Family centre in the Nordic countries – a meeting point for children and families
Family centre in the Nordic countries – a meeting point for children and families

Marjatta Kekkonen, Mia Montonen and Riitta Viitala (ed.)
Family centre in the Nordic countries – a meeting point for children and families.

Nordic co-operation

Nordic co-operation is one of the world’s most extensive forms of regional collaboration, involving Denmark, Finland, Iceland, Norway, Sweden, the Faeroe Islands, Greenland and the Åland Islands.

Nordic co-operation has firm traditions in politics, the economy and culture. It plays an important role in European and international collaboration, and aims at creating a strong Nordic community in a strong Europe.

Nordic co-operation seeks to safeguard Nordic and regional interests and principles in the global community. Common Nordic values help the region solidify its position as one of the world’s most innovative and competitive.

Nordic Council of Ministers
Ved Stranden 18
DK-1061 Copenhagen K
Phone (+45) 3396 0200
Fax (+45) 3396 0202

Nordic Council
Ved Stranden 18
DK-1061 Copenhagen K
Phone (+45) 3396 0400
Fax (+45) 3311 1870

www.norden.org
# Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Foreword</td>
</tr>
<tr>
<td>9</td>
<td>Introduction</td>
</tr>
<tr>
<td>14</td>
<td>Family centre and Family policy in the Nordic countries</td>
</tr>
</tbody>
</table>
| 15 | Historical development of family centres in Sweden and the Nordic countries  
*Vibeke Bing* |
| 21 | Family centres in Finland – a new approach within services for children and families  
*Riitta Viitala, Marjatta Kekkonen and Nina Halme* |
| 29 | The Family’s House in Norway – an interdisciplinary, municipal/community healthcare service for children, adolescents and their families  
*Anette M. Thyrhaug, Gørill W. Vedeler, Monica Martinussen and Frode Adolfsen,* |
| 34 | Danish family policy and Child Reform  
*Anna Jin Rolfgaard* |
| 36 | Child and family services in the Icelandic welfare system  
*Sigrun Juliusdottir and Elisabet Karlsdottir* |
| 40 | Promotion of the well-being of parents and children |
| 41 | The Swedish strategy for developed parental support and the family centre as an arena for the provision of municipal parental support services  
*Johanna Ahnquist* |
| 48 | The importance of social support and reflective functioning for parenthood  
*Mirjam Kalland* |
| 56 | Child’s right to an upbringing – Family centre as a promoter of a rearing culture which respects the child  
*Maria Kaisa Aula* |
Family centre is based on preventive work and collaboration

Preventive services – a guarantee for the well-being of children and families
Sirkka Rousu, Aila Puustinen-Korhonen and Marju Keltanen

The Swedish Leksand model – family preparation as a starting point for the family centre
Thomas Johansson

Mother and father – for the first time
Henriette Weberg

The non-governmental organisation as a player within the family centre
– a vision of collaboration
Milla Kalliomaa

Is preventive work cost-effective?

Effectiveness and costs of preventive services for children and families
Ismo Linnosmaa, Antti Väisänen, Eero Siljander and Jukka Mäkelä

Family centre entails changes in professional skills and knowledge

Knowledge advancement concerning family centres
Vibeke Bing

Collaboration in the Family’s House
Anette M. Thyrhaug, Gørrill W. Vedeler, Monica Martinussen and Frode Adolfsen

Good practice dialogues as a tool for sharing expertise
Jukka Pyhäjoki and Mimosa Koskimies

A picture of future competence needs in family centres
Heidi Backman and Alexandra Nordström

Future challenges

Developing the family centre in the Nordic countries
Marjatta Kekkonen, Mia Montonen and Riitta Viitala

The Authors

Steering group and editorial team
Foreword

Within the field of child and family policy, the Nordic countries have much in common and a long tradition of working together. The challenges the Nordic countries will face in the future are also similar. A variety of initiatives are implemented in the Nordic countries in order to support parenthood. The foundations are laid by the health promotion and early prevention initiatives that are carried out with families with children. Problem prevention and supporting families through the provision of services with a low threshold is an important aspect of Nordic welfare policy. In the Nordic countries, collaboration with civil society and voluntary organisations is highly valued. Broad participation and multifaceted commitment from the third sector in order to achieve the shared goals are vital.

Families with children are of enormous importance for our future welfare. During its chairmanship, Finland is promoting the work that is already underway within the field and placing an emphasis on continuity within the Nordic partnership. One goal is to raise the level of interest in the Nordic collaboration over family centres. The two Nordic family centre conferences – the first held in Sweden in 2005 and the second in Finland in 2010 – demonstrated that exchanging knowledge and networking are worth the investment. Under Finland’s chairmanship, themes such as a healthy lifestyle for families with children, the project concerning families with children who are at risk of social exclusion and the Nordic collaboration relating to the mental health of children and young people will be taken further. Another important theme is the campaign against the corporal punishment of children, which will kick off with a seminar in December 2011.

The discussion surrounding current structural reforms and the development of welfare services for children, young people and families is important. Similar discussions are also underway in an international context. Family centres are a model for improving the health and well-being of children and the whole family and for combating social exclusion by supporting positive parenting. Family centres are also a universal arena that enable children and families to participate and have a say themselves, thus reinforcing solidarity within society.

The important factor as regards family centres is that the work is cross-border and builds on the co-operation of all stakeholders.

This publication represents a curtain-raiser in the discussion surrounding family centres in the Nordic region. The publication brings together experiences and knowledge from the Nordic countries. Family centres are being developed not only in the Nordic countries, but also across Europe and elsewhere. Through this publication, we wish to take part in the international debate.

Kari Välimäki
Permanent Secretary
Ministry of Social Affairs and Health
Introduction

This publication represents a compilation of experiences and current knowledge concerning family centre services in the Nordic countries. The aim of the publication is to clarify the approach of family centres, the desired service structure and the roles of professionals, families and children in family centre services. The child and family welfare policies of the Nordic countries have many common themes. Efforts are being made to steer the services more towards universal health-promoting and preventive services, to promote the psychosocial health and well-being of parents and children, and to safeguard the families’ own resources. Collaboration and a multi-professional approach are valued, and openness and trust are promoted. There is a desire to strengthen the collaboration with the third sector and civil society. These themes also permeate this publication.

The needs of children and families as regards services are defined by changes that take place in society and living conditions. Immigration, internal migration, urbanisation, greater distances between relatives and networks of friends and family, difficulties in reconciling work and family life, the increase in divorce and varied family structures, supply problems and poverty all dictate the living conditions of families with children in the 21st century. On the other hand, social media and the internet are increasingly being seen by parents as a source of information and ideas concerning a good life, good parenting and a good childhood. The general changes that are taking place in living conditions affect all families with children in some way or other, but the consequences for the well-being of children and parents vary. The goal of the family centre is to meet the needs of families with children as regards services in modern society and to even out consequences of changes in living conditions for families with children.

What is a family centre?

A family centre is a service model which brings together the services that promote the well-being and health of children and families on the basis of a promotive and preventive approach. Sweden has been a pioneer in the development of family centres. The first family centres were set up in Sweden back in the 1970s, but the boom in such centres did not really occur until the early 21st century. In Finland and Norway, the development process for family centres began in the early 2000s, and Denmark, Iceland and the other Nordic countries also showed an interest in the initiative at the time. Various terms are used in the Nordic countries to refer to family centres. In Sweden, “familjecentral” (family centre) is a well-established term, whilst in Finland “familjecenter” is the recognised term. In Norway, the term “Familiens hus” (Family’s House) is used.

Regardless of the different terms used, family centres are governed by the same principles. The fundamen-
tal basis for the family centre is that the well-being of children is strongly linked to that of their parents. Well-being of parents is connected to the resources to respond to their children's needs. By reinforcing the parenting skills of mums and dads and supporting the marital relationship, it is possible to improve the child's chances of a secure and happy childhood. The aims are to raise the parents' level of knowledge, to reinforce their community and to encourage them to have their say in society. Secondly, the family centre acts as a service with a low threshold with universal service provision aimed at all families with children. The family centre is based on services that are based on health promotion and early prevention. Promotion is characterised by the promotion of healthy processes which reinforce and safeguard health. The multifaceted family centre service network enables the early identification of problems being experienced by children and families, as well as fast and flexible support and help initiatives. Thirdly, the family centre promotes social integration and solidarity by offering an easily accessible meeting place for all families and children, regardless of any differences in their social or ethnic background. In parent groups, parents get to know other people who are in the same life situation, thereby providing support for equality, friendship and daily social interaction. The basis for well-being can be found in the everyday networks and surroundings of children and families.

The family centres offer a new way of supporting the everyday lives of families with children. Family centres provide services in a multi-professional, cross-sector way in collaboration with the third sector. In accordance with the basis for the family centres, the following goals have been established for the family centres:

- to support and strengthen parents in their role as carers and child-rearers
- to develop the social networks of children and parents
- to act as a local meeting point for children, families and local residents
- to develop working models which engage children and parents
- to identify physical, mental and social risk factors at an early stage
- to offer children and parents support and services with a low threshold
- to develop multi-professional, cross-sector collaboration between the services
- to build up partnerships with the third sector
- to act as a centre for information and competence
- to disseminate knowledge that is based on scientific research and evidence

The Swedish National Institute of Public Health has defined the family centre as a complete range of services which are fully co-located, covering maternal healthcare, child healthcare, open early childhood education and care and the preventive work carried out by the social services. The definition assumes that the four basic services operate from the same premises. In Norway, family centres have been defined as a complete range of services based in the same premises with a health centre that provides antenatal care, preventive child welfare services, educational-psychological services and open daycare for children. In Finland, three models for family centres can be identified: a model with the provision of maternal and child healthcare advice, a model with open early childhood education and care, and a regional model. The fourth model consists of family centres that are run by organisations. There are many different types of family centre in each of the Nordic countries. In Norway, the services that are often co-located in Family’s Houses are a health centre that offers healthcare service for children including pregnancy care, preventive child welfare services, pedagogical-
psychological services and an open kindergarten. A similar trend can also be discerned in Finland in the form of the development of a network of family services. In the Nordic countries there are strong and ground-breaking developments in progress, which are resulting in the reorganisation of child and family services and creation of service models which cut across sector boundaries.

The publication in a nutshell

The first part of the publication *Family centre and family policy in the Nordic countries* describes the historical development of the family centre, the service models and working practice as well as future challenges in Sweden, Norway and Finland. The chapter also presents Denmark and Iceland’s family policy guidelines and service mechanisms for children and families, which provide a stable basis for the family centre service models.

In her article entitled *Historical development of family centres in Sweden and the Nordic countries*, Vibeke Bing describes the long development process that began with the need to prevent child abuse and has now resulted in public health work in which the family centres play a central role as well as in child public health.

In their article *Family centres in Finland – a new approach within services for children and families*, Viitala, Kekkonen and Halme describe the development of family centre services in Finland, which can be subdivided into three phases. The discussion in Finland stemmed from concern over the resources of parents, and has now resulted in the establishment of the family centre as an arena for health promotion, early prevention and a dialogue-engaging working practice.

In the article from Norway entitled *The Family’s House in Norway – an interdisciplinary, municipal/community healthcare service for children, adolescents and their families*, Thyrhaug, Vedeler, Martinussen and Adolfsen describe the Norwegian model. The article’s authors describe the family centre as a venue for a complete range of services, which can offer families health promotive and universal interventions and services, selected interventions and indicated interventions and services. In Norway, family centres have a health centre on the same premises which offers antenatal care, preventive child welfare services, educational-psychological services and open daycare provision for children.

Rolfgaard from Denmark discusses *Danish family policy and Child Reform*, while Juliusdottir and Karlsdottir from Iceland describe *Child and family services in the Icelandic welfare system*. These two articles present an overview of the respective countries’ preventive family policy and child and family service systems. Although there is not as much talk about family centres in Denmark and Iceland as yet, these articles show that the family policy guidelines of the two countries and the service mechanisms for children and families follow the same trends as the family centre concept.

In the second part of the publication *Promotion of the well-being of parents and children*, parenting is interpreted and considered as a national resource. Parenting needs support from society, a consistent service strategy and service structures like that of the family centres where the processes for the support can be realised. The chapter also describes how the ability of parents to interpret and meet the needs of their children in an emotionally sensitive and reflective way contributes to the child and the parents’ mutually positive experiences of each other. This reinforces parenting. Bonding in the child-parent relationship gives the child a sense of security and a
fundamental confidence in life. In the chapter, parenting is also approached through the child’s hopes and experiences.

In her article entitled *The Swedish strategy for developed parental support and the family centre as an arena for the provision of municipal parental support services*, Ahnquist describes the way in which Sweden has adopted the approach of supporting and helping parents in their parenting through a strategy entitled “A benefit for all”, as well as the way in which family centres are seen as an important element in this work. The government’s strategy is based around the view that it is the parents themselves who are the experts on their children.

In her article entitled *The importance of social support and reflective functioning for parenthood*, Kalland discusses the importance of reflective skills, the sense of solidarity and the way in which family centres can support parents in a down-to-earth way. The article describes how the natural prerequisites that most parents possess can be reinforced in a respectful way through exploring reality together in a group.

In her article *The child’s right to an upbringing – Family centre as a promoter of the rearing culture which respects the child*, Aula highlights the child’s view of their parents and parenting. She discusses what the child would want from its parents, as well as aspects of the adults’ behaviour which give rise to anxiety. Aula also explains how family centre services can help parents to be good parents to their children.

The third part of the publication *The family centre is based on preventive work and collaboration* focuses on preventive services and their links with the family centre initiative. This chapter gives a general account of the role of the family centre with the municipal authority’s preventive services. The chapter describes Leksand’s family centre concept and the Danish family preparation model, which has been developed from this concept. The chapter also presents a vision of the role of the non-governmental organisation at the family centre and the way in which the fourth sector – civil society – can work in partnership with the public sector.

In their article entitled *Preventive services – a guarantee for the well-being of children and families*, Rousu, Puustinen-Korhonen and Keltanen emphasise the importance of preventive work in the promotion of the well-being of children and young people and the child policy of municipal authorities. The well-being of children is a common issue for the entire municipality. The authors describe the family centre as a way of organising preventive child welfare work so that it does not involve the exercising of authority. The family centre has concretised the objective of preventive child welfare in Finland and given structures for collaboration across sector boundaries.

In the article entitled *The Swedish Leksand model – family preparation as a starting point for the family centre*, Johansson describes the basis and success factors for the family preparation process and presents a number of suggestions for the further development of the model. In the article entitled *Mother and father – for the first time* Weberg describes how the Swedish Leksand model has been applied in the municipality of Greve in Denmark.

Kalliomaa’s article entitled *The non-governmental organisation as a player within the family centre – a vision of collaboration* highlights the collaboration between the public sector and the fourth sector, i.e. NGOs and civil society. The third sector, i.e. voluntary organisations and associations, act as an important link between professionals and voluntary parties.

By way of conclusion, Kalliomaa discusses how the collaboration between the family centre services that are run by the public sector and the working forms that are based on voluntary work under the direction of NGOs can be facilitated.

The fourth part of the publication concerns the question: *Is preventive work cost-effective?* Linnosmaa, Väisänen, Siljander and Mäkelä discuss preventive work from the perspective of cost-effectiveness. In their article *Preventive child and family services, effects and costs*, the authors describe the objectives of the child and family services and
illustrate, through the use of examples of preventive child welfare, the consequences of unsuccessful early intervention, as well as the costs that the child welfare measures would give rise to in two alternative service strategies. By way of conclusion, the authors discuss why the preventive approach has not been adopted and what sort of evidence can be obtained concerning the effectiveness of the preventive approach. According to the authors, it is also a question of whether the decision-makers believe in the return on investment in preventive work.

The fifth part of the publication *Family centre entails changes in professional skills and knowledge* concerns knowledge, collaboration and interaction. The focus is placed on the staff’s know-how and the new professional roles. Professionals at family centres are being compelled to adopt new working methods and be flexible in their work and professional roles. Collaboration and interaction between different professional groups also facilitates a new form of knowledge advancement.

In the article entitled *Knowledge advancement concerning family centres*, Bing describes the family centre as an organisational form that is filled with learning. For the staff, this means not only that their professional role is altered, but also that their role can change even during the course of a single working day. Bing believes that the roles performed by professionals at family centres vary between that of expert and adviser, that of a good host for parents’ meetings and that of circle leader.

In *Collaboration in the Family’s House*, Thyrøug, Vedeler, Martinussen and Adolfsen describe how competence, commitment and a desire to collaborate have a decisive effect on how high-quality family centre services must be produced for children, young people and families. The authors state that multi-professional collaboration includes both elements that facilitate and elements that burden the work. In the Family’s house, it is shown that most of those employed have positive experiences of working with other professional groups.

In their article entitled *Good practice dialogues as a tool for sharing expertise*, Pyhäjoki and Koskimies describe the importance of tacit knowledge in the development of society. Children, parents and employees need premises and forums where they can make themselves heard and talk to each other about their competence, their fears and their everyday experiences in order to ease their concerns. The method “Dialogues for good practice” can be applied in the development of family centres, where there is a desire to improve collaboration, participation or management relating to family centre service provision.

In their article entitled *A picture of future competence needs at family centres*, Backman and Nordström describe what the future could hold with regard to the competence needs of staff. The authors outline future scenarios for child and family services from a perspective which shows what would happen if the services were to be developed in line with the family centre model. They also discuss a vision of the future as regards what would happen if the service concept were not to be actively developed or if the services did not take account of the changes that occur in the living conditions of families and in society in general.

The publication is concluded with the chapter entitled *Future challenges*. In the article entitled *Developting the family centres in the Nordic countries*, Kekkonen, Montonen and Viitala highlight the views that apply to the common further development of the family centre initiative in the Nordic countries.
Family centre and family policy in the Nordic countries
Historical development of family centres in Sweden and the Nordic countries

Vibeke Bing

This article describes 30 years of development leading up to today’s family centres, which form part of the welfare and public health service and can be understood not only in terms of Child Public Health, supporting environment and equality, but also on the basis of increased knowledge concerning pregnancy, infants, cohabitation and the mental health of children. The article also describes how our knowledge has developed since the first Nordic family centre conference in 2005 and the interest in family centres in the Nordic countries.

Introduction
Family centres rest upon a conception that there is a strong link between well-being of children and their parents. That is why preventive work regarding children must also be aimed at the parents. Sweden currently has over a hundred complete family centres spread across the country. In terms of definition, a complete family centre offers all the healthcare services relating to the prenatal and well baby clinics, co-located with an open nursery. Access to social guidance is also available under the same roof. Social advice also forms part of the social services’ prevention work and is provided without any exercising of authority (National Board of Health and Welfare, 2008).

