outside the FSC, the staff found it interesting to compare their own linking with the referral pattern from health care for mothers and babies when there doesn´t exist a FSC. One of the social workers interviewed midwives and pediatric nurses in 5 different health care centers in other multicultural suburbs.
The informants mainly report about coordination problems when they describe their collaboration with resources for the families in their neighborhoods:

- Midwives and pediatric nurses have problems to meet and transmit complicated cases between them
- There is a problem to motivate the families to seek psychosocial support when they have to go to another reception
- To refer parent or child to a psychiatric clinic is even more difficult
- In all types of collaboration that is available for the midwives and nurses, the competence in social work is missing, social workers are a scarce

Maternal and child health care is traditionally effective arenas for prevention in Sweden because you reach all families there. The interviews with the health care staff tell that referral is random, low in number and do not exist in a follow-up cooperation between professionals when the FSC frame is missing. The interdisciplinary perspective is missing.

The family who need psychosocial support at the Family Service Center in the multicultural area - example of child poverty
The Save the Children report on child poverty in Sweden (2010) defines three groups of children as particularly vulnerable and not included in the "general welfare development":
• Children with a foreign background
• Children in large cities
• Children of single mothers

As a complement to the report, Salonen (2011) studied the degree to which the Swedish family policy compensate families for growing economic weakness in recent years. His conclusion is that family policy "shows a continued decline of poverty-fighting capability" (page 11).

The children presented in this study often belong to all three of these categories above: they have roots in another culture than the Swedish, and they live in a big city and their parents are often separated. Many of the children can be described as completely indigent, given that the multicultural suburb accommodate many of the families called undocumented. They have, in an educated guess, our society's lowest income.

What does it mean to be poor? – Loss of protection

In the western society we often describe the poor child as one that cannot participate in activities. Not being able to participate in school excursions is perhaps the classic example. The feeling about being poor is shame.

But to be poor means so much more. A poor child lives with poor parents, and are therefore also exposed to the adult poverty.

More serious for the child is probably the vulnerability of the poor parent, that makes the child experience a lack of adult protection. Summing up “parent poverty” from the family reports of the staff at the FSC shows a problem picture that illustrates the lack of protection of the child:

- A low-cost housing can be found by generous neighbors, countrymen, etc. But you can not be sure that their kindness last. If not, you stand in the street with the children in a moment.
- You hope to be invited to friends or countrymen for a meal when you have no food.
- Visits to friends and countrymen are also important because it gives the children a chance to play - at home there are no toys and no playmates can be let in.
- The relations of the family become very strained, both between the parents and parents and child. Family violence is not rare.
- The poor parent is prone to join a new partner very fast when the old relationship ends. This means a high risk of falling into a new unhappy relationship, with serious difficulties for the children.
- The poor parent is depressed and frustrated, conditions that intervene with the need of closeness of the small child.
- The risk of becoming involved in crime is higher if you are poor. To steal a chicken is tempting when the children are hungry.

To be extremely poor is to miss space for choices. You are dependent on the goodwill of others, or of their arbitrariness. In this situation the child feel that their parents have lost their protective power.

To be poor in a rich country is something special. These poor children are described as if they have given up, quiet and docile. One interpretation is that they try not to disturb their depressed parents, not to be a heavier burden that they already think they are. For the youngest it is close at hand to relate to the concept of "failure to thrive" when the child gives up all contact attempts.

Conclusions of the study

Mental health prevention for the youngest

In an international overview the Swedish child psychiatrist Marianne Cederblad (2003) refers to some major studies, own and others, of children's mental health and what may be considered as risk factors in the living conditions. Perhaps less common is to try to identify the health factors, the circumstances that promote child health and development. Good enough relations in the family is of cause the most important factor for developing mental health. The protective factors outside the family that Cederblad (2003) identified are presented below. For families excluded from many social settings, for example as newly arrived refugees, the preventive activities of the FSC at least for a period, replace the natural social context that the family just left in the home country.

Protective factors outside the family:

- Much attention during the first year
- Other carers in addition to the mother
- Mother / grandparents involved in the care
- Friends and neighbors provide emotional support
- Teachers and / or the priest gives advice and support
- Appreciation Community - sense of coherence
- Close friends
- Medical and social services and education

Co-ordinated and co-located service in the Family Service Center – best practice today

In another interview study (Asker & Gessler Doberhof, 2005) the staff of the FSC talked, in a focus group, about working methods and organization of the FSC. One employee is quoted: "We are proud of our Family Service Center. We are very proud of the cooperation that functions so well, and we have developed it ourselves."
This cooperation between the prenatal care, the child health care, the open preschool and the social services, is more than the sum of its parts.

The FSC organization of health care and social services is a possibility to give some support to the most marginalized families in the multicultural suburb. The explanation is probably its *availibility* in different aspects:

- its *geographical* availability. FSC is situated where the families live.
- its availability in *time*. The policy is to have an open reception.
- its availability in *service.* The policy is to give the support that the family ask for here and now.
- its availability through *linking*. An interdisciplinary service exist in the FSC itself.

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Developing Swedish Family Centres – A Case Study 2010-2012

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Abstract

Thirty Swedish Family Centers' (Familjecentraler) staff in 2010 participated in a combined educational and action research project initiated by the *Swedish Association to Promote Family Centres* (FFFF) and financed by the *Swedish National Institute of Public Health* (Folkhälsoinstitutet). The project reaching 119 persons were focused on the Family Centers' team skills. The project was continued 2011-2012 reaching in total app. 60 Family Centers' coordinators. The project shows that the teamwork at the Family Centers gain from the team members who show substantial interest for their work with family and health related questions. The activities also gain from the open and rich communication in the team. Organizational and structural prerequisites like e.g. unclear or weak resources and mandate are obstacles for the health promotion efforts directed to small children and their families, a result also confirmed in the previous few studies. Conclusively, the Family Centers seem to demand a clearer priority from the stake holders to achieve their mission to a larger extent. As a kind of wrap-up, a developmental report was written by the responsible researcher, a report now in use and asked for at many Family Centers as a step towards effective teamwork. The report conclusively gives a hint of relevant developmental efforts in order to make the family centres a strong actor in public health work. The findings from this project can tentatively be discussed in terms of e.g. the role of the coordinator, the priority from the different stakeholders at the Family Centers, the prerequisites needed for effective teamwork at the Family Centers and the need for further education, evaluation and research in the field of Family Centers.