Swedish family centres have what are, in terms of public health services, a number of strategic starting points. The first is the time. The aim of the family centres is to give children a healthy start by being there from the beginning and by targeting their services at both as yet unborn and newborn children, and their parents. Secondly, the family centres represent a low-risk strategy, as they are aimed at all future and new parents and their children aged 0-5 years, not just at the most vulnerable. In exactly the same way as with all public health services, the family centres also build on the interaction between different authorities and different professional groups. They are both preventive and health-promoting. This means that they target their services in order to not only reduce risk factors but also to increase health and protection factors. Finally, the family centres act as an everyday meeting place for parents and children in a local area.
Preventing children from suffering

The first steps in the development of the family centres were taken back in the 1970s. This decade saw the introduction of a series of family policy reforms aimed at safeguarding the upbringing of children. These reforms stemmed from the Swedish Paediatric Society highlighting child abuse and its causes at one of its annual meetings back in the 1960s. A lack of care which led to the death of a young girl subsequently fuelled an already intense debate within society. The frightening truth was out: parents who are normally their children’s fiercest protectors can also hurt their children the most. The public debate covered child abuse, children with special needs, a lack of childcare provision and the need for preventive work. It was clear that, if children were to be protected from harm, parents would have to have a reasonable standard of living and the tools they needed to help them cope with parenthood.

This was followed at a national level by a political response in the form of government-initiated studies and subsequent legislation and reforms. One was the parliamentary resolution concerning parenting courses in 1979. The same year saw the introduction of the ban on corporal punishment of children and legislation concerning parental leave in connection with the birth of a child. All this was aimed at facilitating parenting and protecting children. A major expansion of childcare provision made life more secure both for children themselves and for their working parents, particularly single parents.

The 1970s turned out to be a good decade for children, during which interest in and research into children and childhood came into focus and began to be reflected in social policy. An advancement of knowledge began and, together with Sweden’s ratification of the Convention on the Rights of the Child in 1990, helped establish the stable foundations in terms of knowledge and values behind family centres today.

Parliament’s resolution from 1979 concerning a parenting course resulted in an offer to all future and new parents in the first instance. This initiative saw the beginning of the trend towards what 20 years later would come to be called family centres. The aim of the family centres has many similarities with the three objectives of the parenting course, which were to increase parents’ knowledge, reinforce their community and encourage them to influence circumstances within society.

As the isolation of families was seen as a serious threat to the health of children, a new meeting place and nursery provision emerged – open nurseries (Gustafson, 1983). The aim was the same as for the parenting course. Open nurseries immediately became popular amongst parents and an important partner for the children’s healthcare service, which strengthened its expertise in child psychology at the same time. On the whole, professional groups gradually began to work together when it came to their common target group of future and new parents. Gothenburg was one of the first. Back in 1976, councillors there reached a decision concerning the provision of “parent information” and subsequently decided that open nurseries and preventive social workers would be made available to all parents of young children. Social workers abandoned the desks of their social services offices to devote their attention to children and the parents of young children at open nurseries and prenatal and well baby clinics. This form of collaboration has been called “the Gothenburg Model” and became the predecessor to today’s family centres (Bing, 1997).

Family centres

The financial crisis in the early 1990s resulted in cutbacks in the public sector, which had a severe effect on preventive work. Local authorities had to save money. Out of several thousand open nurseries, suddenly only a couple of hundred remained, and preventive social workers were recalled to their offices. The crisis coincided with high levels of immigration, high unemployment and rising sick leave statistics. Public sector employees were seeing a rise in demand amongst the population as the resources available to them dwindled.

In this difficult situation, various professional groups began to work together in the hope that by doing so they could make their resources go further. Midwives and paediatric nurses outside Gothenburg now also gained good experience of working with social workers and nursery teachers on a daily basis. In many parts of the country, collaboration...
had become a habit and there was a readiness to take the next step of
moving in together under one roof. The people on the ground therefore
contacted managers and decision-makers in order to put their ideas
forward. In Sweden, where maternal and children’s healthcare services
are provided by the county council, whilst open nurseries and social
services are run by the municipal authority, the decision-making pro-
cess had to take place in a number of stages. This complicated the
political process and at the time the coffers were empty.

In this situation, projects were seen as a solution. The recently
established Swedish National Institute of Public Health began
to receive applications for project funding. A remarkable number
of applications concerned inter-professional collaboration relating
to pregnancy and the very youngest children. Midwives within the mater-
nal healthcare sector stressed that the time leading up to the birth of a
child represented a golden oppor-
tunity to exert an influence over the
health of an unborn child. In order to
deal with depression, cohabitation
problems, abuse and stress, they
needed help from other professions
such as social workers, family advi-
sors and psychologists.

This orientation corresponded
well with the WHO’s “Health for All
2000” policy, where the principal
goals of the European regions were
“Equity in life” and “Healthy start in
life”. Behind the applications were
politicians and officials which the
National Institute of Public Health
invited to an initial network meet-
ing in Gothenburg in 1995. This was
followed by other meetings, and
a major workshop in Leksand the
following year was attended by 180
people from 14 different municipali-
ties. At this workshop, the delegates
concluded that municipal authori-
ties and county councils should
get together and create a meeting
place for parents, where parents
could meet and play with their own
children, as well as those of other
parents; where children could enjoy
spending time together; and where
various professional groups could
work together in order to make
parenting easier. This meeting place
was giving the working name “fam-
ily centre”. The aims were to:

• offer a local meeting place
• reinforce the social network
  around children and their parents
• identify working methods in which
  children and their parents can
take part
• offer easily accessible support
• act as a centre for knowledge and
  information
• develop a good service

The National Institute of Public
Health’s task was to finance and
coordinate the network in order to
consider, in collaboration with the
delegates, what the work relating to
family centres should involve. At the
turn of the millennium, the National
Institute of Public Health underwent
restructuring and was assigned
what were to some extent new
tasks. Support for the family centre
network ceased. Instead, the family
centre network formed the Förenin-
gen för familjecentralers Främjande
(the Swedish Association for the
Promotion of Family Centres) (www.
familjecentraler.org), which, with its
annual conferences, has since acted
as a hub and a driving national
force. The association’s board
represents all the many professional
groups who work at family centres.
It is an inter-professional vocational
association whose thousands of
members have in common the fact
that they are committed to children,
preventive work and collaboration.
With the exception of one part-
time clerk, all work is carried out
on a non-profit basis. The fruitful
collaboration between the Nordic
countries has come about as a result
of the association’s initiative.

The new public health work
Swedish family centres are therefore
the result of a protracted process,
which has largely been driven
forward by the professional groups
involved themselves. However, dur-
ing the 2000s, family centres, which
grew from a “bottom-up movement”,
came to be included in local and
regional public health plans. This
accelerated their development and,
during the period 1997 to 2010, the
number of family centres increased
from 35 to 130.

In Sweden and other Nordic
countries, public health has held a
strong position in policy, research,
education and practice in recent
decades. This has benefited the
family centres, as the new public
health work places an emphasis on
cross-sector and promotional work.
This work encompasses both more traditional preventive work and health promotion, which has gained a stronger foothold. Promotion is characterised by the promotion of healthy processes which reinforce and protect health. In the new public health work, the responsibility is moved closer to decision-makers and organisations. Living conditions are given greater emphasis and supporting environments are seen as a key strategy (Bing, 2005).

A supportive environment abandons the illness-based approach in favour of a health-based approach and switches from prevention based on risk factors to opportunities for health promotion in everyday arenas. From concentrating on the individual, a holistic view is adopted instead, in which other factors that affect the individual are also considered. The health promotion work involves many players and collaboration partners. The work is transferred to various everyday arenas that are appropriate for health promotion work.

Whilst public health science introduced the new strategies of health promotion and health-promoting arenas (Petersen & Lupton, 2000), traditional mother and child care provision had already begun to adapt. Behind this development was a realisation that the traditional approach was not enough to resolve children's health problems. The relatively poor health of people today is more psychosocial than medical in origin and the solutions will require input from many organisations and professional groups. From a public health perspective, it is obvious that family centres fit in extremely well with the “new public health work”.

**Child health science and education**

In recent decades, a separate field of public health science for children has developed, known as “child public health” (CPH) or “child health science”. This is an intersectorial, multi-scientific and multi-professional initiative, which studies the health and well-being of the population from a social, economic, cultural and political perspective. Child public health is based on the knowledge and experiences of various professions and extends across social sectors. It is an appropriate approach for studying complex relationships which govern the health and development of children. Child public health is a counterweight to super-specialisation and fragmentation (Köhler, 2008). The teams working at family centres find their common anchoring within child public health, which develops the public health work within three areas:

- education and career development of everyone who will work with children, young people and their health
- research
- service and practice

Using child public health as a starting point, Kristianstad University held a distance learning course in 2010. The course, entitled “Working at a family centre”, is so far the only course of its kind and is aimed at all the professions who work at family centres.

**The Nordic countries**

If the development of Swedish family centres was a bottom-up event, their Norwegian equivalents experienced top-down development. In the mid-1990s, Norway adopted a major multi-annual national programme, the Escalation Plan for Mental Health 1999-2006 [Opptrappingsplanen for psykisk helse 1999-2006]. The plan was strongly influenced by the Ottawa Charter, which was drawn up in connection with an international WHO conference in 1986. The Ottawa Charter focuses on social inequality as an important determining factor, on multi-sectoral strategies and on power mobilisation. This reflected a new approach towards public sector services, which had inspired the Norwegian authorities (Haugland et al, 2006).

The Swedish family centre model was presented at a Nordic public health conference in Kristiansand in 1997 and attracted considerable attention. Norwegian public sector employees considered family centres to be a workable arena in which to promote the mental health of children. Later on, an annual budget of NOK 3 million was allocated via the Escalation Plan for the development of family centres in six municipalities. Special funding was also allocated for evaluation and research. During the trial period, Norway adopted the name “Familiens hus” [Family’s House]. This form of organisation is considered to be appropriate for

* Subsequently extended to 2008
providing paediatric mental health services, as it is a low-threshold service which guarantees fast and holistic help. Norwegian municipalities are recommended to organise their health-promoting and preventive services aimed at children and young people according to the Family’s House model. The Regional Centre for Child and Adolescent Mental Health at the University of Tromsø is responsible at a national level for promoting and developing the model. For 14 years, there has been close interaction between Norway and Sweden concerning the development of family centres within both research and practice.

The Finnish family centres have a slightly different history. The national FAMILY project developed the social services and health work relating to children and families. The development of family centre provision in around 100 municipalities received state financial support.

Knowledge concerning family centres
The Swedish Association for the Promotion of Family Centres celebrated its tenth anniversary by inviting delegates to a Nordic family centre conference in Stenungsund in 2005. With the help of contributions from the Nordic Council of Ministers and others, over 600 delegates from the Nordic countries had the opportunity to attend four days of lectures, courses, seminars and workshops (Föreningen för Familjecentralers Främjande, 2005). Conference delegates were given an account of the Nordic countries’ views concerning family centres, as well as relevant experience and knowledge. Representatives of ministries and authorities in Sweden, Norway and Finland also participated. The Nordic Council of Ministers also financed a Nordic meeting of researchers in 2007 at the Nordic School of Public Health (NHV) in Gothenburg (Stiftelsen Allmänna barnhuset, 2008).

After both of these conferences, the Swedish family centres attracted the attention of their own authorities and ministries. The Swedish National Agency for Education and the National Board of Health and Welfare conducted a review of family centres. The latter identified a need for an unambiguous definition of what is meant by a “family centre”. The National Board of Health and Welfare’s Institute for the Development of Methods in Social Work (IMS) also prepared a summary of the current state of knowledge in 2007 (National Board of Health and Welfare, 2008).

The investigators concluded that there was a lack of knowledge concerning the work and effects of family centres. They wanted to see a Nordic evaluation of the effects of family centres and a more precise clarification of the needs that the family centres were intended to meet.

No pan-Nordic studies have yet been published, but when Finland organised the second Nordic family centre conference in Espoo (Esbo) in 2010, the development of knowledge in Sweden had taken a big stride forward in just a few years.

In addition to a large number of local evaluations, three Swedish dissertations on family centres have

“The National Board of Public Health and Welfare proposes that there should be fully co-located family centres offering healthcare services for mothers and their children, open nurseries and the preventive work of the social services, which in future should be referred to using the term ‘family centre’.”
(National Board of Health and Welfare, 2007)
been presented. All three of these dissertations were published within the field of social work (Hjortsjö, 2005; Perdahl, 2009 & Lindskov, 2010). A comprehensive evaluation of 16 family centres in Västra Götaland was also carried out on behalf of the regional public health committee with assistance from Kristianstad University and the University of Borås (Abrahamsson et al, 2009).

References


Family centres in Finland – a new approach within services for children and families

Riitta Viitala, Marjatta Kekkonen and Nina Halme

In recent years, child, youth and family policy has become a topical theme in Finnish political discussion. The promotion of children’s and families’ welfare, by means of co-operation between different administrative and operational sectors, has grown stronger during the new millennium. The basis of well-being has been broadening and it is now perceived as being fundamentally connected to social relationships and experiences of inclusion. Mutual co-operation and partnership between municipal services and congregations, NGOs and private players is also deemed important. The starting point for organising services is the client’s participation and the possibility of having more influence.

The service structure of a family centre combines a meeting place for families with the family service network. In addition to municipal basic and specialised services, the family centre network can also include congregations, NGOs, volunteers and the private sector. The services of a family centre can be either located apart or centralised in the same premises. Operations are based on an agreed co-operation structure.

Family centre discussions in Finland began in the early 2000s

When Finland emerged from the recession, the sufficiency of parents’ resources and their ability to cope were seen as central concerns. Some even said that parenthood was lost. Families with children lead a busy and ever-changing everyday life. These challenges can easily put the resources of many families to the test. During the new millennium, the following issues have become factors which strain parents’ resources: stress, uncertainty as a parent, combining the role of a parent with everyday life, combining work and family life, relationship problems, and control of difficult feelings such as anger in conflict situations (Janhunen & Oulasmaa 2008). At the same time, parenthood began to be respected in a new way. The idea of promoting educational partnerships between parents and professionals grew stronger. The discussion of parenthood broadened into an “it takes a village to raise a child” conversation. Some also asked how parents should be approached and how they could be involved in services. Are parents able to make their voices heard, do they communicate their needs, ask questions, and are they able to have an influence? What meanings do we give to motherhood, fatherhood and parenthood in services for children and families?

Another discussion topic was workers’ professional knowledge and skills. Workers felt that families’ problems have become more complex, more serious and harder to solve. The traditional reply would be to increase specialised services, but this was considered unsustainable. A better starting point was to strengthen the competence for preventive work in order to provide families with the support at an early stage in terms of basic services. Close co-operation between different players became the key method in preventive work.
Indeed, in the birth of the family centre model, the key aspect lay in workers’ feeling that multi-professional co-operation increased their resources, competence and opportunities to support families. Co-operation began to develop into doing things together in a structured, planned manner.

A third factor, still taking shape at the beginning of the new millennium, was a new way of perceiving well-being. Public, social and health services as such were not felt to guarantee well-being. A human being is a sum of physical, psychological and social factors, and his or her well-being is generated through inclusion. The realisation emerged that public services for children and families could empower and create communities and integrate people into society. Crumbling social networks had increased families’ loneliness. Strengthening inclusion and promoting a sense of community became a means of preventing loneliness and social marginalisation. Today, the recently published strategy for social and health policy, Socially Sustainable Finland 2020 (Publications 2011:6), identifies solidifying inclusion and a sense of community as a strategic issue.

**Development of family centres in Finland**

For the time being, no precise information is available on the number of family centres in Finland. It has been estimated that about one-fifth of municipalities have organised services for children and families as family centres or in a similar way. Services similar to family centres are chiefly planned through co-operation between municipalities. (Perälä et al. 2011). Slightly over ten years ago, at the beginning of the 21st century, there were only few family centres in Finland. Family centre work has developed in phases.

The first wave – family centres arrive in Finland

The development of family centres in Finland has taken place in three stages. Family centres first came to Finland in 2002 when the city of Espoo, together with Diaconia University of Applied Sciences, renewed family training at child health clinics, following the example of the Swedish Leksand model. They began to carry out family training in parent groups, which met before and after the child was born. Fathers participated from the very beginning. The seeds of family centre work also began to grow through family work, open early childhood education, NGO peer group activity projects and in projects promoting partnership co-operation between municipalities and the third sector. Development projects of family centres during the first wave were started upon the initiative of and as co-operation between individual municipalities, the Association of Finnish Local and Regional Authorities, NGOs and universities of applied sciences (Paavola 2004). At an early stage, the development work yielded single projects and there was no nationwide, shared development vision or development network to support service renewal. A major shift in viewpoint, however, occurred when the problem-oriented practice was replaced by addressing issues in a proactive and resource-oriented way. The results of the first wave were encouraging and interest was kindled in disseminating family centre work. (Paavola 2004; Pietilä-Hella & Viinikka 2005).

The second wave – family centres’ operating models formed at a local level

The second wave of family centre activities began in 2005 when the Ministry of Social Affairs and Health established the national FAMILY Project (2005–2007) to support the development of family centres. Led by the National Research and Development Centre for Welfare and Health STAKES (currently the National Institute of Health and Welfare), the project became a partnership

---

1 The National Institute for Health and Welfare is conducting a survey on the overall situation concerning family centres in Finland. This survey will be completed in autumn 2011.
project. The FAMILY Project was based on the Government Resolution to Secure the Future of Social Welfare (2003), in which family centres were defined as an operating model based on families' needs and strengthening contacts between families.

During the second wave, set in motion by the FAMILY Project, development was steered at a national level. Such steering comprised interactive co-operation based on strong dialogue, networking between projects and players, sharing know-how and exchanging experiences. Families' participation in such development was supported. Almost 100 municipalities participated in the FAMILY Project, through a total of thirty sets of projects. In 2003–2007, the Ministry of Social Affairs and Health allocated 36 million euros of government subsidy to social welfare development, of which 7.6 million euros were allocated to family centre work. In addition, the provinces allocated a total of 54 million euros to development in the same period, 8.8 million euros of which was set aside for supporting services for children and families (Oosi et al. 2009, 28–29).

Municipalities which participated in the FAMILY Project created a shared vision of the operating concept for family centres. The operating concept was crystallised in five principles which guided the development of local operating models in municipalities and municipal regions. These principles were as follows:


2. Development of basic services for children and families: Support for parenthood is at its most effective in services intended for all families with children. The focus is on strengthening basic services for children and families, namely prenatal and child health clinics, early childhood education and care and preventive work in social services and schools.

3. Promoting peer activities and sense of community: Family centres take advantage of parents' and children's own resources, inclusion and expertise. Parent group activities support both mothers' and fathers' growth into parenthood as well as partnership between parents and professionals while strengthening the value of both parents in their child's life. Peer activities promote the emergence of parents' social networks, sense of community and the attachment of parents to their residential area.

4. Creating a culture of co-operation and partnership: Family centres operate on the basis of co-operation between services for families with children, professional groups and families themselves. Family centre work is co-operative and cross-sectoral. Co-operation is agreed on in partnership contracts between municipalities, congregations, NGOs and voluntary organisations.

5. Renewing the service structure: Family centres are developed with the aim of permanently renewing service structures and creating networks between services. Municipal welfare strategies and child and family welfare policy programmes serve as municipality's strategic steering instruments in the operation of family centres.
Based on these principles, the operating concept of family centres has been summarised as follows:

“A family centre is a locally developing service model whose services include prenatal and child health clinics, open early childhood education, primary school services, early support and family work services. Family centres include meeting places for parents, in which they can participate in unstructured or guided parent group activities. Family-oriented practices promote child welfare, support parenthood and the couple’s relationship, and their nature is preventive. A family centre’s working method is partnership co-operation with NGOs congregations, volunteers and families themselves. Family centres are part of the municipal structure of services for children and families. Case management services ensures that specialised services reach the families who need them.” (Viitala, Kekkonen & Paavola 2008, 23.)

In the second stage of the development wave, family centres were developed into service models whose operations are based on the local service needs and service structures. During the FAMILY Project, three kinds of family centre models emerged in municipalities (Oosi et al. 2009, 57–58; Viitala et al. 2008, 41–42).

1. **Family centre model based on child health clinics**
   Characteristic of the child health clinic based model was implementation of group-based family training in prenatal and well baby clinics, which was based on the Swedish Leksand model. Furthermore a stronger co-operation was built between prenatal and child health clinics, child day care and preventive social work (family work).

2. **Family centre model based on open early childhood education**
   The open early childhood education service was developed in a way which offered meeting places for families with small children. Meeting points operated on a low-threshold basis, and organised peer group activities, offered steered and targeted parent groups and pedagogically steered activities for children and parents. These activities were organised by NGOs and congregations, as well as by municipalities.

3. **Sub-regional family centre model**
   Many FAMILY Projects were sub-regional. This was partly influenced by the consolidation of municipalities which took place during the project period and in which several smaller municipalities joined a central municipality. In the region of Kainuu, family centres operate through a regional operating model in which local services for families with children have been collected into sub-regional family centres and family stations whose operations are slightly more limited. Furthermore, web-based family centre work has been developed, for example in Ostrobothnia.

During the second wave of family centre development, group-type services for children and parents were reinforced as part of services for families with children. Peer support between families and the significance of child-parent groups were increased. Attention was paid to strengthening parents’ relationships. The work of child health clinics and child day care was also developed. Functioning co-operation models also grew between child day care and school, at the school-entry stage. Multi-sectorial co-operation between open early childhood education, congregations and NGOs was intensive, supporting the establishment of families in their residential area. In a family centre, it is essential that children and families themselves participate in planning and implementing activities.

The focus on the development of family centres was on basic services, inclusion and multi-actor co-operation. Partnerships aimed to introduce the family centre working method as a co-operation method in
partners’ (organisations, congregations, resident associations, etc) own activities. The steering group of the FAMILY Project consisted of representatives from the Ministry of Social Affairs and Health, the National Research and Development Centre for Welfare and Health STAKES (currently the National Institute of Health and Welfare), the National Board of Education, the Association of Finnish Local and Regional Authorities, the Central Union for Child Welfare, the Finnish Parents’ Association, the Family Federation and the Evangelical Lutheran Church Council. In municipalities, the group of players was even wider. A partnership-based working method was implemented at both national and local level.

The third wave – family centre as a supporter of child and adolescent development environments
The third wave began when the development of family centres was included in the government programme in 2007. Development has been taken further with the support of the government’s Policy Programme for the Well-being of Children, Youth and Families, steered by the Ministry of Education and Culture. The National Development Plan for Social and Health Care Services 2008–2011, i.e. the KASTE programme, became the actual development engine. Based on the statutory KASTE programme, a thorough, nationwide renewal of services for children, adolescents and families with children was launched. The aim of renewal of services was that children and adolescents could receive the support they need at an earlier stage than now, in their own everyday lives and development environments at home, in day care, at school or in leisure environments. So far, the government subsidy allocated to the development of cross-sectoral services for children, adolescents and families totals 33.5 million.

The KASTE programme emphasises client-orientedness, the promotion of health and welfare, preventive work and inclusion. The starting point is the notion that sector-specific reforms are no longer sufficient. Supporting the development of children and adolescents at home, in day care and at school, and the prevention of emotional, behavioural and learning problems, provision of early support and the appropriate treatment of disorders form a whole. When the various elements of this task work well together, a good childhood is ensured, preventing social marginalisation in young people and psychosocial problems in adulthood. Supporting children and adolescents in their own development environments entails simultaneous support for those adults – parents and professionals – who are responsible for children and adolescents (the Kaste programme 2008, 20; Risikko 2010, 5; Mäkelä 2010, 7). It could be said that family centres’ operating concept, with respect to cross-sectoral co-operation and partnership between players supporting children and families, was also chosen as the leading development principle for the national renewal of services for children, adolescents and families.

For implementation of the programme, the first cross-sectoral national and regional development structure was established, including representatives from non-governmental organisations. The country was divided into five KASTE regions. Instead of single development projects, sets of projects, broad in both operational and geographical terms, were conducted. Development projects of services for children, adolescents and families are currently in progress as distinct projects in all KASTE regions. The development and broadening of family centre work is included in each of these. Furthermore, implementation of the KASTE programme included novel, interactive and active co-operation with numerous players such as universities, universities of applied sciences and Centres of Excellence on Social Welfare. Educational, cultural, sports and youth services became central co-operation partners in child and adolescent services.

The KASTE programme has seen the launch of a significant change process in the operating cultures of child and family services. This has reinforced the preventive role of basic services and early support expertise. Co-operation between basic and specialised services has diversified, and intensive rapid action consultation and co-operation structures have been created as part of these services. The first programme period is about to end and preparations have begun for the KASTE II 2012–2015 programme.

Under the KASTE programmes, basic services for children, adolescents and families have been brought together, both operationally and structurally,
into municipal preventive services, i.e. family centres. However, combining services into family centres has meant different things in different municipalities, such as wide-ranging organisation of services in line with life-cycle thinking, family centres, welfare child health clinics, family stations, shared physical premises, open early childhood education, etc. More detailed information is needed on the preventive services offered by family services and how they are organised and managed. Research data is also needed on the effectiveness of family centres’ health and welfare promoting work, and on preventive activities. In Finland, family centre work faces the challenge of defining criteria and drawing up a guide for family centre work.

In the third stage of family centre development – in which KASTE development work has included all services for children and families, from universal basic services to child- and family-specific specialised services, including child welfare, child psychiatry and adolescent psychiatry – family centres have been emphasised as a structure which promotes the health and welfare of children and entire families, while offering early support. Family centres are becoming a service structure which consists of meeting places for families and a family services network. In addition to municipal basic and specialised service professionals, the family services network may include workers from associations, NGO volunteers and private-sector services. Family centres combine the expertise and know-how of parents, professionals and other players in a way which benefits all parties. Parents not only need information and parenting support, but also the chance to exchange experiences with others in a similar life situation. For this reason, the prerequisites of peer activities have been reinforced. The family centres are universal and intended for all families with children.

The services of a family centre may be located on the same premises, “under one roof”, or in their own locations, in which case the family centre operates as a network. Operations are based on an agreed co-operation structure and a partnership agreement drawn up with NGOs, congregations or other players. Family centre work is organised by municipalities, NGOs or both as multi-actor co-operation. Family centres can also act as centres of expertise, creating networks between professionals in the field and family centre professionals, and developing services, family centre work and working methods which support welfare and health.

The development challenges of the family centre model
The goal of the next KASTE programme period is to continue the reform which has already begun, to regionally entrench new service structures, operating models and best practices and to spread them throughout the nation. In spite of numerous positive accomplishments, there are still challenges in the development of the family centre model.

**Strengthening parenthood and supporting the child’s growth**
The basic task of a family centre is to promote child welfare and health by supporting parenthood. This is based on continuously increasing and diversifying knowledge of the fact that child health and welfare are built during interaction between parent and child. The Finnish family centre model faces the challenge of developing personnel’s shared know-how on the parent–child attachment, and on early interaction and encouraging upbringing practices which support the child’s development. In other Nordic Countries, structured parenting support programmes are widely used. Finnish, nationally developed, cross-occupational training programmes include Supporting early interaction (VAVU), Theraplay, Taking up one’s worries, Educational partnership and Let’s Talk about Children. The family centre of Western Turunmaa supports its know-how with the ICDP programme, originally developed in Norway and known in Sweden as Vägledande samspel.

The International and widely disseminated International Child Development Programme (ICDP) encourages positive interaction with the child. This pro-

---

2 In Finland, parenting support programmes have been developed by the National Research and Development Centre for Welfare and Health, STAKES, and currently by the National Institute for Health and Welfare, THL. The National Public Health Institute and STAKES merged in 2009, to form THL.

3 The International Child Development Programme (ICDP) is a parenting support programme developed by Norwegian professors Karsten Hundeide and Henning Rye at the University of Oslo. It is applied in more than 20 countries.
Family centres offer a place where parenting, normally part of the private home environment, can be communally shared. Support for everyday life and strengthening of families' own resources and expertise are needed for parenting, child upbringing, the relationship between the parents and other everyday challenges. By investing in motivational and preventive services which are easily accessible for families, it is possible to reduce the number of child welfare customers and, in the long run, save on corrective service costs. In preventive work, it is of great importance to have the opportunity to share the joys and sorrows, bafflements and feelings of helplessness, as well as experiences of being capable and coping, and to have premises available for shared activities which strengthen parenting. In preventive group-form parent work, capabilities and skills pertaining to parenthood, shared by all parents, can be reinforced. This, in turn, reinforces social integration.

Open early childhood education services have been a significant part of the family centre model since its beginning. One of family centres' development challenges lies in the need to strengthen their pedagogic groundwork. Pedagogic activities support children's individual development and social activity within child groups. Pedagogically planned activities reinforce parenthood as a promoter of a child's comprehensive learning. Reinforcement of family centres' pedagogic groundwork means combining support for the child's learning with support for parenting.

**Reconciling preventive services and developing management**

The municipal and service reform (2005–2012) has reduced the number of Finnish municipalities and reshaped the structures of social and healthcare services. With the service field in transition, family centres offer an operating model which combines local services for children and families into a whole whose functions are based on families' needs. A family centre consists of multiple services. At its best, a family centre can act as the foundation of services for families with children, reshaping the entire service structure into a whole which is child and family-oriented, consists of basic services and relies on the life cycle model. To achieve this, services must be reconciled and cross-sectoral management must be developed.

Multi-sectorial co-operation is based on the expertise of each partner, clearly defined needs, and goals in which resources, risks and benefits are shared. Partnership reinforces the mutual trust and commitment of service providers, increasing the likelihood of attaining these goals. To achieve this, management needs to be developed in such a way as to form child and family services into unities which are coherent and functional from the viewpoint of families. Multi-sectorial co-operation does not appear spontaneously, but requires plenty of co-operative thinking and planning. One third of municipalities have not made agreements on common goals and operational practices, nor on common follow-up and assessment of work (Perälä et al. 2011, Joensuu et al. 2011). In many municipalities, family centres have already evolved from development work into practice, but family centre players also feel unclear about what a family centre means as a method of organising services, how multi-professional co-operation can be supported and how partnership with the third sector should be organised. A pivotal challenge is to make multi-sectorial co-operation and agreeing on common practices genuinely attached to preventive work and the management of child, adolescent and family services.

**Family centre into legislation**

A thorough reform of social welfare and health-care legislation is currently underway in Finland. The new Health Care Act entered into force in May 2011, the Social Welfare Act is currently being reformed, while preparations are being made to renew legislation on the organisation and development of social welfare and healthcare.

Sector-specific legislation on services for children, adolescents and families with children has been renewed to support a working method which is family-oriented, promotes welfare and health, and is multi-sectoral and network-oriented. In child health clinic work, the emphasis is on directing support towards the whole family. In addition to child welfare, the welfare of both parents and their relationship form the focus. Access to...
family training, parent group activities and home visits for families expecting their first child has been amended in particular. The Child Welfare Act lays down provisions on preventive child welfare, confirming child health clinics, child day care, school and youth work as co-operators in child welfare work. The Act on Children’s Day Care will probably be transformed into an Early Childhood Education Act. Several sector-specific Acts lay down provisions concerning multi-sectoral co-operation working groups. Peer group activities also hold a stronger legislative position than before.

The family centres has been promoted by means of sector-specific legislation, but there is no legislation concerning family centres as such. In addition to national and local development efforts, steering by way of legislation is needed to establish the family centre model.

References


The Family’s House in Norway – an interdisciplinary, municipal/community healthcare service for children, adolescents and their families

Anette M. Thyraug, Gørill W. Vedeler, Monica Martinussen and Frode Adolfsen

This chapter presents a description of the Family’s House/ Family Centre Model, as it is applied in Norway following a national pilot study of Family Centres during 2002–2004. An overview is also given of the number of municipalities that have organised their services in the form of a Family’s House, based on a survey carried out in 2008. One new study associated with the model which focuses on how an open kindergarten can act as a parental support initiative, is also described.

The Family’s House provides interdisciplinary services in the municipalities which addresses mental and physical health of children, adolescents and their families. The municipality’s primary health and social care services aimed at children, adolescents and their families are coordinated, co-located and anchored locally through this service. The aim is for families to receive both well coordinated and family supported services within the same building.

During the period 2002-2004, the Regional Centre for Child and Youth Mental Health and Child Welfare at the University of Tromsø conducted a national pilot study involving family centres (now Family’s Houses) on behalf of the Norwegian Health Authorities. The pilot study was based on the Swedish family centre model, but was adapted to Norwegian conditions (Haugland, Rønning, and Lenschow, 2006). At that time, the project was anchored in the National Plan for Advancing Mental Health Care that was implemented between 1999 and 2008 (Ministry of Health and Care Services, 1998).

The Norwegian authorities recommend that municipalities should organize their services according to the Family’s House model, and emphasise that the model is in line with the intentions of the Co-ordination Reform currently being implemented (Ministry of Health and Care Services, 2009). The model is also highlighted by the National Institute of Public Health, which in a new report on health-promoting and preventive recommendations recommends that the model be further tested as a coordinating initiative and that it should be systematically assessed together with other models (National Institute of Public Health, 2011).

Many different services and departments are collectively responsible for the health, development and well-being of children and adolescents in Norway. These are financed in different ways, have a specialist support function in different departments and directorates, and have different legal frameworks to adhere to. The fragmentation of responsibility for different areas which are nevertheless closely associated with each other can represent a significant challenge for children, adolescents and families with complex needs. In an official report on the co-ordination of services for vulnerable children and adolescents, the Family’s House is promoted as a suitable model for the organization of the collaboration covering this target group (Ministry of Children, Equality and Social Inclusion, 2009).

The Family’s House co-ordination model

The services that are often co-located in Family’s Houses are a health centre that offers healthcare service for children including pregnancy care, preventive child welfare services, ped-
agogical-psychological services and an open kindergarten. Professionals from the various services make up a flexible interdisciplinary team that delegates the work according to the wishes and needs of the users. The goal for the work is to promote well-being and good health amongst children, adolescents and their families, and to improve conditions for children and young people (RKBU Nord, 2008). Amongst other means, this goal can be achieved by:

- Identifying the physical, mental and social challenges faced by the child and the family at an early stage
- Providing readily accessible support and initiatives
- Supporting and reinforcing parents in their role as caregivers
- Enabling children, adolescents and their families to strengthen their social networks
- Developing communication and working methods with the involvement of children and parents
- Developing appropriate, coordinated and interdisciplinary services for users
- Being available as a meeting place in the areas where people live
- Disseminating relevant information

The goal is to develop a good dynamic and ensure that assistance is well-coordinated, whether at a universal, targeted or indicated level (see Figure 1). The model is intended to ensure that services that are co-located work together to develop an integrated service that includes initiatives at all levels.

How many Family’s Houses are there in Norway?
A national survey of Family’s Houses conducted in the autumn of 2008 indicated that many different forms of interdisciplinary collaboration had developed within Norwegian municipalities (Thyrhaug and Martinussen, 2009). All Norwegian municipalities were contacted and asked to give feedback as to whether they had an organization corresponding to that of a family centre or planned to establish such a centre. The 19 County Governor offices were also contacted in order to find out what they knew about municipalities with such organizations. This resulted in a total of 59 organizations spread across 40 municipalities. Many of the 59 organizations that responded to the survey were designated as family centres, Family’s Houses or similar. These were in turn sorted into four categories (see Figure 2). Upon closer inspection, it was apparent that 14 of

**Figure 1**
*Levels of initiative and interventions within a Family’s House*

**Third floor – Indicated interventions**
Children, adolescents and families with particular needs

**Second floor/level – Selected interventions**
Children, adolescents and families with individual needs

**First floor/level – Health promotive and universal interventions**
All children and adolescents with their families

**Foundations**
Professional infrastructure and competence
the participating organizations consisted of all the same services that were included in the model formulated in the trial project, and therefore qualified as a Family’s House. 16 of the organisations were given the name Resource Health Clinic. These were developed on the basis of a health centre, but had only integrated certain individual elements from the Family’s House model.

Two groups of organizations were constructed in an entirely different manner. We found 10 organizations that we decided to refer to as specialist referral teams. These had established an interdisciplinary team consisting of various types of personnel with expertise within mental health work. Amongst the participating organizations, we also found nine more independent open kindergartens with additional resources. The link for collaboration with health centres was unclear for the latter two categories. It was our understanding that it was the parents themselves who contacted the centres, or other child-oriented services referred families there, in cases where the problems facing the child and the family were so great that extended assistance was needed. During the survey, contact was established with nine organisations who informed us that they were in the process of establishing a Family’s House. However, we are unaware of the direction in which these Family’s Houses developed.

Open kindergarten – a parental supportive effort
Open kindergarten in the the Family’s house are a health-promoting and preventive initiative in order to provide users with readily accessible parental support by serving as a pedagogical, open and inclusive meeting place for the parents of young children. The goals of the initiative are to stimulate the development and health of children, to support and reinforce parents in their role as caregivers, to promote a good level of interaction between parents and children and to strengthen the social network of parents. Open kindergartens are open to everyone with children up to the age of six, and the service is free with no one being allocated a permanent place. Parents are given the opportunity to use the kindergarten service at times that suit them during opening hours. Other people caring for children within the target group are also welcome.

Users are invited to actively contribute to the formulation of the kindergarten’s programme and to the performance of daily activities. Pedagogical staff are responsible for ensuring that such participation takes place.