Introduction

"If social scientists really want to understand phenomena in society, they should try to change them. To create a new reality instead of theoretical hypothesis is really to validate – to change by action." (Kurt Lewin)

The project *Family Centres and Hazardous Use of Alcohol* was implemented 2009-2010 by the Swedish Association to Promote Family Centres with the support from The Risky Drinking Project run by the Swedish National Institute of Public Health. During 2010 the project was implemented as education combined with action research. The focus was team efficiency as a formal aspect with hazardous use of alcohol as the subject and content for the teamwork. Some thirty Family Centers with 119 employees from three county councils in Sweden took part of this project. In 2011-2012 the project was extended to sixty Family Centre coordinators from all over Sweden. This report describes the 2010 situation but it has later been shown relevant also for the 2011-2012 education.
The aim with the project was described as: *To strengthen society's efforts to prevent and diminish the hazardous use of alcohol and tobacco with the focus on parents of children age 0-5 years old, by the help of the Family Centers.*

Today, there is a trend towards collaboration between institutions. "Collaboration" and "cooperation" are kind of magic words, not in the least in the Swedish welfare sector[6]. Even if specialization and a clear distinction between professionals seems to be a driving force behind knowledge development, better competence and care[7], there is an obvious risk of narrow mindedness and a lack of holistic perspective.

[6] Hörnemalm (2008, s. 1)
[7] Nylén (2009, s. 75)

The Family Centre has the ambition to bring professional actors from the social service, the preschool, the child and mother care and sometimes the church together. This creates a multiprofessional field. The *National Board of Health and Welfare* (Socialstyrelsen) has the opinion that Family Centers promote children's' and parents' health[8]. In the agency's evaluation from 2008 this board concludes that 90% of the Family Centers generally work as service institutions, while 10% work with more specific problems. The Family Centers seem to be a Scandinavian phenomenon even though Children's' Centre in Great Britain have some similarities due to the common localization of different kinds of social and health service.
Research on Family Centers is rare, due to the fact that it's a new phenomenon and the lack of research resources. It's also a tricky thing to measure preventive efforts. Evaluations show a general positive picture of Family Centers, but also the lack of effects upon the health of the visitors and cost effectiveness (Kekkonen et al. 2011 p. 113). Evaluations have mostly taken as departure a description of how well the Family Centers' have reached the goal of common localization of different kinds of health and social service. Success is based on the number of professional partners at the Family Centers. A small-scale evaluation from Scotland (2009, s. 56)[9] could be considered as typical:

This relatively small-scale evaluation cannot make categorical claims about outcomes for parents and children as a result of the parenting programs run in Langlees Family Centre. However, the views of staff, other professionals and parents were overwhelmingly positive about the ethos, working relationships and support one offer in the Family Centre. These views were supported by direct observations of the staff using their considerable inter-personal skills in the three programs. Overall, the evidence from the study reinforces the importance of the quality of working relationships and indicates that it is not only what staff does with parents that matters, but how they do it.

A Family Centre is a place with different kinds of norm systems or professional logics (Nylén 2009). Due to the organizational logic, the professionals work in accordance with the expectations from the organization paying wages, due to the professional logic the professionals are true to their professional identity and due to the team logic, the professionals try to work for the best of the team at the Family Centre.

The team is an organizational solution with a limited number of actors in which collaboration between different professionals creates functional synergy including a goal direction that goes beyond what other collaborative efforts could give. The team has the capacity of solving difficult problems and to support each team member. The team is a non-hierarchical arena that integrates professional competencies in a democratic way using and creating flexibility, context adjustment and new perspectives in a positive working climate strengthening the team members' wellbeing and health. Efficiency, productivity and development of the individuals as well as of the organization signify the teamwork (Berlin, Carlström & Sandberg 2009 s. 267f).

Methods

The basic idea in this project was to map out and analyze the obstacles and facilitating factors in the Family Centers teamwork with hazardous use of alcohol. In this way the project is clearly oriented to *actions* that might *improve* the work at the Family Centers. To make it possible to contextualize the obstacles and the facilitating factors, it was necessary to also focus on the mission and the result of the Family Centers work. During 2010 119 team members from app. 30 Family Centers took part of the education/action research project. Out of this number 36 had but one day of education, whilst the others had two, three or four days depending on the amount of time that could be used for the education. Out of this number of 119 professionals 27 were Family Center coordinators, 22 pediatric nurses, 21 preschool teachers, 20 midwifes, 7 school managers, 5 social workers, 5 managers in social service, 5 managers in primary care, 1 family pedagogue, 1 social pedagogue, 1 priest, 1 nursing child assistant, 1 assistant nurse, 1 psychologist and 1 physician. The working hour at the Family Centers stretched from almost no time at all, but still formally affiliated, to full time, with a

[8] Socialstyrelsen (2008)

[9] Scottish Executive's national program for improving mental health and well-being & Aberlour Child Care Trust (2009)

median of two hours and a mean of six hours. This means a small amount of time for many professionals and a large amount of time for a few professionals at the Family Centers.
The implementation of the days with education and action research was a mix of questions about hazardous use of alcohol on one side and collaboration, cooperation and teamwork on the other side. There was also a mix of lectures and workshops. For those that had more than one day of education, questions and challenges had been brought back home and were made up to some kind of "homework". The result of this "homework" was brought back to the next training opportunity and thereby energizing the ongoing education and making it even more useful in practice. In the workshops, the professionals were mixed in different ways to create a fruitful exchange of ideas and knowledge.

A fundamental idea with this kind of educational work is that the professionals have a basic knowledge about their own work and how collaboration and cooperation are implemented at their work. Added to this, current research was presented during the lectures in a kind of "discussion seminars" to challenge the existing experiences. This process created new tools for the teamwork with hazardous use of alcohol as the "catalytic content".

The educational strategy, inspired as it was from action research, also supported the creation of new perspectives and knowledge based on previous experiences, discussions, reflections and facts. This can be described in "steps" moving from a *naïve stage* to a *discussed stage* to a *developed stage*, a kind of development also anchored in educational research.[10] The move from one stage to another can be described with the example *communication*, that initially (the "naïve" phase) generally was viewed as personal qualities but in the "discussed" and "developed" phase generally more was formulated as a structural question – which has no implication for what is the "truth"; the perspectives/phases exist side by side simultaneously. The contextualization of facts, both facts presented in the lectures and from the staff's experiences, created a development from the naïve stage to the developed stage.

Results

The results reported as "Stages of knowledge" comes from the education of 45 team members from 9 Family Centers divided in two separate trainings (20 and 25 team members from 4 respectively 5 different Family Centers). These team members had a two-days schooling followed by one or two days of follow up. The other 74 team members had not the possibility to schedule their education in this way, but the result from the education of these 74 do not in any way contradict what was found for these reported 45 team members. The concept of *qualitatively defined units* was used in the education as a way to describe (Sandberg 2006, s. 41; 2009, s. 198):

- Conditions with heavy impact on the teamwork
- Conditions possible to change
- Conditions possible to measure/judge both before and after a change
- Conditions possible for all the team members to communicate in a meaningful way; we all know what we are talking about

The naive stage
Data from the beginning of day 1 in the education show that *the meaning of teamwork* was considered as a way to make work more efficient by being more accessible for the parents, creating trust between the family and the team and as a way to develop a common perspective. Teamwork was also considered to make personal development possible. Teamwork as a way of being more efficient was e.g. expressed as a contribution to "lean production", e.g. bringing up different health aspects at the same time thereby using different competencies. The teamwork crossed professional borders when talking about alcohol, family abuse and wellbeing in the family. *Facilitating factors or obstacles* in the work at the Family Centre were both individual and organizational. Dominating organizational circumstances were the need for more time at the Family Centre, the need for an inspiring leadership and directing documents. Which professional groups that should work at the Family Centre and the individuals' collaborative competences were also considered important factors. The need for regular

[10] Cf Sandberg (2009)

meetings with every profession involved, a good communication within the team, clarity about the mission for the Family Centre and the emphasis of not being an authority were also mentioned as facilitating factors, more or less at hand. When it comes to the individual competencies, the interpersonal skills like using each other's competence, working in the same direction, supporting each other, having open discussions, being engaged and having an interest in developing the Family Centre were considered as important.

The discussed stage

Data from the end of the second day show an interest in reaching new families, refugees and immigrants and for that purpose there is a need for an asylum-nurse and description of the Family Centre in many languages. Once again, the need for more time at the Family Centre was emphasized. It was considered that the management of the organizations where the team members were employed needed to express their open support for the Family Centre and make that clear in documents and formal agreements. A need for exchanges of information and ideas between collaborative partners and politicians were expressed as well the need for systematic evaluations of the Family Centers.

Considering the basic values, there was a need for clarity about:

- The mission of the Family Centre
- In what way each one at the Family Centre was a part of this mission
- Which health related activities strengthen the family
- How efficiently handle the questions about alcohol and tobacco in relation to the families
- Which activities will bring the families multifunctional service
- The professionals' working roles at the Family Centre
- What to learn from the successful maternal care

The developed stage

Data at this stage were collected app. three month after the discussed stage at the third day of education. At this point, four of the teams reported:

1. The first team reported a positive development the last year, partly due to the education. This was really the first time the team could catch up with the idea of what a Family Centre is about and how a meaningful and efficient Family Centre could be built up.
2. The report from the second team was dominated by a description of a lack of management, but the team tried to work out their own management.
3. The third team was under hard pressure due to the threat of withdrawn economic resources from one of the stakeholders. The team members described the situation as "depressive". Five month after this third day of education the economic trouble was solved.
4. The fourth team described a situation in which it experienced a strong managerial support, explicit e.g. in the presence of the managers at the Family Centre's meeting. The team members could also use their working time to a great extent at the Family Centre. Problems could be solved.

The other five teams reported the third day of education the following:

1. The need for more time at the Family Centers to get to know each other and make the teamwork more "genuine".
2. A lack of enthusiasm from the mangers and a lack of a common way of reasoning from the managers.
3. The need for a higher degree of clarity of the Family Centers' mission.
4. The need for regular meetings, adequate information, common education and relevant working roles.
5. A special time to create a model for the work with alcohol and tobacco.
6. The need to develop the local activity plan.
7. The exchange of knowledge and experiences between the Family Centers.

Conclusively

Factors that facilitate good work on the Family Centers are generally individual and interpersonal skills. The professional and personal competencies generally seem to have positive values and the working climate is good. This means that it's simple to collaborate when the professionals really are at the Family Centre, they have a common idea of the mission and they are supported by the stakeholders/employers. In a certain case, structural prerequisites also support the work with common offices and other areas that are functional, enough time, formal supporting agreements between the stakeholders and managers taking part of the activities at the Family centre.

Individual qualities generally are never obstacle for the work at the Family Centers. The obstacles are entirely structural and organizational. In spite of a good will often expressed, the financial resources are too limited, in concrete terms a lack of time and sometimes a lack of a functional working place. Managerial issues are a huge problem for the Family Centers and along with this goes the uncertainty of working roles, schedules etc.

From the "naïve" to the "developed" stage, there is a slight but clear shift of attention from what is "close" to the team members, such as other individuals' personal skills, to the more "distant" but still heavily influencing factors of an organizational and structural, partly political, kind. Above all, the need for *more time* comes back over and over again. The participants of this education have evaluated the education and conclusively found it to be positive. In the cases where the value of the education is judged as less positive, the participants associate this with the fact that they as a group don't have reached the phase of being a team.

Discussion

Data from this study gives an impression of an organizational lack of clarity, a lack of management, a lack of evaluations and research support. The effects of the Family Centers are not evaluated in relation to their meaning for the health of small children and families with small children, a purpose emphasized as the real meaning with the Family Centers. The evaluations stick to the question whether the Family Centers succeed in bringing different professionals together from different organizations, which creates an indirect measure of success. It is "expected" that this coordination and interaction between these professionals will create "more than the sum of each activity" (Landstinget Sörmland, 2008, s. 6).

This lack of systematic evaluation or research support makes it plausible to think that the Family Centre will not have the capacity to go from one "ideal" to an arena where different stakeholders/employers with real power will create an arena will substantial resources, clear steering documents and management. The Family Centre remains *"theoretically correct"* but generally unrealized. To reach the "sustainable" stadium and not having to wait for "new money", a first step for the Family Centers would be to create an evaluative and research position. Nyberg (Stiftelsen Allmänna Barnhuset, 2008) touches a crucial question by pointing out that the Family Centers' work on a multiprofessional and multi-paradigmatic field. It's important for the Family Centers to create a "map" were social science, behavioral science and medical science can work hand in hand.

From a more problematic perspective, the question is whether it's possible at all to realize this *ideal* in some other way that relying on the engagement from fiery spirits. The conclusions drawn by Almqvist m.fl. (2008, s. 165, authors' translation) are in line with the result from this study:

An evaluation of the Family Centers in Gävleborg showed that collaboration in the daily work went well because of the professionals' competence and engagement, but that there were problems with management. … due to the management with the involvement of collaborating partners from different stakeholders with their own budget and goals. The realization of the family centre idea was done by the professionals….

The Family Centre is a female arena. In this study three men participated out of a total of 119. The environment at the Family Centre is predominately “feminine” in colors, furniture, journals etc. Does this exclude men?

The existence of the Family Centre and the creation of new Family Centers, in spite of heavy transactional costs, have probably got to do with the *collaborative trend*. Created as it is by several different stakeholders/employers with different professions and with the ambition to work in teams, there is also a risk of tensions between the stakeholders’ interest and priorities and the interest and priorities of the Family Centre. The tension between the professionals and the structure is very obvious.
Another tension lies in the direction the Family Centre has when it comes to being an arena for the everyday family and/or being an arena for the underprivileged. Do we have *real teams* on the Family Centers? Both yes and no. In an efficient team the team members meet regularly in a way that can lead to *functional synergy* (positive values that come from collaboration, cf. Sandberg 2010). This is largely not the case. Other necessary prerequisites in a good teamwork such as clear management, working roles and enough time to teamwork are not at hand either. What keep the Family Centers in some way “above the surface” is the competent and engaged professionals and the time for collaboration they anyway seem to take from time that really is not there.
On the basis of this project, a report in Swedish (Sandberg 2012) suggests long-term strategies, management and actions in order to develop the Family Centers.