Open kindergartens supplement Family’s House services in several ways. First and foremost, they add a new dimension to the range of

**Figure 2**
Proportion of different types of organisation

- The Family’s House, n=14
- Resource health clinics, n=16
- Specialised referral teams, n=10
- Open kindergarten with extra resources, n=9
- Organizations under establishment, n=9
municipal services on offer by being available to users without the need for prior appointments or referrals. During opening hours, users are given access to a social meeting place and a secure and stimulating environment in which their children can meet other children. They can also receive support and guidance there. The kindergarten strengthens the Family's House's interdisciplinary team through low-threshold pedagogic skills, and the kindergartens' premises locations may be used for other Family's House services outside its opening hours. The functionality of the locations provides space for a diverse range of activities. The value of the kindergarten, as an interdisciplinary arena, is apparent when professionals from the Family's House's other services are present and make themselves available to users during the kindergartens's opening hours.

Open kindergartens recruit users via the healthcare service, the local area around the Family's House or from the surrounding geographical areas. Almost all parents in Norway use the healthcare service, and information concerning the kindergartens' services has often already been disseminated via the antenatal care service before the child has even been born. The nurse from the healthcare service can be helpful in establishing personal contact between the user and pedagogical staff, and thereby contribute to the further lowering of the threshold. A user survey conducted in five open kindergartens in 2009, to which 185 people responded, indicated that the average user of open kindergartens was a mother aged around 31, who attended with a child of around 1.6 years of age, and that they visited the kindergarten on a weekly basis (70%) (Vedeler, 2009). Compared with figures from Statistics Norway, the survey suggested that the level of education of users was somewhat lower than the national average, which could indicate that kindergartens with parental support initiatives also recruit users from a somewhat lower socio-economic background than those with a somewhat higher threshold, e.g. where parents have to register for courses (Reedtz, Martinussen, Wang Jørgensen, Mørch and Handegård, 2009). Other studies have shown that parents with a lower socio-economic background seek out informal services to a greater extent, rather than use formal bodies or course services requiring prior appointments or referrals.

One of the main goals of open kindergartens is to create an arena where parents can strengthen their social networks. Of those who responded to the survey, 75% stated that they got to know other parents through visits to the kindergarten either to a great extent or a very great extent. Even though most of the users were stay-at-home parents, the 2009 survey indicated that around 30% of parents were working or in education. It is notable that 68% of the users stated that they had moved during the past five years, of which 40% had moved two or more times during the same period. This could indicate that the user group was relatively mobile and therefore required integrating community initiatives corresponding to open kindergartens.

**Summary**
The Norwegian authorities recommend the establishment of Family's Houses in Norwegian municipalities. A national survey indicates that there are also a number of other organizational forms. The characteristic features of the Family's House model are the fact that a number of services are co-located and coordinated in order to provide users with a holistic range of services, and the fact that open kindergartens are included in this model, in addition to the traditional municipal services such as healthcare services, child welfare services and pedagogical-psychological services. Assessments indicate that parents using open kindergartens are very pleased with the service.
References


Contact information: Gørrill Warvik Vedeler (gorill.vedeler@uit.no), Monica Martinussen (monica.martinussen@uit.no), Frode Adolfsen (frode.adolfsen@uit.no) and Anette Moltu Thyrhaug (anette.thyrhaug@uit.no). Regional Centre for Child and Youth Mental Health and Child Welfare, University of Tromsø, NO-9037 Tromsø, Norway.
Danish family policy and the Child Reform

Anna Jin Rolfgaard

Danish family policy
Strong, self-supporting families are essential for a secure and strong society experiencing growth. Families are the focal point for people throughout their lives. It is first and foremost within the family that individuals acquire their basic values, attitudes and perspective on life, and the family is the unit that performs a wide variety of basic and particularly important functions. This applies when it comes to both having children and providing them with key social skills which equip the individual for life and enable them to understand and function as a citizen in society.

Furthermore, families are an absolutely essential prerequisite for the existence of society, simply because it is within families that the population reproduces.

Family policy is not just about maternity rules and day care provision; it is also about health policy, social policy, environmental policy, etc. The circumstances and well-being of families are therefore key parameters in the formulation and implementation of new political initiatives.

The Danish government sees a successful family policy as a family policy as one that gives families the freedom to organise their own lives. The initial assumption is that families can and want to take responsibility for themselves and those closest to them. The task of society is to provide services which secure families’ freedom of choice and uninhibited development and provide a safety net for those who find it difficult to cope on their own. Society must provide an appropriate framework, but the families themselves also have a responsibility to create a good family life.

There are five underlying principles in Danish family policy:

- The family policy must give families the flexibility and freedom to organise their family life as they wish
- The family policy must help to promote a balance between family and working life
- The family policy must ensure good framework conditions for families across initiative areas
- The family policy is based on the necessity of utilising the resources that are available within civil society
- Family policy and social policy are interlinked. Vulnerable families must receive the help and support that will enable them to take advantage of society’s opportunities and create a secure framework for their children’s upbringing and the family’s well-being

The vast majority of children in Denmark grow up in appropriate and secure surroundings with parents who support them throughout their childhood. However, this is not true for all children. Some children do not have a secure framework or receive the support they need at home. It is a key task of society to support these children and their families, in order to ensure that the children have the same opportunities as their peers for personal self-realisation, development and health in spite of their difficulties and challenging circumstances.

Achieving this goal will require the framework behind the initiative to be optimal. This framework was considerably strengthened through the child welfare reform of 2006, which amongst other things focused on the importance of a comprehensive review of the child’s problems and an action plan for the initiative. Through the agreement – the Child’s Reform of 2009 – the political parties behind the rate adjustment pool agreement brought focus to the following three themes:

1. Closeness and care (Strengthening of foster family programmes)
2. Children’s rights and the previous initiative (The legal position of vulnerable children must be strength-
ened, so that the child’s interests are always the most important consideration, and prevention and an early response are of vital importance in order to secure vulnerable children a good childhood.

3. Quality in the initiative (Many areas must be considered if it is to be ensured that the initiative will make a positive difference to vulnerable children and in the long term help to ensure that they get the same opportunities as other children, including the elimination of red tape, knowledge production and dissemination, etc.)

The parents of vulnerable children play a major role in their children’s lives, regardless of any failure or deficiencies on their part. It is therefore important to be aware of the parents’ needs for special support if they are to contribute to their children’s well-being and development. In some cases, placement in foster care is essential, but this does not alter the fact that a placement outside the home is always an unhappy situation which must be prevented wherever possible. At the same time, the parents still have a major role to play for the children during a foster placement. It is therefore vital that efforts are made to resolve the family’s problems during the placement wherever possible, both so that the time which the child and the parents spend together can be as positive as possible and in order to ensure that the child can return to their parents wherever possible.

“Family centre provision” in Denmark

As part of the Child’s Reform, funding was allocated to the development of the “Mødrenes Hus” (The Mothers’ House) model. The Mothers’ House has the characteristics of a model that local authorities, in partnership with a voluntary association, will implement and test. The model was developed by drawing on inspiration from practice, including “Familiehuse” (Family’s Houses) in the Nordic countries and the Netherlands, and the “I gang” (Underway) project, which is being carried out under the direction of the Danish NGO “Mødrehjælpen” (Mothers’ Help). The model is based on our current best knowledge of how an initiative aimed at vulnerable young mothers should be organised so that the goals for education, employment, parenting skills, networks and housing are achieved. The model’s starting point is a holistic and non-stigmatising approach to the target group of vulnerable young mothers, their children, networks, etc.

If you have any questions regarding Danish family policy, please contact Head of Section Anna Jin Rolfgaard (anr@sm.dk) or Special Consultant Anne Katrine Bertelsen (atb@sm.dk) at the Danish Ministry of Social Affairs.
Child and family services in the Icelandic welfare system

Sigrun Juliusdottir and Elisabet Karlsdottir

The aim of this chapter is to present a picture of the range of services available to children and families in the Icelandic welfare system based on three perspectives: the public, state and municipal sector, the voluntary sector and the private sector. The principal focus has therefore been placed on the general and preventive, rather than on vulnerable families or marginalised groups.

Welfare services in Iceland for children and families are in many respects similar to the Nordic welfare system, particularly when it comes to public sector childcare. Various general services are described, along with social initiatives for various types of family based on their varying needs. Finally, the presentation is linked to results from Icelandic family research, amongst other things on the basis of family policy aspects and the role of social work in postmodern family development.

The public, state and municipal sector

Care and services for children, families and young people represent an important part of the welfare society. Formal, public sector family services are enshrined in Icelandic laws concerning social support for families and children in the form of social services and maternal and children’s healthcare, as well as geriatric care. According to Icelandic legislation covering welfare and social services, municipal authorities are required to ensure the financial and social security and welfare of the population. This must take place through improvements in the living conditions of vulnerable groups and through ensuring the development of generally favourable upbringings for children and young people (Act No. 40/1991).

The purpose of this is welfare with social and financial support for all (universal). There are also special services for those with special needs, particularly children and young people. Services and resources are provided by both the state and the municipal authorities. The range of services provided for children and families in the Icelandic welfare society varies from municipality to municipality. Framework legislation provides scope for differing interpretations of the laws and the range of services offered by municipal authorities under family policy. A further factor that plays a part in this respect is the fact that the 76 municipalities in Iceland vary greatly in terms of size and therefore also their needs in terms of services and support. Reykjavik is the largest municipality, with approximately 119,000 inhabitants, compared with the smallest municipality which has 52 inhabitants. A total of 33 municipalities have fewer than 1,000 inhabitants. Over 60% of the Icelandic population live in the Reykjavik area (203,000 out of the entire population of 318,452) (Hagstofa Íslands, 2011). A recent survey of municipal services for children and families in Iceland (in municipalities with more than 1,000 inhabitants) showed that, of 58 different services available, Reykjavik provided 50, compared with one of the smallest which only offered 20 of the services (Félag- og tryggingamálaráðuneytð, 2010).

The range of services offered to children and families can be divided into six areas: welfare and social services, educational initiatives, leisure, cultural issues, communication, third sector and non-governmental organisations (Félag- og tryggingamálaráðuneytð, 2010). The
range of services offered to children and families from a preventive perspective covers the provision of both preventive advice and support for parents, as well as varying levels of financial support for single parents, the unemployed, those on sick leave, parents living below the poverty threshold, etc. Financial support includes for example a sibling discount at nurseries, discounts for childcare in the home and discounts for single parents, as well as financial support for participation in leisure activities for children, totalling 23 different benefits. This preventive service is offered to 47% of the population (Félags- og tryggingamálarðuneytið, 2010).

Another resource concerns state contributions to families with children in the form of, for example, parental leave, child benefit, children’s pensions for disabled parents and parental allowances for single parents (Hagstofa Íslands, 2009). Parental leave in Iceland can be taken by both the mother and the father. A total of nine months’ leave is given: three months for mothers only, three months for fathers only and three months which the parents can allocate between themselves (Eydal & Gíslason, 2008). Child benefit is paid via taxes and varies according to the income of the family, except that the same amount is paid to everyone with children under the age of seven (Arnaldur Sölvi Kristjánsson, 2011).

There are opportunities to take part in educational initiatives for children of non-Icelandic origin (mother tongue lessons), and for prioritisation or special treatment as regards admission to nursery for disabled children. In addition, certain municipalities offer allowances for the care of children in the home. Eydal and Rostgaard (2010 in Gíslason and Eydal (ed.)) have discussed the concept of “børnepasning” (childcare) with regard to the integration of care and learning. One of their findings is that all Nordic countries except Iceland offer daycare centre allowances as a direct continuation of parental leave. Some of the family services concern leisure activity provision. This area includes social club activities for children aged 13–16, sports centres for the whole family, and the provision of employment and leisure activities during the summer for children of school age. It also includes free entry for children to swimming pools, entertainment for children at libraries and free bus travel for children. Healthcare centres in the larger municipalities provide not only maternal care but also access to certain family support services, particularly for families with very young children, but the focus is primarily on the physical health and development of children. Some healthcare centres provide targeted parental care with teaching and advice.

Very little family work is carried out through schools, but the ordinary parents’ associations cooperate in various “home and school” programmes and the schools themselves are to some extent involved in collaboration with social and childcare services. A few schools, mainly in the Reykjavik area, have study advisors and/or school welfare officers, usually the same person.

Services for families, children and young people provided by the third sector

Voluntary work has traditionally played a role within social and non-profit organisations in Iceland and represents what is known as “the third sector” (Juliusdottir, 1999: Juliusdottir & Sigurdardottir, 1997). This activity falls between the public and private sectors and is aimed at non-profit services for the benefit of the general public (Hrafnsdóttir & Kristmundsson, 2010). It is common for various interest groups in Iceland to do voluntary work and, according to Hrafnsdóttir (2006), around 40% of people now participate in various types of voluntary work. This mostly concerns sports and parents’ associations, as well as various charitable organisations. One unexpected finding was that it is the age group which is most likely to have their own children that contributes most to voluntary work. Activities that are specifically aimed at families, children and young people are the most comprehensive, both now and in the past, and these activities are often supported by the public sector (Steinunn Hrafnsdóttir, 2008).

Parents often participate with their own children in various sports and youth organisations on a voluntary basis. A major voluntary contribution is the involvement of parents with various service programmes and the provision of advice to children and young people with various types of
disability or long-term illness, such as Sjónarhóll (http://www.sjonarholl.net) and Proskahjálp (http://www.throskahjalp.is).

Another organisation that works in the interests of children and families and for attitude change concerning their affairs is Barnaheill (Save the Children), which works both nationally and internationally. There are also organisations such as Kyrkans välgör-enhet (Charity work of the Church), the Red Cross and Mödral Compositepen (The Aid of Mothers), which have specifically dealt with parents and children living below the poverty threshold since the economic crisis in 2008. Voluntary work has long been important in family welfare issues in Iceland (Steinunn Hrafnsdóttir, 2006).

**Family services in the private sector**

Private sector services covering family issues are not particularly extensive in Icelandic society. It is primarily social workers and psychologists who have clinical expertise or who are authorised psychotherapists. This service is primarily available in the Reykjavik area. The first reception clinic, Föräldrarådgivningen, was started by two female psychologists in 1979 and reorganised to form Psykologcentrum in 1983, an organisation which is still active and offers both individual and family therapy. In 1982, a team of family therapists, three social workers and two psychologists founded Familjemottagni-gen Tengsl, which also offered family courses and management, as well as longer family therapy education programmes, e.g. in collaboration with the University of Iceland’s institute for continuing education. All five were full-time public sector employees, two of whom still run a private clinic for couples, parents and children. Kyrkans familjerådgivning provides access to family advisors, three social workers and a psychologist. Some clergymen have specialised in bereavement counselling for families, whilst a few lawyers work with social workers and psychologists providing mediation to divorcing couples in conflict over child custody and access issues. The limited provision of family services due to a failure to acknowledge the need for specialist expertise relating to families (Félags- og tryggingamálaráðuneytið, 2009; Nososco, 2009) has contributed to a growing number of social workers and psychologists opening private clinics for families with special needs, e.g. associated with Alzheimer’s disease, ageing, relationships, etc. Research has shown that the need and demand for family advice and support, particularly in connection with divorce issues and step-child relationships, has increased in line with the post-modern development of families (Juliusdottir, 2009 a & b).

**Welfare services and evidence-based knowledge**

Icelandic society has changed since the banking crisis in 2008 with (almost previously unheard of) unemployment and reduced spending power as a result. This has had a marked negative effect, particularly in terms of the ability of families with children to provide for and maintain their quality of life. The Ministry of Welfare has implemented comprehensive measures to deal with this new situation, including initiatives to counteract the financial difficulties faced by families and the threat of bankruptcy and wherever possible to protect the public sector welfare service that had previously been built up (Félags- og tryggingmálaráðuneytið, 2009a).

Greater acknowledgement of the importance of evidence-based knowledge within the social arena has contributed to social services for children and families now being increasingly based on research and evaluations of various service programmes and methods. This has resulted in greater ambitions amongst social workers and other professionals within social care for participation in development projects and the evaluation of services, and thus helping to raise the level of quality of post-modern social work. The result is a better developed range of services for users of social services (Guðmundsson, Jónsdóttir & Júlíusdóttir, 2010). An example of a service that is based on evidence-based practice within the state and municipal sector (Reykjavík) is Kvennasmiðjan, which is a collaborative project between the City of Reykjavik and the Social Insurance Administration (Guðmundsson, Jónsdóttir and Júlíusdóttir, 2010; Hrafnsdóttir & Karlsdóttir, 2009).
References


Promotion of the well-being of parents and children
The Swedish strategy for developed parental support and the family centre as an arena for the provision of municipal parental support services

Johanna Ahnquist

In order to support the country’s parents, the Swedish government has formulated a national strategy for developed parental support – A benefit for all (Nationell strategi för ett utvecklat föräldrastöd - En vinst för alla). The aim of the strategy is to promote local collaboration surrounding the provision of support and assistance to parents in their parenting. The strategy places an emphasis on the family centre as an example of both a form of collaboration and a health-promoting arena for parents and their children. During 2010–2012, some 10 pilot projects are being carried out in various locations across the country with the common aim of developing and evaluating municipal strategies for parental support in accordance with the national strategy. Some interesting development work is underway in many of these projects using the family centre as a starting point. The aim of this article is to give an account of the Swedish strategy for developed parental support and to present a number of specific examples of the way in which family centres can play a key role in building up new structures and forms of collaboration for parental support provision.

Parents are important

Parents are the most important people in every child’s life and are best placed to influence their children’s health. Whilst a good and trusting relationship between a child and his or her parents acts as a safety factor for a child, deficiencies in the home environment can also have a negative impact on the child. Inadequate supervision, parents who have a positive attitude towards norm-breaking behaviour and serious conflicts between children and their parents are known risk factors. Poor relationships within a family can for example increase the risk of mental ill-health as well as high-risk behaviour such as alcohol and drug abuse, smoking, obesity, etc. in children (Resnick et al, 1997; Rhoades, 2008; Stewart-Brown, 2008; Weich, Patterson, Shaw & Stewart-Brown, 2009).

When children themselves are asked, they consider that the most important factor for feeling good is to have parents who get involved, i.e. who set aside time, who care about and who listen to their children (Backett-Milburn, Cunningham-Burley & Davis, 2003).
Support for parents

The preamble to the Convention of the Rights of the Child states “Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community” (Ministry of Foreign Affairs, 1990). A fundamental concept of Swedish welfare policy has been to offer parents good living conditions, which are one of the preconditions for good parenting. Sweden therefore has a well-developed safety net that provides families with fundamental support and protection in the form of, for example, child allowance, a parents’ allowance that enables parents to be at home with their children for around a year, good access to care, school and nursery provision, leisure activities, etc.

The health of Swedish children stands up well in a historical and international perspective. However, despite a well-developed safety net, there are still a number of disturbing trends. One of these trends is the increase in mental and psychosomatic disorders amongst adolescents that has become apparent in recent years (Danielson & National Institute of Public Health, 2006; National Board of Health and Welfare, 2009). Developing social support for parents is therefore an important piece of the jigsaw associated with reversing this negative trend.

The government’s initiative concerning support for parents – “A benefit for all”

From a social perspective, it is vital to provide parents with support and assistance that strengthens them in their parental role and helps to reinforce the safety factors within the family. In order to better enable Swedish parents to give their children a secure and good upbringing, the Swedish government has established the “National Strategy for Parental Support – a benefit for all” (Ministry of Health and Social Affairs, 2009). The Swedish national strategy for parental support forms part of the government’s long-term initiative to promote health and prevent ill-health amongst children and adolescents. The strategy is based around the view that the responsibility for the child’s best interests is a joint one and the strategy is therefore aimed at promoting local collaboration concerning the provision of support and assistance to parents in their parenting. The strategy offers a definition of parental support and one overarching objective and three secondary objectives.

The overarching objective of the strategy is to offer parental support to all parents until their child reaches the age of 18. The Swedish national strategy for developed parental support highlights the view that the support must build on existing structures, promote collaboration and provide the right circumstances to enable parents to meet.

Parental support is defined in the strategy as an activity that “teaches parents about their child’s health, emotional, cognitive and social development and/or strengthens the social network of parents”.

Forms of parental support

There are many occasions during a child’s upbringing when support in some form may be needed. The report entitled “Föräldrastöd – en vinst för alla. Nationell strategi för samhällets stöd och hjälp till föräldrar i deras föräldraskap” (Parental support – a benefit for all. National strategy for social support and assistance for parents in their parenting) (Föräldrastödsutredningen, 2008), which forms the basis for the Swedish government’s national strategy, states that there is a void when it comes to support for parents. Studies have, for example,
shown that many Swedish parents say that they need support in their role as parents (Lagerberg, Magnusson, & Sundelin, 2008) and that they would be interested in becoming involved in various parental support activities. This is particularly true of parents with young children (Bremberg, 2004; Bremberg & Eriksson, 2008).

The government’s strategy emphasises that it is the parents themselves who are experts on their children and that it is therefore the needs of parents and children that will determine the content of the support that is offered. According to the strategy, it must also be voluntary to participate and take advantage of the opportunities that are available.

If all needs are to be met, a broad range of types of support will be needed. In Swedish society today, many different players provide services which, if they were to be developed, could provide parents with better help and support in their parenting. One of the secondary objectives of the strategy is therefore to increase co-operation over parental support between players whose services are aimed at parents. Examples of such organisations are local authorities, county councils, religious communities, parent associations, sports clubs and other non-profit organisations and adult education associations. Another means of achieving the overarching objective is to ensure that the parental support offered is based on science and tried and tested experience by increasing the number of parental support players with training in health-promoting methods and universal evidence-based parental support programmes.

The strategy also emphasises the view that no one can do everything, but each initiative is a piece of the jigsaw which, when combined, can form an entirety.

The family centre – a well-established health-promoting arena for parents

The family centre (Familjecentralen) is an example of both a form of co-operation and a health-promoting arena for parents and their children, a view that is given particular emphasis in both the report and the strategy. At family centres, the promotion and prevention work relating to children aged 0-18 is coordinated and co-located. There is no official interpretation of the term, hence the meaning can vary. The centres normally provide an open nursery, as well as maternal healthcare, children’s healthcare and social services. Many professional categories, such as midwives, nurses, nursery teachers, social workers, family advisors, recreational leaders, psychologists, etc., work together around the family with children. According to an inventory drawn up in autumn 2007, there were 131 family centres across Sweden in 2007 (National Board of Health and Welfare, 2008).
short opening hours, an insufficient number of waiting rooms and a lack of activities (National Board of Health and Welfare, 2008).

**Development of municipal strategies for parental support**

During the period 2010–2012, a number of government projects are underway within the framework of the national strategy with the aim of developing and evaluating municipal strategies for parental support in accordance with the national strategy.

On behalf of the government, the National Institute of Public Health (FHI) has, for example, distributed SEK 70 million in stimulation grants to a total of 10 principal municipalities which, together with researchers and in co-operation with other municipalities, will develop municipal strategies for parental support. Within the framework of the project, many projects have been initiated to develop municipal strategies for parental support. The work carried out within the framework of the project has primarily involved the development of structures for the local co-ordination of parental support bodies, partly through the appointment of project leaders/project coordinators, work on cross-sectorial co-operation, constituted steering groups, reviews, etc. Structures have also been built up for the dissemination of information, e.g. websites and the preparation of information and training material. The supply and demand of parental support methods has also been reviewed and among other things courses have been held for leaders within existing parental support methods. Most projects are also aimed at expanding the range of parental support activities by developing new forms of parental support that can attract new groups of parents, e.g. single parents, young parents, parents with several children and parents with an immigrant background, who do not normally attend parental support groups.

Many of the projects are also aimed at developing the family centre into an important part of the municipal family support services as well as a meeting place and health-promoting arena for parents and their children. Examples are given below of two projects that have been allocated funding within the framework of the parental support initiative, where the work to develop the provision of parental support is being carried out in close co-operation with the family centres.

**Parental support partnership within the Umeå region – the Familjepappen project**

“Familjepappen” is a collaborative project that is aimed at all parents with children aged 0–17 in the Umeå region. The principal aim of the project is to help ensure that children have a secure and good environment in which to grow up. The starting point for the project is that all parents need meeting places in order to have the opportunity to reflect on their role as parents and to learn positive approaches in order to handle future conflicts in the best possible way.

Within the framework of the project, a broad range of activities is therefore offered in the form of talks and eight general parental support programmes around the Umeå region. The idea is that the range of programmes and methods should be suitable for as many parents as possible. A special website has also been developed where parents can find easily accessible information on the parenting courses that are available in their municipality within the Umeå region. The parental support is offered to all parents in the region that have children under 18.

Co-operation with family centres is an important aspect of the project and there is co-operation with all the family centres in the Umeå region, including the “family centre-like services” that are available.

The project is being carried out in close collaboration with researchers from the Department of Clinical
Sciences at Umeå University, which is evaluating the results. No results have yet been published. However, experience from the project so far indicates that the family centres have acted as an enabler for both Familjepeppen and the parental support work as a whole. This has resulted in the family centres becoming the arena for the most comprehensive parental group services within the framework of the project.

It has also proven easier to attract parents of children aged 0–4 to participate in parental groups via the family centres. It is believed that this is primarily because parents trust in the staff at the family centres and the parents listen to what they recommend. The reason why the family centres have succeeded in recruiting the parents of young children in particular is believed to partly be because new parents are more open to new networks and information concerning their children than parents who have a few years of parenthood behind them. They have finished the groups at the BVCs (the childcare centres) and many people find that they still have a need to meet up with other parents in order to discuss issues. Younger children are also involved in fewer activities, which provides scope for the parents of young children to participate in groups.

Another experience from the project is that the family centres themselves have been given a boost by the project in terms of their work introducing and running parental support groups. Today, six out of a total of eight family centres run parental support groups, either under their own auspices or in collaboration with an adult education association. All the staff at the family centres have completed Stage 1 training in the parental support method entitled “Guiding interaction” (Vägledande samspel). One person from each family centre will also undergo Stage 2. This initiative is expected to result in an improvement in the quality of the groups at MVCs (maternal healthcare centres) and BVCs (childcare centres).

It is also believed that the fact that all staff at the family centres have undergone training will also result in greater uniformity in interaction and the views concerning children at the family centres. Follow-up of staff who completed the course this spring shows that they have found that they now have a common language and common values as a basis for talking about children and parenthood. These issues have been put on the agenda through the “Guiding interaction” course.

**Interacting parental support – a network for research and development in Östergötland**

Linköping, together with nine other municipalities in the county of Östergötland, are collaborating on the project entitled “Interacting parental support – a network for research and development” (Samverkande föräldrastöd – nätverk för forskning och utveckling), which has the aim of creating a network for those in the county who are involved in the provision of parental support: municipal authorities, county councils, non-profit associations and adult education associations, as well as Linköping University (Tema Barn), which is evaluating the results of the project. The aim is to create a parental support network which reaches all parents. The network will work to raise awareness of children's circumstances amongst parents and professionals who work with children and parental support. The guiding words for the project are: “universal, complementary, long-term”. The project involves activities that concern, among other things, parental support at school parents’ evenings, parental support in connection with SFI (Swedish For Immigrants), parent forums (a shorter alternative to traditional parenting courses), a network for COPE leaders and group leader training.

Within the framework of the project, the family centres are an important arena for developing the work relating to coherent parent groups. Activities that directly involve family centres are aimed at creating a countywide network for family centres as well as greater cultural expertise at family centres (“bridge-builders”).

Within the sub-project “Countywide network for family centres” (Länsnätverk för familjecentraler), a network is being established for the county’s family centre staff as well as other staff who carry out similar work, i.e. maternal healthcare nurses, children's healthcare nurses, educationists and social workers. The family centre network is a forum where staff can meet and share good ideas and challenges that they face in their (fairly special) profession. There are regular meetings (once a term) with various relevant themes and talks and with relevant research. The aim is
to provide an opportunity for discussion and the exchange of experience between the county’s family centres and thereby promote method development and interaction.

The aim of the sub-project “bridge-builders” is to increase the linguistic and cultural expertise available at family centres in multicultural areas using “bridge-builders”, who can act as a cultural and linguistic link between parents and professionals. The project utilises staff within municipal authorities and county councils who have a mother tongue other than Swedish and who possess cultural expertise that is important in order to inform people of and promote parental support initiatives. An example of such a staff category is mother tongue instructors/teachers, who normally possess cultural expertise in two cultures. Another example is teaching assistants. The bridge-builders work to motivate people with an immigrant background into visiting the family centre and taking part in the family programmes that are offered. The demand arose when staff at the family centres said that they did not feel they were able to communicate with all visitors because of language barriers and that they were therefore unable to offer the same support and provide the same information to all visitors. The “bridge-builders” concept has previously been successfully developed at the family centre at Skäggstorps in Linköping. Experience to date indicates that the “bridge-builders” initiative has been a success and achieves its purpose in the areas concerned. The method is currently being evaluated by Tema Barn at Linköping University, which is also evaluating other sub-projects.

Researchers from Tema Barn at Linköping University are also carrying out a qualitative research study of family centres with the aim of describing and analysing the experiences of staff and parents concerning various types of initiatives at the family centres. The research study is being conducted at three family centres in three municipalities in areas with different characteristics. Interviews with staff members have been concluded and interviews of parents are currently underway. The results so far indicate that externally the family centres differ through the differing characteristics of the areas, the length of time that the family centre has been in existence, actual co-location or “visiting”, the layout of the rooms and premises, opening hours and accessibility, the degree of structure in activities (“we decide what to do as we go along” or “at 10 o’clock, we sing songs”) and the way in which the staff relate to targeted groups. The similarities between the family centres are also striking. There is pride in the initiative amongst the staff and a belief that the family centres are appreciated by the parents. The analyses present certain themes, e.g. the family centre as a meeting place and the network-building that is being carried out, something that is considered to be the main task of the family centre. It is also clear that the staff place an emphasis on a professional approach – it is important for the staff not to be “a close friend”. Many members of staff have based their arguments on the concepts: professional, personal and private. Some parents are identified as being in need of more support from the staff in the network-building work than others. As an individual member of staff, it is about observing and supporting, sitting next to people with a cup of coffee and trying to involve people in conversation. One member of staff said something along the lines of: “no one should have to go home and feel that there was no one for them to talk to today.” Another theme is the relationship between the different areas of expertise. In relation to parents, social services are the least clear area of expertise. People who work within social services approach their work in slightly different ways. One approach is to become a “name” rather than a professional role, even though you are working as a professional of course. The research study will be concluded and the results published during the latter part of 2012.
References


The importance of social support and reflective functioning for parenthood

Mirjam Kalland

Family centre provision is based on the basic idea that the best thing we can do to support public health as a whole in the long term is to work for a secure childhood. This basic idea is underpinned by extensive research into how our childhood circumstances, starting during pregnancy, influence our physical and mental health later in life.

In Finland, most of our children and families are happy and healthy. However, there is a growing proportion of children who are at risk. The proportion of children living in families with low incomes or below the poverty threshold has risen from less than 5% to 13% over the past 15 years. We have received reports of increasing alcohol abuse at a level which poses a risk in families with young children (Halme, 2008), and we are seeing a steady rise in the number of children who are covered by the child welfare open care system (5.4%) or who are growing up outside the home (1.2%, equivalent to over 16,000 children). Children are also increasingly being affected by their parents divorcing. Divorce has consequences for the health and life expectancy of adults (it increases both mortality and morbidity amongst both genders, (Köhler et al, 1986)). The way in which divorce affects children has long been debated, but a comprehensive study published in The Lancet in 2003 shows that children who live with single parents run a greater risk of suffering mental illness than other children. The study covered 65,085 children with single parents (primarily single mothers) and compared their development with that of 921,257 children from families with two parents (Ringbäck et al, 2003).

The care that children receive during their early years has far-reaching consequences for their development and factors such as abuse and domestic violence pose a serious risk for subsequent marginalisation and drop-out from society (Kalland et al. 2001; Kalland et al, 2006). If the mother experiences stress during her pregnancy, this will have an adverse effect on the unborn child (Mulder et al, 2002). During the past decade, a group of researchers in the USA has been studying the links between an insecure upbringing and mental and physical ill-health as an adult. They found strong links with both subsequent misuse and mental ill-health and our most commonly occurring widespread diseases such as cardio-vascular disease (see for example Felliti et al, 1998). A Finnish study also demonstrated that the most important psychosocial factor for contracting cardio-vascular disease later in life was the emotional distance between the mother and her child and a lack of support and appreciation (Keltikangas-Järvinen, 2001). More recently, the significance of stress during childhood as regards the brain’s development, the immunological system as a whole and the link between traumatic events during childhood and depression has also been highlighted. In summary, it can be said that stress during childhood can result in a reduction in the volume of the brain, adversely affect the child’s ability to learn, increase the risk of diseases relating to the immunological system and affect the child’s capacity to handle stress in the future (Middlebrooks & Audage, 2008).

In turn, epigenetic research has begun to explore the way in which traumatic events experienced by parents can leave their mark on their children’s genetic make-up and thus affect the characteristics of future generations. Traumatic experiences do not affect DNA, but they do affect the way in which DNA is read. A group of methyls which can be connected to or disconnected from the genes seems to be of decisive importance. The important factor in this context is that the interaction between inheritance and the environment is more complicated than was previ-
ously believed, and this points to the importance for future health of a secure environment in which to grow up (Franklin et al, 2010; Yehuda R & Bierer L, 2009).

Parenthood, a sense of coherence and the importance of social support

When people become parents, their identity undergoes a change, as they have to make room in their inner self not just for the child, but also to become a mother or father to their child. This change is fundamental and irreversible – Daniel Stern has described it as a gate which you pass through and which then closes behind you. However, becoming a parent is not just a psychological change; it must also be anchored in a cultural and sociological context.

In Aaron Antonovsky’s theory on Sense of Coherence, the individual's perception of life as meaningful, comprehensible and manageable is highlighted as fundamental. Antonovsky assumes that this perception of the world arises at an early age, when the infant experiences emotionally and cognitively correct responses to his or her needs. He refers to examples from Seligman, who assumes that learned helplessness has its origins in experiences of a lack of synchronicity between response and outcome or, seen from the child’s perspective, a lack of synchronicity between activity and response. If the child finds that nothing it does makes any difference, it will decide that it is unable to influence its surroundings and give up. Children grow up in an environment with “a lot of noise, but no information” about how they should act (Antonovsky, 1979). An example of such an environment is a home where the parents have an addiction or suffer from mental problems, with the result that they are neither physically nor mentally available to meet their child's needs in a predictable way and the parents’ actions are dictated by their own mental condition rather than the child’s needs.

However, Antonovsky notes that the sense of coherence is not about having absolute internal control. If one wants to experience absolute control, it is a question of an inner rigidity, where the tolerance of uncertainty is low and the capacity for flexibility prior to changes can be limited. If the need for control is too strong, it can lead to a spasmodic orientation towards the outside world, where the existence of the uncontrollable is not tolerated. At the same time, he also points out that his theory has a sociological anchoring and that what defines stress factors and the way in which they are handled is anchored in macrocultural and cultural contexts.

Compared with post-modern society, people in industrial and agrarian society were tied to their workplace or home in a different way than is the case today. The days and weeks revolved around routines. One can imagine that the transition to parenthood was a lower stress factor than it is in today’s society. On the contrary, being tied to the home because of a child could give life more meaning, whilst today it can be seen as an interruption in the lifestyle that one has grown accustomed to leading.

One must therefore ask oneself: what does parenthood mean in the post-modern society? In simplified terms, it can be said that well-being in post-modern society could mean a perception that anything is possible, on-line, at any time. The sense of freedom and infinite possibilities can be total amongst young, well-educated and resourceful parents-to-be. However, the child can be described as anti post-modern, as the child demands continuity, stability and recurring routines. It could even be said that post-modern life ends with the birth of the child. This can have consequences for the parents which can be perceived as both positive and negative.
It can therefore be assumed that the sense of coherence can be very stable in a stable life situation, but it can also be disturbed when that life situation changes. A number of studies have shown that Antonovsky's original assumption, that the sense of coherence (as expressed with the aid of the formula) should express a lasting feeling that is independent of the life situation one finds oneself in, cannot be verified (Eriksson & Lindström, 2006). The question then arises as to whether the sense of coherence is something that is re-established more quickly in some individuals after a life crisis than in others, and what significance it has as regards well-being and health.

When life takes a new direction and new demands are placed on the individual, the general level of stress will often increase. It is natural to take one's new tasks as a parent seriously and this often also leads to feelings of inadequacy. Some parents experience a strong sense that they do not have the resources that are needed for parenthood. This feeling is called “parental stress” (Östberg, 1999). It is worth noting that everyday worries and concerns, such as food and sleeping problems, often seem to weigh down parents more than major, life-defining events (Crnic & Grenberg, 1990; Krech & Johnston, 1992). A number of studies show that mothers who have no social support become significantly more stressed over their parenthood (Sepa et al, 2004) and that stress and depression are strongly linked (Milgrom & MacCloud, 1996). It has also been shown that mothers who are single at the time of the birth of their child show significantly more parental stress than mothers who have a partner (Copeland & Harbaug, 2005). Research furthermore shows that social support has a damping effect on parental stress – more support means less stress. Finally, recent research indicates a link between type 1 diabetes in infants and parental stress (Sepa, 2005), indicating that the stress that parents experience can affect the health of the whole family.