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The Building Blocks of a Relationship

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Project in Finland
The Evangelical Lutheran Church of Finland is organizing a large project (2007-2015) to support relationship and marriage.
Executive Committee (the working group) of the project contained representatives from various churches, denominations and organizations, which are all involved in Marriage and Family ministry.

- International Lutheran Marriage Encounter in Finland
- Kansan Raamattuseura, National Bible Society
- Kataja ry,"Juniper" Association
- Pentecostal Church in Finland
- Seventh-day Adventist Church in Finland
- Young Men's Christian Association (YMCA) of Helsinki
- The Evangelical Free Church of Finland
- The Evangelical Lutheran Church in Finland
- The Finnish Bible Institute

Goals of the project
1. To promote love and loyalty
When love and loyalty are nurtured, well-being between couples, in families and in society is improved.

2. To increase Commitment
When people increase and deepen their mutual interaction in their marital relationships, emotional commitment will be strengthened and divorces are reduced

3. To get wider media coverage for the marital and family ministry
The positive publicity appearing in the media increases people's awareness of intimate relationship and makes it easier to care about their own relationship by participating in lectures, courses and camps.

4. To get more resources for marital and family ministry
Well-being of families is increasing, while the municipalities, organizations and congregations get financial and educational support to make proactive and preventative family work.

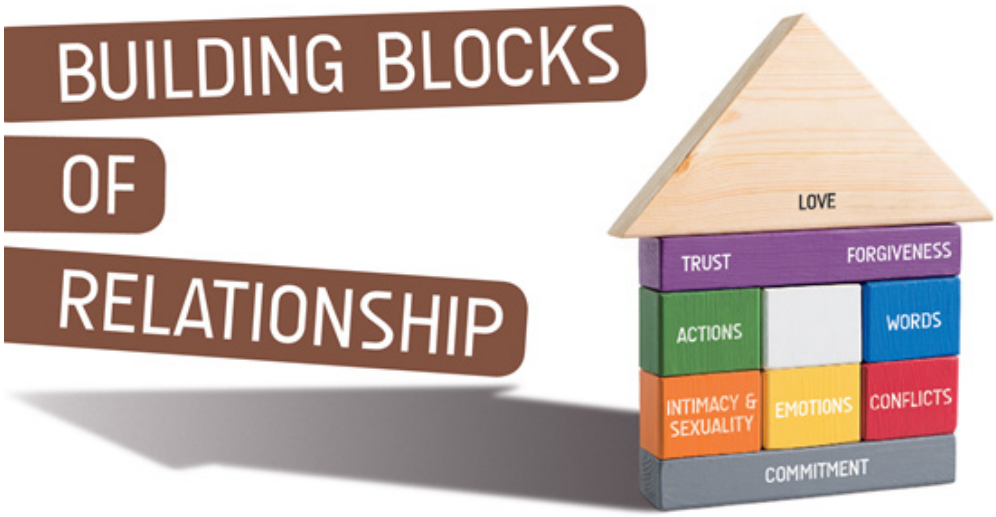
5. To get relationship skills for everyone in society
The basic interpersonal skills are possible to learn even before adulthood. Schools and educational curricula should include a long-term training of interpersonal skills with age appropriate learning goals.

Wooden house as a tool
Working group has developed a simple tool, a wooden block house named *The Building Blocks of a Relationship*. The house has nine blocks.

Basic Idea of the Building Blocks of a Relationship

The Building Blocks is a practical tool to make the different areas of a relationship visible. This helps people to have better understanding of relationships and thus makes it easier to discuss about them.

Figure 1: The working group has written on the card below an essential paragraph per each block.



COMMITMENT
Commitment is the willingness and a choice to stay together in a relationship. Marriage is a shelter, where one has time to grow.

EMOTIONS
A relationship activates whole range of emotions. Identifying and confiding feelings are the keys to a mutual understanding.

INTIMACY & SEXUALITY
Tenderness, passion and humour are important in a close relationship. Sexuality is a bodily hunger, a longing for closeness.

CONFLICTS
Conflicts are part of any couple's relationship. Confrontation offers a chance to develop a relationship.

WORDS
By speaking and listening, we learn more and wonder less about our partners. The deepest human needs are to be recognized, heard and loved.

ACTIONS
Everyday choices build or destroy love. Actions confirm the things a couple has agreed on and prevent from aimless drifting.

TRUST
Respect and loyalty are the base of a trusting partnership. Trust creates security and stability in a relationship.

FORGIVENESS
Misunderstandings and mistakes happen every day. It is difficult to maintain wellbeing without solving the issues that block the relationship. Asking forgiveness and receiving forgiveness cleans the atmosphere.

LOVE
Love feels like invisible strands between two people. It is as important to give love as receive it. Love requires care in order to be able to grow.

PARISUHTEEN PALIKAT

Functionality of the Building Blocks

- Building Blocks of a Relationship
- illustrates that the relationship is not a formless "chunk"
- makes visible how wide-ranging a relationship is
- gives names to the main areas of partnership
- helps examine the relationship from different perspectives
- makes visible how the elements of a relationship are interacting between each other.

Building Blocks as a tool for

- employees and volunteers of churches, municipalities and organizations
- lectures, lessons and small groups
- prenatal classes
- marriage/relationship courses
- marital counselling in clinics
- pre-marital counselling with couples before wedding
- family/couple therapy

The employee needs not to be therapist to use the block house.

Results

- the feedback from the users of the Building Blocks has been strongly favorable
- over 2500 employees of Churches, Municipalities and Organizations had taken part to basic education offered in different places in Finland
- over 50 person have taken part to educator training of the building blocks
- the versatile material linked in the Building Blocks has been very popular (some of our material is translated also in English, Swedish, French, Russian, Estonia and Arabic)

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Evaluation of a school-based alcohol intervention in Norway

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Abstract

The prevalence rate and problematic consequences of underage drinking warrant a comprehensive public health approach. Alcohol interventions are therefore an important priority within school-based prevention strategies where educators can reach large numbers of adolescents. The W8 [wait] project is an evaluation of a Norwegian school-based alcohol intervention program called Youth & Alcohol (Wilhelmsen, Laberg & Klepp, 1994). The program aims to prevent the use of alcohol, with a focus on adolescents' attitudes and behavior in relation to alcohol. The purpose of the present study was to assess the short term effect of selected variables among 8th grade pupils in Norway. A quasi-experimental design from 44 junior high schools was conducted involving a comparison group and an intervention group consisting of parents, adolescents and teachers.

Introduction

A range of interventions have been developed to prevent alcohol use among adolescents, and schools are an important setting for interventions where educators can reach large numbers of children while keeping costs low (Barry & Jenkins, 2007). The primary goal of school-based alcohol prevention programs is usually to prevent or delay the onset of alcohol use. However, it is unclear whether universal prevention programs are effective for adolescents alcohol use since preventive programs in general have shown small effects on adolescents drinking (Tobler et al., 2000; Foxcroft & Tsertsvadze, 2011). Some alcohol prevention programmes targeting parents as a protective factor have shown positive effects in postponing drinking among adolescents (van der Vorst, 2006; Koutakis, 2008). The present intervention targets adolescents, parents and teachers. It is implemented in an early stage of adolescence to influence alcohol related attitudes and behavior. Youth & Alcohol is based on two previous interventions: "Young and Alcohol" (Wilhelmsen et al., 1994) and "Parents working together" (Henriksen, 1999). A quasi-experimental evaluation of "Young and Alcohol" has previously been conducted (Wilhelmsen et al., 1994), and based on these previous findings the program has been recommended by the Norwegian Health and Social Affairs for implementation in Norwegian schools (Nordahl et al, 2006). Since several changes has been undertaken to revise and expand the previous intervention the Directorate of Health in Norway has commissioned The Regional Center for Child and Youth Mental Health and Welfare at the University of Tromsø to evaluate the effectiveness of the program. The purpose of this paper was to examine short term effects of the program on adolescent's frequencies of drinking and alcohol related behavior, short term effects on parent's attitudes and rule settings, and describe teachers experiences working with the program. We expected that the intervention group would have lower scores in frequency of monthly alcohol drinking, alcohol related attitudes and alcohol expectancies compared with the control group. Additionally, we expected that parents in the intervention group would change their attitudes against adolescents drinking and adopt more conservative rules for their son/daughter. The online version of the program has previously been reported as a user friendly tool (Trondsen, 2005), so we expected teachers to report overall good experience working with the program.

Methods

Participants and procedure
The baseline sample consisted of 44 junior high schools including 1574 8th grade pupils, 1166 parents and 105 teachers recruited from two large municipalities in southern Norway. As the implementation is a mandatory educational program in the capital of Norway, all 47 junior high schools were invited to participate in the W8 [wait] project and 27 schools accepted. Schools from the neighbor municipality were invited to participate as a comparison group and 17 schools volunteered. Data was collected with self-reported online questionnaires distributed in classroom by teachers for adolescents, and parents received their questionnaire by mail given in their written consent. A quasi-experimental pre- posttest design, with a comparison and an intervention group was used. The study compared pupils exposed to the intervention program Youth & Alcohol to a control group receiving standard alcohol curriculum given in Norwegian schools measured after four months. The study was approved by the Regional Committee for Medical Research Ethics.

Intervention
The intervention is designed with elements from problem based learning and use of information and communication technology. Duration of the program is normally 10 to 30 hours in 8th grade with two parent evenings organized. The intervention aims to prevent alcohol use with a focus on adolescents alcohol related attitude and behavior. The parents are involved in the program through meetings in the school discussing alcohol attitudes and norms. The intervention is free of charge and for access at: www.ungeogrus.no.

Measures
Demographic variables measured adolescents age and gender at baseline. Adolescent's alcohol debut was measured by one question: "Have you ever had at least one glass of alcohol?" Adolescent's monthly alcohol use was measured by the following question: "How often have you been drinking alcohol over the last three months?" The seven answer categories that ranged from "4 – 7 times a week" (= 23.6) to "no times" (= 0) were recoded to represent a 30-day frequency measure. Adolescent's a*ttitudes* were a sum of five items where lower scores represented less positive attitudes to alcohol usage. The alpha was 0.86. Adolescent's alcohol expectancies were based on Alcohol Expectancy Questionnaire (Christiansen & Goldman, 1983; Aas, 1993). Five items asked pupil to estimate the degree of alcohol expectancies on a 7-point scale where lower scores represented more low alcohol expectancies. The alpha was 0.75.

Parent's attitudes were assessed with four items. Response categories ranged from (1) "totally disagree" to (5) "totally agree" (e.g., It is important to focus on alcohol prevention among adolescents). Measures on parent's response of discussing limit settings with other parents were assessed by one question, responses were given in a three point scale.

Teacher's experiences working with the program was measured by two questions; "I will recommend the intervention to other teachers" and "My motivation to use the program next time is good". Response rated from (1) "in very low degree" to (5) "in very high degree".

Statistical analyses
Multilevel analysis was used examine the effect of the intervention in order to account for within-pupils and within-school class dependency in adolescent's frequency of monthly alcohol use, alcohol related attitudes and alcohol expectancies. Differences from pre-to-posttest among parents in the intervention group were tested using one-way ANOVA and ordinal regression analysis on gain score variables.

Results

The response rate from adolescents was 78% at pretest and 77% at posttest. Participation from parents in organized parent's evenings showed that 48% of the parents were present at one meeting, 32% in two meetings and 17% did not participate in any parents meetings at school.

Adolescents

Baseline characteristics showed a mean age 13.46 years (*SD* = 0.68) with 50.6% female respondents. Descriptive results for adolescents with means and standard deviations are presented in Table 1. The total rate of alcohol debuts was 18.6% (*n* = 375). Results from the multilevel analysis with change statistics for adolescents are presented in Table 2. The interaction term between group and time was close to zero and non-significant in frequency of monthly alcohol drinking (*t* = -0.045, *p* = .96). There was a significant group by time interaction in alcohol related attitudes (*t* = -2.23, *p* = .03) and in alcohol expectancies (*t* = -3.07, *p* = .002). Pupils from the control group developed more positive alcohol related attitudes and alcohol expectancies than pupils from the intervention group (Table 1).

Table 1. Descriptive Results for Adolescents

Measures	*Pretest*		*Posttest*	
	Intervention	Control	Intervention	Control
	M (SD*; n*)	M (SD*; n*)	M (SD*; n*)	M (SD*; n*)
Alcohol use	0.22 (1.88; *n* = 999)	0.18 (1.55; *n* = 566)	0.48 (2.78; *n* = 962)	0.45 (2.79; *n* = 578)
Attitudes	2.18 (1.33; *n* = 987)	2.29 (1.38; *n* = 561)	2.46 (1.50; *n* = 943)	2.68 (1.59; *n* = 573)
Expectation	2.41 (1.25; *n* = 980)	2.54 (1.23; *n* = 556)	2.59 (1.39; *n* = 938)	2.94 (1.49; *n* = 560)

Note. Range; Alcohol use (0-23.6), Attitudes (1-7), Expectations (1-7).