The link between inadequate social networks and parental stress is a factor worth noting, as an increasing number of parents have moved from the environment in which they grew up in order to study or find work and therefore have no natural network.

The importance of parent groups
Long-term research indicates that early home visit-based support, preferably during the first pregnancy, has beneficial effects on the well-being and development of children and families, and is also economically profitable (Olds, 2002). Of particular importance is home-based support for parents in the risk zone. In recent decades, interest in group-based support for parenting has increased. Parent groups can be set up as universal, targeted (e.g. for single parents) or indicated support (the risk has already been identified). Groups can also be open or closed. There is evidence to suggest that indicated group-based support is cost-effective. However, there are also strong arguments for universal groups, particularly for couples who are expecting their first child. The advantage of a universal approach is that one can reach parents in the risk zone who have not yet been identified and who would not seek out a service where they risk being categorised. One can also reach parents with a suboptimal parenting capacity who would never become involved in targeted or indicated programmes, but who would still benefit greatly from support. Stress research also shows that social support is of fundamental importance for all parents, regardless of their initial circumstances, and for the health of the family as a whole.

As virtually all parents in Finland (99%) visit a mother and child advisor within the public healthcare system, there is enormous potential here for preventive work which is only partly being exploited. There is also a need to further develop the universal service and the service aimed at particularly vulnerable groups. One popular form of support has been the open nurseries and family cafés, as well as other open groups. Most studies show that these services are appreciated by parents and that the parents themselves believe that they have enabled them to make new friends and reduced their need to seek professional help. It is often believed that parent groups can reach resourceful parents more easily, but this view is not supported by the Finnish study that is presented by Kalliomaa (see page 80–85 of this publication). On the other hand, it can be difficult to compare different countries with each other, as open parent groups in Finland are primarily
organised within the third sector (non-governmental organisations), whilst closed (and often targeted) groups are also organised within the primary healthcare sector, under the child welfare service and within the framework of the family advice service. However, both reports and practical experience indicate that a special effort should be made to include parents with an immigrant background.

Few ambitious comparative studies have been carried out into the effects of open universal parent groups, and those that do exist do not give strong support to the view that they have any demonstrable effect. Carrying out research in this form is problematic, as both the activity and the intensity of participation can vary greatly. However, there is evidence to suggest that closed and structured groups can have a positive effect (Thomas & Zimmer-Gembeck, 2008). One study (Cox & Docherty, 2008) shows that perceived health is improved amongst parents who received group support after the birth of their first child, but more studies are needed in order to show the possible long-term effects.

More theoretically anchored interventions and ambitious experimental research are needed in order to improve our knowledge within this area.

**Mentalising capacity and reflective functioning in parenthood**

An individual’s reflective functioning concerns the (metacognitive) capacity to think about how one thinks and feels, and the links between these inner thoughts and feelings and how one acts. The basis for this process is mentalising capacity, which in turn embraces a sort of obvious basic assumption that people have an actively processing mind or consciousness. The mentalising process is initiated when an individual attempts to understand how he himself or someone else thinks and feels, and the reflective functioning is characterised by being interpersonal. During the past decade, a group of researchers from London and Yale has created a theory concerning the way in which this reflective functioning affects our ability to form relationships with other people (Fonagy et al, 2002). According to Peter Fonagy, reflective functioning protects the individual’s development, as it gives us the opportunity to understand and predict the feelings and actions of other individuals. With the aid of this reflective function, we create a “theory of mind”, a consciousness theory. An individual with a high reflective functioning can thus distinguish between internal and external reality, separate his or her own feelings and needs from those of others, and understand his or her own feelings and needs in different ways (Fonagy, 1996).

According to Peter Fonagy, the individual’s reflective functioning can also represent a modifying factor between one’s early experiences and the way in which one practises parenting. Of particular importance is the observation that individuals with difficult experiences but a high reflective level have the capacity to create secure relationships with their own children. Fonagy’s colleagues, Professor Linda C. Mayes and Dr Arietta Slade, of Yale University and City College of New York, have developed a research tool and intervention models based on these theories which are applicable to both the normative population and to parents in various high risk situations.

In parenthood, reflective functioning is particularly important. This capacity is both commonplace and
sophisticated: a mother who realises that her baby is crying because he is hungry needs to have the capacity to respond to both the child’s physical needs and the child’s emotional needs for affection and security – only meeting the physical needs of the child is not enough to ensure the development of the child. The mother then understands that the child is crying in order to express both a need and a feeling, and she understands (intuitively) that the way in which she responds to the child’s needs will affect the child. If she is irritated and heavy-handed or indifferent and mechanical when she feeds the child, this will have an adverse effect on the child, but if she is calm and playful, she will affect the child in a favourable way.

Reflective functioning in parenthood is therefore less about having ability and knowledge, and more about being open and receptive to the child’s signals. As parents, it is important to observe one’s child and its reactions, to consider and wonder, to take an interest in the feelings and needs of one’s child and to see one’s child at all times as a unique person with a unique way of perceiving the outside world and a unique way of expressing their feelings and needs. Relatively little empirical research has so far been carried out concerning this capacity, but research into parenting in high risk situations shows that it is possible to influence the reflective functioning of parents in interventions and that this is linked to their capacity for parenthood (Schechter et al, 2002 and 2003; Slade et al, 2005; Pajulo & Kalland, 2006).

The Parents First programme is the first support service for parenthood to be explicitly developed to support the reflective function in parenthood (Goyette-Ewing et al, 2002). The parent groups are organised into 12-week periods and have been developed and tested by Yale Child Study Center, Yale University, New Haven. The aim of the groups is to meet other parents to consider what feelings and needs (newborn) infants express through their behaviour. The groups do not focus on strategies or solutions, but on giving meaning and significance to the infant’s or child’s signals. The Parents First groups therefore offer a forum for parents to discuss parenting and family life, to understand their child better and support their development, and to work for changes in family life where necessary. They also act as a source of social support for parents. The parent groups are also a source of information for other forms of support which are available and which may be needed, e.g. family advice, family work, etc. In Finland, the Parents First groups (Föräldraskapet Främst in Swedish and Vahvuttavahemmuuteen in Finnish) are intended for both parents who come to the group together with their child. After the conclusion of a parent group, the parents can hire parent cafés and other services linked to family centres or non-governmental organisations.

Folkhälans förbund has adapted and developed the manual for Parents First groups through four pilot groups: two in Helsinki (one organised by Folkhälans and another organised by the City of Helsinki), one in Uusimaa (Nyland) and one in Ostrobothnia (Österbotten). The manual was completed in January 2010 and has been translated into Finnish. From 2010 onwards, the Mannerheim League for Child Welfare has, in collaboration with Folkhälans, developed the method further and intends to implement the model across the entire country in collaboration with the municipal authorities. Parents who are expecting their first child are recruited to the groups by the antenatal groups and are given the chance to continue attending meetings after the birth when the child is around four months old. The project is linked to research according to a “case-control design” with follow-up until the child reaches the age of two. The principal research issue is whether it is possible, via these theoretically anchored, closed and structured groups intended for both parents together with their
Why support reflectivity in parenthood?
The National Institute of Public Health’s report states that all involvement in parenthood is a sensitive issue, as it can violate the family’s right to self-determination. On the other hand, here in Finland we have perhaps been unnecessarily sensitive towards the right of the family to independence and individual solutions. One could even claim that we have developed a “non-intervention ethic”, where in the worst case scenario we sacrifice the well-being and health of the child and family in the name of humanism and respect. As a result of this initial exaggerated respect, we can be forced to intervene more dramatically later, e.g. by taking custody of the child.

However, it is also clear that what we offer parents on a universal basis should be voluntary, and that what we do should be based on tried and tested evidence that we really can support the well-being of families and children in this way. There is also a risk that parents will become lost in a jungle of contradictory advice and that their parenting could actually be adversely affected by increasing confusion. The theoretical starting point for parent groups based on reinforcing the reflective functioning of parents is based on the simple assumption that meeting the emotional needs of the infant/child is a unique process which each individual parent and each individual child must learn together. This process cannot be learned through an “ABC book with tricks and tips”, but the parents have natural preconditions which can be supported in a respectful manner by exploring the reality together.

Reflectivity is shielding, as through the development of our reflectivity we can protect our child from any harm or traumatic experiences that we might have been through ourselves. Reflectivity is also liberating, as it helps us to understand that there are various ways of being here in the world. Reflectivity releases us from the shackles of childhood and helps us to distinguish between the way in which we have been treated and who we are (“he was unloving, but I am not unlovable”). Reflective thinking is also dynamic: nothing is ever finally achieved; we have our whole life ahead of us at every stage of our lives. The dynamic aspect is also restorative by nature – we can return to what was wrong, we can repair damaged relationships and we can give and receive new chances.

Finally, I would go so far as to claim that supporting reflectivity increases the resilience of individuals and families. Resilience is about a sort of mental elasticity, about being able to bounce back after experiencing hardship, about picking yourself up and dusting yourself off, and so on. In international literature, resilience is defined as an individual’s positive development in spite of the presence of harmful factors during their childhood. Harmful factors are defined as factors that have statistically been shown to be linked to an increased risk of physical, mental and social problems, such as a childhood environment characterised by violence, abuse or poverty. Positive development, on the other hand, is about coping with the task of developing which the development stage presupposes without any major difficulties. Research into resilience is considered to have potential for finding opportunities for the prevention of diseases and for promoting individual competence and adaptation in spite of perceived difficulties, and could therefore form the basis for a social, health and education policy that can support human resources in the best possible way and reduce the “erosion” of aptitude and potential that is brought about by mental illness and marginalisation (Luthar & Cicchetti, 2000).

It was originally believed that there were, or could be, a number of special protective factors that contribute to resilience which are of importance for those who are not vulnerable. Today, we work more to a cumulative or compensatory model. The cumulative model is based on the assumption that the more supporting factors an individual has, the less risk there will be of problems in the future. The compensatory model is based on
the assumption that the factors that support children in general (such as good self-esteem, good relationships with parents, good relationships with friends) also support children with regard to risk factors in their surroundings (Fergusson & Horwood, 2003), and that we can support the health of individual children and families with very ordinary things, with the “magic of the ordinary”. This approach can be reflected against the fact that what weighs down parents more than anything else are these very everyday concerns.

Perhaps this is precisely the magic of the family centres, the family cafés and other open meeting places? That we support very ordinary families with ordinary problems in a way that is down-to-earth and mundane? And that all this is so mundane that it even evades strictly scientific investigation, so that we just have to trust the mundane words of ordinary families – they make me feel better, they help me get through the day and I now have some new friends?

References


Sepa A, Frodi A, Ludvigsson J (2002) Could parenting stress and lack of support/confidence function as mediating mechanisms between certain environmental factors and the development of social strain in the family, seems to be involved in the induction, or progression, of diabetes-related autoimmunity in the child during the 1st year of life.


Child’s right to an upbringing
– Family centre as a promoter of a rearing culture which respects the child

Maria Kaisa Aula

This article examines upbringing from the point of view of Finnish children. What constitutes a good upbringing from a child’s perspective? How can family services promote an upbringing culture which respects the child? The information used in this text has been collected from Finnish school children, but the same questions are topical throughout the Nordic Countries. The UN Convention on the Rights of the Child emphasises the mother’s and the father’s primary and shared responsibility for a child’s upbringing. A child has the right to parental care, nurture and guidance. Public services should support parents, acting as educational partners both at schools and in daycare. At its best, a family centre can promote a culture in child-rearing which respects children, helping the parents to recognise their value as guardians.

For children, the most important upbringing is provided by parents
Based on children’s own opinions, it is clear who the most important childrearer is. One of the principles of family centre activities is to support parenthood and, by doing so, increase children’s well-being. The parents, i.e. the mother and father, both together and separately, were mentioned most often when, in the spring of 2010, the office of the Ombudsman for Children in Finland asked over two hundred school children about the most important person involved in their upbringing (Nivala 2010).

“Because they have always been around, asking me about things” (secondary school pupil).

In addition to parents, important childrearers often include grandparents, who are associated with providing a role model and experience of life.

“Let’s also mention my late grandma, because she was always encouraging, tolerant and proud of each of her children and grandchildren” (secondary school pupil).

Other relatives are also considered important to upbringing. As close family members, siblings, especially older sisters and brothers, are mentioned as childrearers. Persons named from outside the family include godparents in particular, as well as aunts and uncles in general. Children also name “professional childrearers” such as teachers and hobby instructors as important childrearers, but...
their status is not as clear as that of parents. Hobby instructors become important childrearers if they support the child in ways other than teaching the hobby.

Children see upbringing as an important activity which affects them. It partly overlaps with teaching, but is not entirely the same. Upbringing includes teaching, but also something more. Support, help, care, teaching to distinguish right from wrong, listening, understanding, caring, spending time together and being present are components of this.

“It’s like teaching, but you also take care of the child you’re bringing up” (girl, 10 years)

“Upbringing is supporting someone, teaching them the difference between right and wrong, spending time together with that person, etc.” (primary school pupil)

“A good child-rearer is present, cares and wants to listen to and understand today’s children and adolescents. He or she is also interested in the child as an individual and wants to get to know him or her better.

“He always helps me and takes an interest in my life” (secondary school pupil).

A good child-rearer is encouraging and can be trusted. Limits are important for children, but they also want those bringing them up to demonstrate suitable, situation-specific flexibility.

A good child-rearer is non-violent, while offering affection and tenderness. Children and adolescents also wish that those bringing them up show patience and listen and encourage more, rather than shouting. Violence does not make for a more effective, but a more devastating, upbringing.

“Some people believe that a child learns through punishment, but that’s not true. He or she only feels terrible or becomes angry with the parent.” (primary school pupil)

“More affection, no bossing around, etc.” (primary school pupil)

“The ability to listen, and not being pointlessly judgemental” (secondary school pupil)

Children want their childrearers and parents to be actively at their disposal. This includes caring, asking questions and offering support, even when the child does not ask for these things:

“That they take care of the child and ask how the child is really doing” (secondary school pupil)

A good child-rearer is useful in a concrete way, being able to give advice and guidance on the important matters in life. He or she does not concentrate solely on a single aspect of the child, but views the child or adolescent as a whole. A good child-rearer also grows with the task, not treating an adolescent like a child.

Shared time, good food and harmony

Upbringing cannot be distance work. It is living and being together. In surveys conducted by the office of the Ombudsman for Children, school children wished for a greater adult presence in their lives and for less loneliness. In addition, they wished for more harmony and fewer quarrels. A tense atmosphere and tetchiness in the home are often connected to hurry and stress. (Tuononen 2008)

“(I’d like to persuade) Mum and Dad to stop arguing, but I’ve noticed that it’s no use trying” (primary school pupil)

Common mealtimes are the kind of shared family time which Finnish families seem to lack: according to surveys, in Finland, children and parents eat together less frequently than in other European countries. The meaning of good food and mealtimes to children’s experience of care at home should not be underestimated.

Not all children are beset by parents who lack time, or by loneliness. Naturally, most children have a lot of good and positive things to say about their families.
“I’m safe, I have food, a loving family and a roof over my head,” summarises a primary school pupil.

In another survey recently conducted for the Council of Europe, Finnish children felt that home was the very place where they were best heard, taken seriously and where they could influence their life. They compared their homes to school and hobbies, among other things. However, when there is room for improvement, children’s wishes usually concentrate on common time, doing things together and interacting in harmony:

“Everything is fine in my family, but my sister and I often need to spend almost the whole day alone, as the grown-ups are working late or running important errands” (primary school pupil, the “It concerns adults!” report).

According to Leena Valkonen’s doctoral dissertation (2006), 5th and 6th grade pupils mention giving time as one of the characteristics of a good parent. A good parent gives his/her time, thinks that the child is important, is easy to get along with, sets limits, provides the child with an appropriate upbringing and has a suitable way of life. In addition, the children surveyed by Valkonen sometimes viewed work as a rival for their parents’ time: “I wish they [my parents] were rich and unemployed” (boy, 12 years).

From children’s point of view, family services need to encourage parents to remember their value, to maintain a family-work balance, to cherish their relationship, and to avoid over-programming free time and putting pressure on their children to achieve.

**Value for children – time for upbringing**

How have parents’ status and the challenges of parenthood developed in recent decades? Many things have changed for the better. More parents now support their children’s schooling and hobbies, and are present in their children’s lives than, for example, in the 1960s or 1970s. Levels of mild violence (pulling the child’s hair, spanking) used for upbringing purposes are around half of what they were 20 years ago. Progress also includes understanding the significance of mutual respect between parents and children, and the wish to listen to their children.

“Everybody gets along well, and everyone’s opinions are taken into account. Everyone has a good time together. Our family is big but everyone gets the same amount of attention” (secondary school pupil)

However, growing inequality between children poses a problem. A small portion of parents lack the means to provide their children with a positive upbringing and to set limits. They are burdened by relationship problems, mental illness and substance abuse, for which support is too slow to arrive. Changing relationships may see the child cast aside. Adolescents in particular experience difficulties in finding one’s place in a blended family. Work and career-orientedness can be all-consuming, resulting in the child’s needs being neglected or going unnoticed.

“They could keep a closer eye on their alcohol consumption. Another thing is the amount of work. They are under terrible stress at work -- and they take it out on me”

“I don’t like my stepfather, because he sometimes shouts at me for nothing” (primary school child)

Parenting involves more tasks than before. Media and advertising penetrate a child’s world at a wholly different level than they did, for example, during my own childhood in the 1970s. Parents are needed more than before, to filter messages from the media and advertising, and to define the limits of moderation. On the other hand, parents often take care of upbringing alone. Migration can mean that relatives live far away. Friends and relatives also have their own work and priorities.
In the adult world, success is measured based on working life. The rhythm of working life has accelerated, resulting in greater stress. The shift to a so-called 24/7 society, the day-and-night availability of various services, is visible in children’s lives. Working life requires flexibility and readiness to work evenings, nights and weekends. Single parents, in particular, are forced to make difficult choices between work and subsistence on the one hand, and parental responsibilities on the other. In Finland, even the parents of very young children often work full-time.

To children and adolescents, services mean people and human relationships

From children’s and adolescents’ perspective, the relevant issue is having people who are easy to contact in order to discuss their lives – both joys and sorrows – rather than services and professions in themselves.

Most problems faced by children and adolescents in their everyday lives result from a lack of timely support for parents in facing their own problems. Such problems include relationship issues, alcohol consumption, excessive work or lack of parenting skills. Most low-threshold services which provide child-rearing and peer support after the maternity clinic phase are rarely available to parents. In practice, however, such services and support would be highly significant to the everyday lives of children and adolescents. Support for families with a baby is important, because the interactional basis between parents and children is established in the early years. The foundation for a good life, stretching far into the future, is created during the child’s infancy. Parents may also find fragmented family services difficult to grasp. Professionals tend to use unfamiliar terms to denote such services.