Table 2. Multilevel Model Results of Short Term Effects

	Alc. Use	*Attitudes*	*Expectations*
Fixed parameters			
Intercept	0.43 (0.07)*	2.48 (0.07)*	2.58 (0.58)*
Group	-0.06 (0.11)	0.19 (0.10)	0.34 (0.09)*
Time	-0.21 (0.09)*	-0.24 (0.05)*	-0.15 (0.04)*
Group x Time	-0.00 (0.14)	-0.16 (0.07)*	-0.23 (0.08)*
Random parameters			
Level 1 Within subjects	4.07 (0.15)*	0.80 (0.03)*	0.85 (0.04)*
Level 2 Between subjects	0.59 (0.14)*	1.15 (0.06)*	0.88 (0.05)*
Level 3 Between classes	0.03 (0.03)	0.16 (0.04)*	0.11 (0.03)*

*Note. * p* < .05. Parameter estimate and standard errors (in parantetheses). Intervention group = 1, Control group = 0. Time coded monthly; baseline = 0, posttest = 4.

Parents

Descriptive results showing the differences in means and standard deviations between parents are presented in Table 3. Parents in the intervention group showed no significant difference in attitudes from pre to posttest. Discussion of limit settings were significantly more reported in the intervention group from pre to post-test (Wald = 12.30, *p* = .002).

Table 3. Descriptive Results for Parents

Measures	*Pretest*		*Posttest*	
	Intervention (*n* = 597 – 603) M (SD)	Control (*n* = 457 – 461) M (SD)	Intervention (*n* = 578 – 583) M (SD)	Control (*n* = 399 – 400) M (SD)
Attitudes	4.23 (0.60)	4.16 (0.59)	4.23 (0.61)	4.16 (0.63)
Limits	1.62 (0.83)	1.54 (0.84)	1.81 (0.82)	1.64 (0.92)

Note. Range; Attitudes (1-5), Discussed limits (1-3).

Teachers

Descriptive results showed that 70.4% (n = 19) of the responding teachers were females. Results showed a willingness to recommend the intervention to other teachers with 4% of very high degree of

willingness, 37% with high degree of willingness, 41% with medium degree willingness, and 15% had a low degree of willingness. Further results showed that teacher's motivation to use the program next time was reported with 30% high degree, 63% neutral, 4% low degree and 4% responded with very low degree.

Discussion

The aim of the present study was to evaluate short term effect on some selected variables of a school-based alcohol intervention. The results of this study showed that the rate of change among adolescent's frequency of monthly alcohol drinking from the two groups did not change significantly measured after four months. As the frequency of monthly alcohol drinking was low in both groups measured at baseline this might be a possible explanation to lack of results. The results from this study showed that pupils in the control group developed more positive alcohol related attitudes and higher alcohol expectancies compared to pupils in the intervention group measured after four months. The effect size is small, but does indicate that the intervention affect the adolescents alcohol related attitudes and alcohol expectancies in the preferred direction. Parent's rule settings against alcohol drinking did change in the preferred direction after the intervention was implemented. Teacher reported overall a good satisfaction working with the program and their willingness to continue was generally high. These short term effects of selected variables indicated that the program have an influence on adolescents alcohol related attitudes and alcohol expectancies. Additionally, positive findings among parents and teachers were reported. However, the result of this study does not support the main purpose of the program in terms of preventing alcohol drinking among adolescents. The W8 [wait] project is a longitudinal pre-, post- one, and two-year follow-up study measuring the effectiveness of the program Youth & Alcohol. The longitudinal results are in a process of being published.

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Families First (FF) – family groups to provide support for changes in life

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Abstract

This paper describes results produced by the Families First (FF) family group interventions in Finland. FF family groups are targeted for infant families with their first baby. The current Finnish family group model is based on the Parents First programme developed by the Child Study Center of Yale University. In Finland, the work on the family group model, including the first pilot groups, was launched by the NGO 'Folkhälsan'. Their *Föräldrarskapet främst* project between 2007 and 2009 was targeted at Swedish-speaking families in Finland. After this Mannerheim League for Child Welfare (MLL), has carried on the development work in its *Vahvuutta Vanhemmuuteen (VV)* / Families First (FF) project disseminating the model nationwide and working in collaboration with the child welfare clinics and the rest of the family centre network.

The objective of the project is to develop a family group model that enhances the psychosocial support provided for families. The aim of the group interventions is to improve parents' ability to see beyond explicit behaviour of the baby or other family members and to facilitate understanding and interpretation of others' needs, experiences and emotions. At the same time, the aim is to train municipal employees to become group leaders in line with this family group model. The purpose is also to support the families on their path from the professionally guided family groups and child welfare clinics towards open voluntary activities that bring families together and enhance their social networks locally. Such activities may include family cafés run by family organisations or other residential family activities run by municipalities, family centres or parishes.

Family groups have been followed from two perspectives: that of the parents' and that of the professionals involved in the FF family group interventions. Family groups enhance families' well-being in multiple ways. Participating in a family group has brightened both the mother's and father's positive image of themselves as parents and also improved parents' understanding of infant needs and emotions. Participation has also strengthened the relationship between partners and heightened the experience of equal parenthood.

Professionals that have been trained to FF family group guidance find that they have acquired a new approach applicable to all family-related work. They find themselves more prepared to bring up also difficult issues with parents and feel less vulnerable to parents' responses. They have become more curious of parents' own thoughts and emotions and less inclined to give direct solutions to parents' problems.
The original Parents First programme was targeted at parents of small children in risk families. The Finnish family group model differs from the original Parents First programme in the sense that it is designed and offered to all so-called normal families with their first infant. The family group is marketed to the future parents mainly in the context of family coaching provided by the child welfare clinics. In addition to the two parents, the baby is also a group member.

Introduction

Central theoretical framework underlying the FF family group model consists of attachment theory, mentalization theory and the concept of reflective parenting. The term 'metalizing capacity' refers to

the ability to see things from the other person's perspective and to reflect on one's own and the other person's feelings or experience and to keep the two apart.

In parenthood the capacity to mentalize helps the parents to act reflectively, calmly and sensitively with their child. A reflective parent is able to see through the child's visible behaviour and distinguish the underpinning experience. The parent is also able to understand that behind the explicit behaviour, there are individual states of mind, such as feelings, thoughts or wishes. The parent tries curiously to understand what could be hiding behind his behaviour; what is the feeling, purpose or motive? The parent will think of various interpretations and alternatives to explain the child's behaviour and will not jump into rapid black-and-white conclusions on the basis of the visible behaviour. The more capable the parents are in mentalization, the more sensitive and calm they are in interacting with the baby. The capacity to mentalize also makes it possible for the parents to formulate positive thoughts of not only the child but also of themselves as parents.

Family group starting points
At the beginning of the group, the babies are about 3 or 4 months old, and they will be almost a year when the group work ends. The group is a professionally guided closed group, with 12 meetings focusing on different themes each time. The basic structure for the meetings is always the same: the meeting starts with a joint snack, allowing the families to interact and talk freely. Then the theme of that evening's meeting is taken up. First, the group hears the parents' experience and feelings about the homework they have been given. Most of the meeting time is spent on discussions on the theme, with the group leaders giving some brief outlining ideas in the beginning of the session.