Children and adolescents are unaware of special services. Neither are they sufficiently informed about such services in a suitable manner for their age level. Furthermore, children do not always trust services, because they do not understand their proceedings or know the professionals involved. Services do not always involve asking children about how they are treated at home, in which case problems pertaining to violence or alcohol abuse are not revealed. Seeking the services of a school psychologist or school social worker can be hindered if the person in question is not present or well-known in the school community, or if adolescents have not been told what his/her tasks include. (see e.g. Ministry of Social Affairs and Health 2010)

“People often talk about violence but do not provide children with sufficient information on what to do, or how the matter should be handled, if they fall victim to violence. Being removed from home and the thought of strangers scare children to the extent that they dare not inform anyone about the issue”

Children and adolescents expect schools to do more. School provides children with a familiar forum and could provide better support for their well-being. Within the school environment, various forms of support could be offered to both children and, through them, to parents via an upbringing partnership. By this, I also mean affordable hobbies and the support provided by friendships. Many young people would like to see youth workers at school. School could also provide more information on municipal services and the kind of support children commonly have the right to expect from parents.

The better that parents support their children’s education and hobbies, care for them and set limits, are present in their everyday lives and have the appropriate lifestyle, the less of a need there is for other special services (see Valkonen 2008). For children without major worries, the most familiar services include their school, sports and leisure services, libraries and health services.

Family centres and a child-respecting rearing culture

At their best, family centres bring together the full range of services which support children, adolescents and families. Such services aim to support children’s and families’ everyday lives, which do not correspond to the boundaries of administrative sectors. In family centres, services have been developed as units with common objectives. They also aim to include children’s and adolescents’ practical expertise in improving service quality. In
Finland, family services are challenged by uncoordinated management of preventive work, as well as sector-specific administration. Pupil care, services for children in need of special support, relationship support and services for divorced families particularly suffer from this. The family centre concept offers an opportunity for positive change.

The various professionals who meet children and adolescents need sound basic knowledge of child development and children’s rights, adequate social skills with respect to children and adolescents, and good general knowledge of municipal services. They should also respect children’s and their parents’ opinions as a source of support in their own work. Each should be capable of conducting case management and providing basic information on services to children, adolescents and their parents. Family centres would have greater possibilities if the basic and continuing education of professionals working with children and young people were renewed in light of such issues. Such themes should be covered in the education of different professionals, as studies common to all students.

In addition to professional help, an emphasis is placed on supporting the dialogue between peer groups and parents. Such support can also be organised by family organisations. It would also be necessary to speak openly about a violence-free upbringing and to give advice, particularly to the parents of small children and children in need of special support, as well as immigrant families.

In addition, it is important to help the parents of secondary school-aged children recognise their own value as child-rearers. The services may help to bring children’s and adolescents’ hopes and opinions about upbringing to the attention of their parents. The better the connections family services have with the school, the better low-threshold support for upbringing and the provision of early assistance for parents experiencing problems is enabled. Challenges in Finland also include developing educational partnership between teachers and parents and support children and families by means of family work.

In Finland, in particular parents of children of secondary school age are not engaged with schools. Children must not be left to grow up alone. Neither should their parents be left to raise children on their own. In turn, each adult teaches through his or her own example. At its best, an educational partnership between teachers and parents together with the support from family services, can create a new community spirit and responsible adulthood. This ensures all children’s right to a good life.
References


Family centre is based on preventive work and collaboration
Preventive services – a guarantee for the well-being of children and families

Sirkka Rousu, Aila Puustinen-Korhonen and Marju Keltanen

“Today’s decisions will define future child policy. Creating a balanced growth and development conditions for children is the most important investment society can make – nothing surpasses a child in importance. The welfare of children is much discussed and acted upon by adults, but do value choices that respect the child and childhood steer decision-making in society, or are childhood and the child population dwarfed by “big” issues and market-oriented values? Our globalising world strives for efficiency. This is characterised by selfishness and short-sighted pursuit of individual gain. Protection of a child’s – a human being’s – life from exploitation and neglect requires a policy of assuming joint responsibility, based on sustainable underlying values.”

Child Policy Programme “Long live the children” 2000–2015, by the Association of Finnish Local and Regional Authorities

This article describes the development of child and family policy in Finnish municipalities. It describes preventive work promoting health and welfare, the steering and preparation of welfare programmes for children and adolescents, and the status of family centre activities in municipalities. The article utilises the results of a survey of municipalities conducted by the Association of Finnish Local and Regional Authorities in 2010.

Finland’s approximately 1.1 million children live with some 590,000 families. Children account for around one-fifth of the entire population, but child and adolescent age groups are shrinking. While well-being of the most Finnish children and adolescents has been good over the last fifteen years the number of children and adolescents requiring special services has increased.

Many factors underlying this trend can be identified, such as Finland’s deep economic recession of the early 1990s, which saw reductions in many basic municipal services for children and families, among guidance and counselling centres, day care, schools, youth work, etc. For instance, the availability of home-
help services for families with children plummeted. High unemployment among families with children, thinning out of basic services supporting children and families, and a drastic reduction in preventive service activities resulted in an increase in the use of specialised services for children and adolescents.

**Change of direction in municipal child and family policy**

Several national development programmes and legislative initiatives are indicating the increasing malaise among children and adolescents, as well as problems in the service system. In Finland, municipalities are largely responsible for providing basic and specialised services for children and families. Service system reform in the municipalities has therefore been considered essential.

Together with municipalities, the Association of Finnish Local and Regional Authorities launched a child policy reform process in the late 1990s. This was based on the idea that child welfare is a common concern throughout the whole municipality. The Child Policy Programme “Long live the children’, which steers the activities of the Association of Finnish Local and Regional Authorities, was approved in 2000. Programme objectives are anchored in the Convention on the Rights of the Child. The programme will continue to guide the Association’s activities until 2015. Its key theses are as follows:

- A child is prepared for life and finds basic security from the home, but it takes a “whole village” to raise a child. Child protection is a common concern. (Protection)
- Childhood is a social investment that benefits all. A long-term social and child policy that prevents problems is the lowest-cost strategy. (Provision)
- Social skills do not appear of their own accord, but via inclusion and being heard. Appreciating a child’s views fosters healthy self-esteem in the child and prevents insecurity. (Participation)

The aim of the Association of Finnish Local and Regional Authorities’ child policy document was to trigger a broad-based discussion of the status of children and services for families with children. In municipalities, the need arose to develop basic services and preventive work, in order to halt the growth of specialised services. The Association of Finnish Local and Regional Authorities recommended that municipalities, too, draw up a municipal or regional child policy programme in support of decision-making on children and adolescents’ welfare policy, the management and development of activities, and practical work with children, adolescents and families. In addition, local actors were encouraged to engage in an extensive preparation and learning process involving various parties and actors.

The 2005 follow-up survey on child policy programmes by the Association of Finnish Local and Regional Authorities revealed that the majority of municipalities had prepared municipal programmes for comprehensive development of child and adolescent welfare.

In these programmes, the key was to develop a child and family oriented working method in order to strengthen parenthood. The intent was to provide a natural provider of services for families during each phase of childhood, which would be responsible for supporting parenthood. At child welfare and prenatal clinics, staff skills in supporting early interaction between child and parent were improved and co-operation models developed between the clinics and day care, and day care and pre-primary education. Renewal of child and family policy, and co-operation between actors in municipalities, were also promoted via other programmes. The most significant of these was the Harava project implemented in 2000–2004. Harava was a national joint project between the public and various NGOs aimed at producing collaboration and service models for children and adolescents’ psycho-social services. The project also generated numerous new tools for practical work.

Inspired by the project, a family centre called “Pihapiiri” was established in the city of Raisio in southwest Finland in 2002. This family centre, operating on a low threshold principle, is one of Finland’s first. It was established in co-operation with the City of Raisio, the local parish and various NGOs which jointly developed a strategic partnership for service provision. Pihapiiri provides open, alternative activities to standard day care services for those families and parents, who are looking after their
children at home. The objective was to develop forms of child welfare support for non-institutional care and healthcare, to provide diversified support for parenthood, to introduce peer support and early support models and to develop co-operation between the authorities, NGOs and volunteer organisations (records of the Raisio Social Welfare Board 27 February 2002). According to customer surveys conducted in Pihapiiri, parents bring their children to the centre for the chance to meet other children, and in order for the parents to meet other childrearers in a similar situation. Parents also feel that they receive support in their personal parenthood, raising children and in coping. In 2005, Pihapiiri’s operations were rendered permanent. The centre centre continues to operate (http://lapsitieto.fi).

In developing Finland’s municipal services in the 2000s, the key concept posits that the best way to help a child is to offer support to child’s own everyday environments at home, school and day care. Opportunities to receive support for the healthy development of children and adolescents, and parenting activities, should be made available for all families and children.

Emphasis on preventive child welfare
Child welfare is currently viewed as a broad process protecting the welfare of children. This involves not only the social welfare authorities, but also other public authorities and all citizens. The primary objective of child welfare is to secure the right of all children to a safe growth environment, balanced and diverse development, and special protection. Parents are responsible for bringing up children and ensuring their well-being, but society is responsible for supporting parents and child welfare professionals in this task.

The amended Child Welfare Act (417/2007) entered into force on 1 January 2008. In particular, the purpose of the Act was to enhance the inclusion and legal protection of children and families, to ensure that the authorities co-operate in supporting families and to specify local authority obligations with respect to child welfare. Key issues in terms of family centre activities included the incorporation of the concept of preventive child welfare in the Act, as well as imposing an obligation on municipalities to draw up a four-yearly comprehensive welfare plan for children and adolescents. The Act thereby also obliges municipalities to manage preventive work on a more comprehensive basis, and to develop services for families with children in support of upbringing activities.

The new Child Welfare Act clarified the extent to which promoting and securing the welfare of children and adolescents is a matter for municipal child welfare authorities in particular. It also defined the extent to which this should be carried out by other municipal authorities or other actors and through co-operation. Being the responsibility of the municipality, tasks concerning the development of growth conditions and support for parenthood, and those involving preventive child welfare, involve various municipal sectors. Government decree (380/2009), issued on the basis of the Primary Health Care Act and adopted in 2009, also strives to support families. According to the decree, some of a child’s regular check-ups at prenatal and child health clinics, and in school healthcare, concern the entire family. The role of preventive healthcare, and co-operation with other operators, have been confirmed by decree.

Correspondingly, municipalities’ responsibilities for developing the living conditions of adolescents were strengthened by the Youth Act (72/2006), amended in 2006. Valid since 1 January 2011, an obligation on municipalities to establish a multi-sectoral co-operation group for developing the living conditions and services of adolescents was added to the Youth Act. A provision was also added which obliged municipalities to perform outreach youth work. Through this, all adolescents must be provided with the possibility of early support. For instance, early support must be offered in situations where a young person encounters trouble in finding a study place or employment.

Child and adolescent welfare plan
The Child Welfare Act obliges municipalities to prepare, either on their own, or together with other municipalities, a child and adolescent welfare plan that must be revised at least once every four years. This child and adolescent welfare plan must also be taken into account when preparing the municipal budget. As a consequence of the amended Child Welfare Act, municipalities’ child
policy programmes have been largely merged in line with the statutory child and adolescent welfare plan. Initiated by the Association of Finnish Local and Regional Authorities together with the municipalities, child policy development work helped pave the way for enshrining the child welfare plan more extensively in legislation. The child and adolescent welfare plan must also include objectives and measures of preventive child welfare. This plan is prepared in co-operation with various administrative sectors and actors. In many cases, representatives of NGOs, parishes or other corresponding parties also contribute to its preparation. The views of clients, i.e. children and adolescents, must also be consulted.

Among other issues, strategic objectives and measures facilitating the implementation of support for parents and parenthood, as part of preventive child welfare services within primary social and healthcare services, must be recorded in the child and adolescent welfare plan. Children and parents must be provided with the support they need at the earliest possible stage, in their familiar, ordinary environments. Activities supporting the health and welfare of children include physical activities and cultural and artistic activities of various types. In addition, in terms of the well-being of children and parents alike, it is vital for them to experience a sense of togetherness and to see themselves as part of a community they view as significant. Today’s families need a new sense of community. Family centre activities, among other factors, can create this.

Preventive child welfare services are also provided by other municipal services, such as prenatal and child health clinics and other healthcare providers, home-help services, day care, primary education/school or youth work as specialised support, even when the child or family is not a client of child welfare services. Organisations, associations and other civic activity may offer valuable support to the child and family, without defining any particular problems (Taskinen, S. lastensuoje-lulaki (417/2007), Soveltamisopas. Stakes, Oppaita 65).

The family centre as a preventive child welfare structure
When adopting the child policy programme, the Association of Finnish Local and Regional Authorities also decided to monitor the programme. The 2010 follow-up survey handled the implementation and enforcement of the new Child Welfare Act on an extensive basis. Within municipalities, the survey analysed the status of child and adolescent welfare plans and services for children and families. A total of 252 municipalities, out of 326 in continental Finland, responded to the survey, conducted in co-operation with the Ministry of Social Affairs and Health, the National Institute for Health and Welfare and the Ministry of Education and Culture’s policy programme for children, adolescents and families. The research report on the follow-up survey was completed in June 2011.

Resourcing, goal-setting and management of preventive work
Resourcing of preventive child welfare, goal-setting for work, and management of preventive work within municipalities is vital. Of the municipalities that responded to the survey by the Association of Finnish Local and Regional Authorities, 94 per cent (192 municipalities) reported that the statutory child and adolescent welfare plan had been completed, or was underway. Nine out of ten municipalities prepared the welfare plans under the guidance of a multi-sectoral co-operation group comprising several service sectors. Welfare plans had been prepared by multi-sectoral co-operation groups in more than one half of the municipalities responding to the survey. A multi-sectoral preparation process was viewed as a factor that enhanced a more comprehensive review of child and adolescent welfare and services. Implementation of the plans, and monitoring of development, was also implemented by a multi-sectoral co-operation group in almost all respondent municipalities.

In general, the municipalities had taken careful account of service system development needs included in the plan, and the set goals had been met. However, less than one-third of respondents were of the view that the plan took good account of children and adolescents’ possibilities to participate and influence matters, and of developing such a possibility. Objectives involving appropriations and human resources were fulfilled well in only every fourth municipality. The municipality’s financial situation
was regarded as the main reason for this shortcoming.

According to the survey results, multi-sectoral management and political decision-making were still evolving in the municipalities. Management of preventive child welfare is being implemented in more than fifty per cent of respondent municipalities in such a way that multi-sectoral expert groups can integrate and develop their activities during client work. On the basis of the results, it can be concluded that, pursuant to the Child Welfare Act, the joint long-term preparation process for child and adolescent welfare plans will promote the emergence of multi-sectoral management and decision-making structures in municipalities. Such structures can promote responsibility within the entire municipality for the well-being of children and adolescents, and families.

Availability of preventive services

The results of the survey reveal that the services assessed by the respondents as at least moderately successful in preventing the need for child welfare measures are still quite poorly or not at all available to children and families. In the municipalities' view, basic services, and the individual, group and community-level support measures available through them, could well prevent the need for child welfare measures from arising. The survey indicates that, to at least a moderate extent, family centre activities could prevent the need for child welfare.

For families with children under school age, and those expecting a child, the need for child and family specific child welfare services was assessed as best prevented with the help of support services by family workers. More than 80 per cent of respondents found that support services by family workers prevented the need for child welfare fairly or extremely well. These support services were fairly or fully available in half of the municipalities that responded. The situation has improved considerably from the recession years in the 1990s.

As regards children in primary school, early support family work was assessed as the best method for preventing the need for child welfare (80 per cent of respondents). Only some 40 per cent of respondents, however, regarded family work as rather easily or easily available. Early family work refers to support that can be offered to families on the initiative of child health clinics, day care or school healthcare services. In some municipalities, families can apply for family work services on their own initiative, without a referral.

For lower secondary level students, the most efficient method of preventing the need for child welfare was evaluated as having a safe adult close by, with preventive social work services being available (68 per cent of respondents) from school. However, preventive school-based social work services are easily or fairly easily available in only 47 per cent of the municipalities that responded. It is noteworthy that a safe adult close by is at least fairly easily available in only 11 per cent of municipalities. However, responses by municipalities expressed most concern about the mental well-being of children between the ages of 13 and 20.

Number of family centres increasing

The key aim of family centres is to support parenthood. Such activities are characterised by family-oriented, community-oriented and multiprofessional co-operation, family work based on early support and groups for children and parents. In 2005–2007, the focus of family centre development was on preventive work through basic services and creating supportive co-operation networks involving child and family services. In 2008–2011, the operating method and model was developed further, based on a municipality-driven approach in projects receiving state aid, under the National Development Programme for Social Welfare and Health Care (Kaste).

The survey by the Association of Finnish Local and Regional Authorities indicated that the number of family centres was increasing, with 45 municipalities, i.e. approximately a quarter of the municipalities that responded, reporting that they provided family centre services. More than half of municipalities providing family centre services produce them as one of the municipality’s own activities. On the basis of free-form responses, family centre activity seems to be intended for children under school age. However, information on the number of family centres, and implementation methods and practices, varies between studies.¹

¹ The National Institute for Health and Welfare is conducting a survey into the overall status of family centres in Finland.
The development of family centres has concretised the goals of preventive child welfare in a number of ways, while bringing structure to the preventive child welfare. Family centres should therefore develop in the direction of providing a basis for preventive child welfare in every part of every municipality. Family centre activities create preventive co-operation structures for services aimed at families with children and for those co-operating within such services. At various stages of life, family centre activities promote the partnership between professionals and parents, peer support by other parents, and early support for families and children and adolescents of different ages. Family centres could also form a child and family-oriented approach that steers all implementation of child and family policy within municipalities.

References


The Swedish Leksand model – family preparation as a starting point for the family centre

Thomas Johansson

“Support for parents makes for happy and secure children who can grow up into sociable and responsible adults.”

Introduction: The Swedish Leksand model has become widespread across many countries, particularly within the Nordic region. The reason for the success of the model is probably the simplicity of the concept.

This article summarises 15 years of work experience related to the Leksand model.

The article presents a number of results and factors that have played a major role in the development of the Leksand model, factors which are repeatedly referred to in the various evaluations. The article describes the original Leksand model in brief and the way in which various staff groups and voluntary organisations cooperate with regard to the support. The article also describes the additional initiatives relating to fathers, the topics that are usually covered and the methods for parental support that are usually used. A brief overview is also presented of the results produced by various evaluations over the 15-year period concerned and the success factors that we were able to identify through the evaluations. Finally, a number of proposals are presented ahead of the future work relating to parental support in Leksand.

I hope the article will inspire the creation of appropriate and comprehensive parenting support provision and that between the Nordic countries we can develop our knowledge exchange and experience associated with parental support.