During the discussion, the group leaders act as facilitators. The idea is not to give lectures or standard advice and solutions to the issues raised by the families. Instead, their task is to lead the parents through reflective questions and ensuing discussion towards wondering together and self-reflection so that they find their own solutions to the questions or problems at hand. Before leaving, the parents are given a homework related to the theme. Each meeting normally ends e.g. with a familiar song or nursery rhyme for the babies.

Twelve family group meetings
The twelve meetings of the family group programme are based on the progressive reflective process. The group leaders seek to deepen the discussions gradually towards more profound reflective thinking among the parents.

The first four meetings are all about creating a safe atmosphere of trust. In addition the parents are encouraged to be aware and observe the child with open eyes in various everyday situations, elaborating on the message the baby is trying to convey through its behaviour. For example, the parents will think about the characteristics of their own child, trying to see the similarities or differences they can distinguish in such a small child in comparison to their own temperament. The parents will discuss the issue of how easy or difficult it may be to recognise the child's physiological feelings and related thoughts. They will also think about their own expectations in relation to what the baby might possibly expect from the parents. Little by little, the discussion will go deeper into what feelings and thoughts the observations about the baby and his behaviour create in the parents.

Towards the middle of the group programme, the group will go deeper and concentrate in the observation and discussion of the parents' own, the baby's and other family members' feelings and thoughts. When and how can the parents understand that the child has strong feelings of joy or discomfort? How do these feelings affect the parent? And what about the parent's own strong feelings - how do they impact the baby or other family members? During the group meetings, the parents reflect on their own modes of operation in different everyday situations, thinking of their potential impact on the child's feeling of security and its developing independence.

The four last themes, lead the parents to even deeper reflections on how the emotional states of each family member impact the others' behaviour or thoughts. The objective is to make the parents stronger in anticipating the child's reactions in various situations, becoming better experts in noticing the reasons or thoughts behind the child's reactions. The last meeting concentrates on the outlook for the future, constructing a positive image of the upcoming toddler stage.

Methods

The project has collected the parents' experience and the perceived benefits of the family group, asking about the impacts felt on their everyday life and thinking. In turn, the group leaders have shared their experience on both the actual family group guiding work and the introduction of the reflective mode into their other work with customers and situations where they meet with parents, children and families. Parents' feedback has been gathered with an Internet-based Webropol form. From early 2012 until April 2013, there are 290 responses, 67% from women and 33% from men. 73% of the respondents were between 25 and 35 years of age, and those under 25 accounted for 13%. The professionals' (n=215) experiences have been collected in written exercises during the training process. They also fill in a web-based self-evaluation questionnaire both before and after the training.

Results

By the end of 2012 the project has signed a written partnership agreement with almost 80 municipalities in various parts of Finland. Based on this agreement, the project undertakes to train municipal employees in mentalization and in FF family group guiding skills. By the spring of 2013, the project has trained almost 300 family group leaders. The professionals come from various professional backgrounds but are all involved in the work with families with small children. About half of the group leaders trained by the spring of 2013, have been public health nurses working in child welfare clinics. There have also been many family workers, preschool teachers representing early childhood education, nurses and psychologists.

A total of 125 FF family groups following the FF family group model have been launched in various parts of Finland. The aggregate number of group meetings is almost 1,000 and the families joining the groups over 550. Almost 1,600 persons have participated in the groups; mothers and fathers have been very equal in participating. Mothers account for 54% and fathers of 46% of the adults in the group.
The groups have attracted a great variety of parents from most diversified educational backgrounds or professions. There have been nurses, engineers, shop assistants, hairdressers, farmers, teachers, mechanics, construction workers, assistants, entrepreneurs etc. Most respondents have at least a professional qualification or a BA-level university degree.

Reasons for joining the groups
The single most important factor of joining the group was the wish to strengthen the social peer network. Both mothers and fathers were looking for a discussion forum with other adults in the same life situation. They were expecting to get new perspectives from the other families in the group. Many respondents felt also alone and hoped that the group could help them meet other families with the baby in their neighbourhood. Besides social relationships and peer support, the families found that increased understanding of the life with a baby was a determining factor to join the groups. They wanted to learn to know and better understand their own baby. More than the fathers, the mothers were keen to learn concrete hints and advice for the everyday life with a baby while fathers were more eager to understand how to live with a baby in the first place.

Table1. Reasons for joining the group

	% All	% Moms	% Dads
I wanted to get an opportunity to discuss with other parents in the same life situation	**78**	**85**	**63**
I hoped to get access to other families with their first baby	**71**	**78**	**57**
I wanted to have concrete hints and advice	**62**	**68**	**49**
I wanted to share everyday life experiences with other parents with the baby	**59**	**67**	**43**
I wanted to deepen my understanding how to live with a baby	**53**	**53**	**54**

Impacts of the family group

The parents evaluated the impacts of the family group using the scale from 'great impact' to 'modest impact', 'cannot say', 'hardly any impact' and 'no impact at all'. Since most of the parents' responses were in the upper end of the scale, the categories 'modest' and 'great impact' were combined to constitute the new category 'significant impact'.

Most mothers and fathers reported that they understand the needs and feelings of the baby much better than earlier. They felt that their relationship with the baby was significantly stronger and they felt significantly more confident in taking care of the child.

Table 2. Impacts of the family group

	% All	% Moms	% Dads
I understand much better the needs and feelings of my baby	**86**	**86**	**87**
My relationship with my baby is significantly stronger	**77**	**80**	**70**
I feel significantly more confident in taking care of my baby	**72**	**73**	**70**

"I learned to understand my own baby. If the baby has a bad day and he cries a lot, it doesn't mean that I would be a bad mother"

Impact on perceived wellbeing

The respondents assessed potential impacts on their personal wellbeing or that of the other parent or family. Mothers, in particular, felt that their wellbeing had increased owing to the group. What is noteworthy is the fact that the fathers had also noticed that the spouse's wellbeing had increased, and they gave almost the same percentage score in this respect. A good half of the parents felt that the wellbeing of the entire family had increased, thanks to the group. Both the mothers and the fathers were particularly happy with the opportunity to participate in the group as a family.

Table 3. Impact on perceived wellbeing

	% All	% Moms	% Dads
The group had a lot of impact on my well-being	**64**	**72**	**46**
The group had a lot of impact on my spouse's well-being	**50**	**38**	**75**
The group had a lot of impact on my family's well-being	**64**	**65**	**62**
The group had a lot of impact on relationship with the spouse	**39**	**37**	**41**

Impact on the interaction between the parents
The parents also assessed the impacts of family groups on the interaction and relationship between the spouses. About 80 % of the parents report that the discussion on the group themes and ideas raised in the group continued at home. The parents also felt that the group had significantly helped them to share both the joys and the difficulties with the spouse.

Table 4. Impact on the interaction between the parents

	% All	% Moms	% Dads
The discussion on the thoughts and ideas raised in the group continued at home	**76**	**76**	**77**
It is much easier to share the everyday joys with my spouse	**54**	**51**	**61**
It is much easier to talk about various difficulties with my spouse	**41**	**40**	**44**

> *"We have had a hard year and it is probably no exaggeration to say the group has prevented us from ending up in divorce. We thought we want to find solutions to our problems until the group ends…"*

The most useful discussion contents

The families were asked whether they felt the discussions in the meetings had been useful personally. The scale was: 'very useful' – 'somewhat useful' – 'mostly useless' – 'no use at all' – 'cannot say'. Almost all of the parents' responses (from 80% to 99 %) were in the upper end of the scale. Based on this feedback, we have to think that the parents with their first baby feel that any discussions on parenthood, various everyday situations and life with a child and ensuing responsibilities in general, are useful. The parents need a forum where they can go together and meet with other parents and deepen their understanding of the new situation in life.

> *"All themes and discussions were important. We could hear how the other families do it, and it was nice to know that you are not alone with all kinds of thoughts and worries."*

The families' social network after the group

The families' social network seems to get significantly stronger as a result of the group. All families respond that they have met other families with a baby, and some report that they have acquired new friends. Almost half of the parents tell that they intend to continue to meet each other after the group work ends, both informally and through the social media. It seems that also new friendships with other families were created during the group meetings to quite an extent because about 40% of the parents report on meetings and visits between the families. Inspired by the group, one fifth of the families seem to seek family activities organised by the local municipalities, parish or the family organisations after the group.

Trained professionals' feedback and experience in summary

The group leaders report that they have a new work orientation promoting equal parenthood, and they have started to apply this new orientation also to other family work: at child welfare clinics, in other individual or group situations, as a family work method, in encounters with school children, in challenging customer situations, etc. Using the mentalizing based working mode, they felt that the encounters with the parents were more profound and that they were now more actively taking the whole family into consideration. Many of them found that they had also acquired a wider perspective in recognising the child's emotional states and understanding his behaviour. Many professionals also felt that what they had learned in their basic training had developed into deeper and more concrete insight.

The professionals reported that handling difficult issues at the child welfare clinic or in other encounter situations feel easier. Many of them felt that they were less afraid to bring up difficult issues and to hear the parents' responses. This was due to the fact that they had understood that they need not have a standard response or solution to the question raised by the parents. It is enough to start thinking about the situation with the parent, and to show genuine interest and wish to understand. Many trained professionals also felt that the working method with an emotional depth feels heavier but is in fact very much more rewarding than the old ways.

Several earlier operative practices had undergone changes. For example, the questions that used to be routinely asked at the child welfare clinic appointments were formulated anew, to be more suitable for the child's age and more apt to lead to a deeper reflective thinking. Going over various questionnaires and interview forms with the children and the parents had also become more versatile and deeper.

The professionals reported that they have become more curious and interested in the thoughts and feelings of both parents, and they have less tendency to present direct answers and solutions to the

problems raised by the parents. One of the professionals formulated the joint idea of the new working method as follows:

> *"There is less reject, refusal and 'I-know-best' attitude. Instead, there is more compassion, encouragement and joint reflection."*

Discussion

For now our experiences in our family interventions have been very encouraging. Parents have reported that they have become more observant and appreciative of their child's experience and that their self-confidence as parents has increased. By observing the "small" moments in everyday life parents had discovered new perspectives about their babies and their partners. These findings helped them to better understand and appreciate the other family members' feelings and thoughts and the everyday life felt more predictable and manageable.

Earlier research has shown that the enhanced mentalization and reflective capacities of parents will significantly boost the whole family's wellbeing, especially in risk families. Relying on this information, we are strongly convinced that FF family groups promote the positive interaction between the child and the parent, also in so-called normative families. We also go from the assumption that the family group model being developed in our project is not only preventive but also proactively strengthening. This means that the discussions in the group and the peer support provided by other parents increase the parents' preparedness in encountering possible future setbacks and adversities. What is noteworthy is that the group had also many therapeutic impacts although it is not intended to be a therapy group. One of the mothers has sent us feedback about this as follows:

> *"I had post-natal depression and I'd like to think that the family group helped me not to sink so deep... We also had a reason to "go out" as a family..."*

Most of the parents miss the family group after the meetings. Committing themselves to twelve family group meetings may have raised some issues in many parents. Before the group started they might have thought that investing so much time in the group is simply too much. However, towards the latter part of the programme, the parents frequently felt that it is a shame the group work is drawing to its end, and they were often contacting the professionals asking them to arrange continuing group programmes and new meetings.

For professionals a new motivating working orientation seems to have a wider impact not only on encounters with families at work but also at leisure-time activities and in their own families. Increased understanding of the impact of the states on mind on people's behaviour had made the professionals more understanding and accepting both as regarded themselves and the encountered person. Our important conclusion of the FF family group interventions is that it is possible to train and develop one's mentalizing capacities. This capacity can be trained by both the parents and the professionals who encounter families in their daily work.
Impact study (started in 2012**)**

Encouraged by the good results the family group interventions are also the object of scientific impact study carried out in Finland (Mirjam Kalland, Åse Fagerlund, Marjukka Pajulo, Tuovi Hakulinen-Viitanen etc.). The study will focus both on the mother and the father. The impact is assessed by comparing the families in the groups (n 200) to control group families (n 1,000). The methods used are internationally recognised meters used for questionnaires. Participation in the study is offered to families 1) expecting the (mother's) first baby; 2) expecting just one baby (no twins, based on the first echography); 3) where the parents speak either Finnish and/or Swedish. Parents from the 80 municipalities co-operating with Mannerheim League for Child Welfare (MLL) and from the Swedish-speaking municipalities collaborating with NGO Folkhälsan are invited to participate as study subjects.

The questionnaire-based survey will be sent to the mothers and fathers either via the web or on paper. There are five survey times: 1. During the late pregnancy (weeks 28–32): 2-3. Before and after the family group intervention: 4. When the baby is 3 months old; 5. When the baby is 1 year old. The follow-up survey will take place when the child is 2 years old. The study will focus on the mother and

the father, looking at the following factors: depressive symptoms (EPDS), couple satisfaction (IMS), reflective capacity (PRFQ), coherence (SOC), experience on the respondents' own parents (PBI), parenthood-related stress (Sw-PSI), child development (BITSEA) and impressions of the baby.

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Professor Monica Martinussen, RKBU Nord, UiT and Professor Michael West (keynote speaker), Lanchaster University, United Kingdom.

Ombudsman for Children in Norway, Anne Lindboe.

Participants from Greenland




From the conference

The Regional Centre for Child and Youth Mental Health and Child Welfare
The Regional Centre for Child and Youth Mental Health and Child Welfare is a department of the Faculty of Health Sciences at the UiT, The Arctic University of Norway. The northern center is one of four regional centers in Norway that offer research, professional development and education within child and adolescent mental health and child welfare.

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