The original Swedish Leksand model in brief

Since 1996, Leksand has offered parents various forms of support in order to improve the circumstances of children and make life easier for parents. This support is primarily provided through a structure that is based on extended and reinforced parental education in groups, where the groups learn skills and establish contacts with various functions in society. As the staff have shared goals and cooperate around a clear remit, the sense of social togetherness in the groups and the level of knowledge and awareness of the child’s needs are increased.

Parental support starts with the first antenatal appointment with the midwife. Both mum and dad attend this appointment. Both must feel welcome after the appointment and have no doubts about joining a parent group some weeks later. In the group, the parents get advice, support and education.

Initially, the parents meet in their groups around eight or nine times before the birth and an equal number of times afterwards, right up until the child’s first birthday. Three out of four groups choose to continue meeting in their groups. Some groups have been meeting for 10 years. The responsibility for activities after the child’s first birthday rests with the group itself, the adult education association and the open nursery.

When a problem arises within a family, it is easy to obtain advice, support and treatment, as the parents already know many of the relevant professionals through their visits and talks to the parent group. The service is provided in partnership between Dalarna County Council, the Municipality of Leksand, religious communities, adult education associations and voluntary organisations. The aim is to equip parents with the tools they need in order to handle their family situation, whilst at the same time reinforcing social interaction and networks between parents and other adults surrounding children and young people. Special support either in groups or individually is offered to parents who find their children difficult to manage.
Before the birth
Provision of the support begins when the midwife meets the future parents at their first antenatal appointment. The midwife greets the parents and welcomes them to the parent group, which starts at around pregnancy week 25. If the marketing of the group is successful, virtually all of the 12-20 parents who are invited will attend. Each parent is given the opportunity to be seen and heard. The number of parents in a group varies with the number of pregnancies. Children who are due at around the same time will end up in the same group. People remain with their original group when siblings are born. At this initial meeting, the aim is for the parents to feel secure and to want to continue in the group. One way of creating identity and a good atmosphere is for the parents to choose a name for their group, e.g. Potty 98, the Millennium Group, the Rising Stars, the Spring Flowers, End-game and The Untouchables.

A meeting often starts with a short talk or presentation by an invited guest, either professional or voluntary. After perhaps a half-hour talk, the day's topic is discussed, with mums and dads in separate groups. A dads' mentor usually leads the dads' discussion. The meeting is closed with the mums and dads discussing the day's topic together over a cup of coffee.

The professional groups involved prior to the birth are midwives from the maternal healthcare unit, nurses from the child healthcare (paediatric healthcare) unit, psychologists, nursery teachers, family advisors, family therapists, social workers and administrators from the Swedish Social Insurance Agency. The midwives are responsible for the meetings before the birth. Dads' mentors and couples who have recently had children also take part.

After the birth
When all the children in the group have been born, all the parents will be invited to a postnatal meeting which reinforces the sense of solidarity within the group. Nurses from the child healthcare (paediatric healthcare) unit are responsible for the meetings right up until the child's first birthday. In addition to the professional groups referred to above, other professionals who will also participate, including family law experts, nursery head teachers and dental hygienists. The parents also make visits to a library, where the children's librarian will tell the parents about children's literature.

Through to the child's first birthday, the parents will have plenty of time to get to know each other and the various professional groups in the team, as well as take part in other activities within the community. Representatives of local authorities, adult education and other associations, religious communities and businesses can visit the group.

Dads' mentors
Dads' mentors have been a natural part of the Leksand model ever since the very beginning in 1996. Dads' mentors normally take part in two to four meetings before and two to four meetings after the birth, right up until the child's first birthday. The group will then agree with the dads' mentor as to how often he will be needed. A dads' mentor is a completely normal, slightly more experienced dad with two or more children. He will attend a short course/introduction before participating in the groups and receive a small fee from the county council. The role of the dads' mentor is to support the dads and answer their questions. He can also tell them about his own experiences. Evaluations indicate that the dads' mentor is appreciated by the dads in general and the mums in particular.

The role of volunteers
An important role is played by the adult education associations, especially during the early years. (The Swedish Study Promotion Association (Studieförbundet Vuxenskolan and Bilda.) Voluntary organisations give guest lectures and talk to the parent groups, or alternatively the parents can make study visits to see the work of the association in practice. Examples of participating voluntary organisations include the various municipal bodies, the Civil Defence Association, the Red Cross, the parents' associations Lek i Leksand and Kids & Dads and the local hockey team Leksands 1

---

1 Adult education associations are organisations that promote popular education through study circles, meeting programmes, projects and arrangements/events with the aim of giving the participants knowledge. The study circle, a small group that learns together, is the core of popular education and an educational concept that has been around in Sweden for over a hundred years. The adult education associations are collectively the largest cultural organiser in Sweden. (Source: sv.wikipedia.org)
IF (Idrottsförening). Companies can also be invited to the parent group, or alternatively the group can be invited to visit the company on a study visit. Examples of such companies are insurance companies and banks. After the child’s first birthday, the importance of the voluntary organisations for the parent group increases, as the activities are customised to meet the needs and wishes of the parents and the children.

**Themes**
Themes prior to the birth and during the first year of parental education include emotional ups and downs; safe and secure bonding; the loving relationship; task delegation and new roles; the child’s needs and development; male-female language; breastfeeding; children’s food; accident risks; fairy tales; songs, music and visits to libraries; dental health; family law; parental leave; household finances and insurance; child safety; maturity and self-esteem; balancing family and work; information on medicines, alcohol and other drugs; and siblings and step-siblings.

**Methods**
Examples of methods that are used within the framework of the Leksand model include PREP – Prevention Relationship Enhancement Programme (a programme for couples), ICDP – International Child Development Programme/Guiding interaction (for parents with infants/nursery age children), Active Parenting (for parents with children aged 2-12 years), Familjeverkstan (for parents with children aged 3-12 years), COPE – Community Parent Education Programme (for parents with children aged 3-12 years), ÖPP – Örebro Prevention Programme (for parents with children aged 13-16) and LUT – Leksand Utbildar Tonårsföräldrar (for parents with children aged 12-18).

**Results and evaluations of the Swedish Leksand model**

**Attendance**
The proportion of parents who attend the groups is high. The average attendance amongst mums at the eight to nine meetings prior to the birth was around 95%, whilst attendance amongst the dads for the same period was around 90%. During the subsequent eight to nine meetings through to the child’s first birthday, attendance amongst mums was just under 90%, whilst that for dads was just under 70%. The control groups were given a traditional programme with fewer meetings. This resulted in much lower attendance, particularly amongst dads. Attendance prior to the birth is currently almost 100%.

**Some more results from the same evaluations**
On average, seven new parent groups started each year in Leksand (15,500 inhabitants with 120 births/year).
- Each parent group had around 12-18 parents and siblings were included in the original group
- Participation was very high in a national comparison
- Two questionnaire surveys showed that parents had a lot of confidence in the staff
- The parents appreciated the gender-separated discussions, as this approach often led to a more open discussion
- The dads’ mentors were appreciated by both the mums and the dads

---

2 all methods are universal, i.e. they are intended for everyone
• Parents in control groups who received traditional parental support were dissatisfied with this support
• The taking of leave amongst the dads increased during the period by 3.3%

Continuity
Up until 2006, an average of three out of every four parent groups continued to meet after the child’s first birthday. Around half have continued to meet over a period of five years. After the child’s first birthday, the parents meet between six to eight times per year on average during the first four years. Attendance amongst mums during this period averaged around 60%, whilst that for the dads was around 30%.

The success factors for the Swedish Leksand model
1. Continuity – the same parent groups continue to meet over time, and the staff have a holistic perspective. The continuity stems from having the same leaders for the various meetings before and after the birth right up until the child’s first birthday. It also stems from not breaking up the original group, i.e. the same parents continue to meet after the birth of the child. Also of importance for continuity is the fact that the staff encourage the parents to continue to meet and through their attendance “overlap” the various stages through which the group passes. Another important factor is that political decisions and organisational changes interact over time and facilitate and support the collaborative structure

2. Early start
The Leksand model starts “early” with the first antenatal appointment and parent groups with a high level of attendance. This enables early discoveries and initiatives. When a parent feels secure in their environment and surroundings, he or she will be more likely to seek help for a problem. Help that is given at this stage will often be more effective and far less expensive from every perspective than if it had been provided a few years later. Economist Ingvar Nilsson has calculated the profitability of the Leksand model from a social and individual perspective. Source: “Det är bättre att stämma i bäcken än i ån” www.seaab.se

3. Support for the dad
a. Dads are welcomed to the first antenatal appointment and receive their own invitation to join the parent group
b. Dads have their own dads’ mentor at most meetings of the parent group
c. Dads’ mentors are given brief training and receive some remuneration
d. There is open provision for dads on Saturdays, with a special “Kids & Dads” club for all dads with children

These dads’ initiatives have resulted in more paternity leave and parental leave being taken, as well as more dads participating in nurseries and spending more time with their children.

4. “We feeling”
Networks, a “we feeling” and identity are probably the decisive reasons why the Leksand initiative has won support amongst both parents and staff. A lot of time and care has been put into creating well-being and a sense of solidarity, with the result that networks have subsequently been formed and further developed in various forms, as the child grows older. Parents meet over a common and important goal – the good of the child

5. Own strength
Gradually increasing the parents’ own involvement in a group reinforces the group spirit and increases the parents’ own strength and insight into their own abilities as a parent and role model. Parents have also had representatives on development groups, enabling them to be involved and influence developments

6. Co-operation
Despite many setbacks and financial difficulties, the staff still believed in the working method and have continued to perform their role as group leader. The Leksand model is the result of (a) collaboration between the county council and municipal authority. Decisions are taken by both of these bodies individually. The collaborative body is the political collaboration committee (Politisk Samverkans-beredning) (POLSAM). There have always been groups for collaboration between different professional groups, whilst groups between civil servants and politicians have fluctuated over the years. Voluntary organisations have been invited to meetings. It is important for the survival and success of the
initiative that the collaboration works not only between decision-makers, but also between professional groups.

7. Feedback
The staff have been good at picking up on the need for change and this has resulted in the service being renewed. One instrument for follow-up and action has been and remains the “diary sheets”. During the early years, these were distributed after each meeting to each parent and member of staff. Today, they are given out more sparingly. The sheet asks what the person thought was good, what they thought was bad and how it can be changed. The sheets are collated and form the basis for possible changes and improvements. It is important that the changes are also implemented in reality.

Difficulties over the years
- A reduced budget has resulted in fewer temporary and permanent staff, fewer meetings and fewer occasions on which support is provided
- A lack of coordinators has adversely affected management and communication between members of staff
- Certain political decisions have adversely affected the collaboration and contact between professionals
- Important meeting forums have been withdrawn and this has adversely affected the dialogue between groups of staff and between staff and decision-makers.

The future
From 2011, the Municipality of Leksand has abolished the traditional committees and administrations, and all work relating to children, young people and their parents is now concentrated within a single organisation. This organisation will now build up the new, developed support in Leksand in collaboration with the county council and voluntary organisations. Of the following initiatives, the family centre is the one that is most established and a decision will be taken shortly. Other proposals will be considered over the next 12 months.

Family centre for all ages
A decision will soon be made concerning the establishment of a family centre in the town centre, probably adjacent to an existing activity centre for all ages. The aim is for the family centre to provide support for all children, young people and their parents. It is proposed that the current age-based provision at the activity centre, as well as the open and group-based activity relating to children and young people, be continued. This presents an excellent opportunity to develop the age and culture-integrating work. One aim is for the family centre to also offer education, advice and support to parents with teenage children.

It is proposed that family centres should house an open nursery, the social services’ family team, social services for advice and support, maternal healthcare, children’s healthcare, school healthcare, leisure activities, activities for the elderly and an arena for cultural programmes such as dance, theatre, films, talks, conferences, etc.

The following is still only at the proposal stage and may be trialled either in full or in part.

Parent groups at nursery
A proposal has been put forward according to whom responsibility for ongoing group-linked parental support after the child’s first birthday should be transferred to the preschool nursery, i.e. that each preschool nursery department should become a parent group – an educational unit for parents. The advantage of this structure is that the municipal authority takes a clear responsibility for the activity when the county council “hands over” at the time of the child’s first birthday. It is proposed that parents who do not take advantage of the nursery’s service should still belong to a group. The preschool nursery principal (head teacher) is responsible for convening the parent group. The activity can be carried out in collaboration with an adult education association, which can provide a leader and materials. It must be largely free of charge for the parents. The principal (head teacher) is given more responsibility, but on the other hand benefits through having more committed parents and through a

Economist Ingvar Nilsson on the Leksand model:
“I find it inexplicable that the Leksand model could have survived and achieved such good results over all these years with the minimal budget that has been available.”
proposed parental support unit within the municipality.

**Parent groups at schools**
Children join a preschool (nursery) class at the age of six. Under the proposal that has been put forward, it is proposed that each school class should become a parent group – an educational unit for parents. With this arrangement, the municipal authority’s clear responsibility to provide education, advice and support for parents can therefore continue. The principal (head teacher) takes responsibility for the activity at the school and the class teacher convenes the parent group. The activity can be carried out in collaboration with an adult education association, which can provide a leader and materials. It must be largely free of charge for the parents. The expanded responsibility for the school can again be offset through more committed, active parents and through a proposed parental support unit within the municipality.

**Parents of teenagers**
Existing courses for parents of teenagers have primarily been based on COPE or LUT (Leksand Utbildar Tonårsföräldrar). Interest has been strong and attendance high. In the case of LUT, attendance by mothers during the eight meetings of the programme was around 90%, whilst the corresponding figure for fathers was 80%.

**Role-play for parents – created by their children...**
A proposal has been put forward for a way of increasing the level of involvement amongst the parents of teenagers. The proposal is based on children and young people themselves identifying the conflicts that occur most frequently at home and the consequences that such conflicts usually have. This could for example be done through a questionnaire survey, combined with personal visits to schools. The ongoing idea can then also be presented – creating small scenes/Role-plays in about five minutes, which reflect the conflict. The actors will be the young people themselves. The audience will consist of parents and professionals. The scenes will be used as ice-breakers at parent meetings/parent cafés. The primary target groups will be the parent groups at the schools.

The meetings will be interesting and good-humoured. A meeting could be opened with young people singing and playing instruments. This would then be followed by the Role-play described above. An employee could, for example, then give a brief talk, which in turn is then followed by group discussions. The meeting can be concluded with a cup of coffee, a summary and perhaps more singing and music. The meeting would take up to 90 minutes in total. An adult education association can also be involved as a collaboration partner here.

There are many benefits to this method of working. The young people become more aware of how their parents can perceive different situations and of their own responsibilities. The parents become more aware of how their children can perceive different situations as well as more secure in their own role as a parent. The aim is to equip the parents not only with more and better tools for handling different situations, but also with sustainable networks for the future.

---

**Source references for the Leksand model 1996–2011**

Some evaluations have no source reference. Please contact the author of the article for more information.

The term “parental support” and Methods for parental support
http://www.fhi.se/Handbocker/Uppslagsverk-barn-och-unga/Foraldrastod/
1998 – Evaluation 1 by Dalarna Research Council (Kerstin Hopstadius)
2000 – Evaluation 2 by Dalarna Research Council (Kerstin Hopstadius)
http://www.dfr.se/
2001 – Midwives in the team distribute their own questionnaire to all parents (Ingegerd Jons)
2002 – Summary diary sheet (Thomas Johansson)
2002 – “Föräldragrupper i praktiken”, handbook by Thomas Johansson & Ingegerd Jons, Gothia Forlag
2004 – Pilot study for FHI “New tools” (Nya verktyg) (Sven Bremberg, FHI)
http://www.fhi.se/Publikationer/Alla-publikationer/Nya-verktyg-for-foraldrar/
2006 – Social anthropological study in parent group (Sköndal Institute)
2007 – National economic study (Ingvar Nilsson) “Det är bättre att stämma i bäcken än i ån”
http://www.seeab.se/
2007 – Quality assurance ahead of change work (Marianne Sellner and Thomas Johansson)
Thomas Johansson,
Public health planner, Municipality of Leksand
thomas.johansson@leksand.se +46 247 80137
Mother and father – for the first time

Henriette Weberg

This article describes the experiences gained through the project entitled “Mother and father – for the first time.” The project was previously carried out in Greve Municipality as an attempt to test the Leksand model in practice in a Danish context. At a time when resources are scarce, it is unfortunately not yet possible to adopt the method on a permanent basis, but there are now signs of political interest in the project once again.

Being a child or adolescent in Greve Municipality

Greve Municipality is situated just south of Copenhagen. There are approximately 48,000 inhabitants and around 500 births a year. In the work with families, there is a long tradition of interdisciplinary initiatives.

Within Greve Municipality, this work is carried out on the basis of an overarching Child and Adolescent Policy, which states amongst other things that children and adolescents should thrive in Greve Municipality. They should be happy in themselves and they should be part of communities. They should be looked after, so that they are safe. Yet they must also be challenged, so that they grow up believing in themselves and their own abilities. Greve Municipality wants to create the best possible framework and opportunities to enable both childhood and adolescence to become a valuable period in itself during which children and adolescents with widely varying circumstances, needs and interests can develop and realise themselves. Similarly, it is also an aim that childhood and adolescence will provide the foundations for a meaningful adult existence. Greve Municipality is of course unable to guarantee this on its own. The vital factors for all children and adolescents are always their parents and their close network. Greve Municipality therefore aims to help parents and families achieve the best for their children and adolescents, even when they find life difficult. We also want to ensure that all our institutions, schools, clubs and other places involved with children are permeated by our ambition on behalf of our youngest citizens, i.e. that they can lead a good and happy life.

More specifically, this results in a series of overarching objectives for the work with families:

Children and parents belong together:
The work is based on the view that children and parents should be together. When there is a need to work with the family, the approach must therefore be based on the provision of extensive support and assistance and the least possible intervention with regard to the child.

Prevention and health promotion are accorded a high priority:
Children and adolescents are offered assistance within this area at an early stage in order to reduce the need for more comprehensive measures later on in the child’s life.

A targeted service is offered to people who are in need of assistance:
The family is a very real and active collaboration partner and is always involved in the objectives of the initiative, regardless of whether assistance, support or supervision is required.

It must be ensured that a broad range of services is provided at all times in order to meet the individual needs of families for support and development insofar as this is possible.

An interdisciplinary approach shall be ensured:
The family services that are provided are based on an interdisciplinary collaboration, bringing together a broad range of knowledge concerning the family’s resources and ensuring an individual and holistic approach.

Professional, methodical development shall be ensured:
Professional development shall be ensured at all times, so that relevant support can be given to families at any one time.

**Why a parents’ course? – a brief history**

In line with developments within society and changes in the structure of the family, there is an ongoing need to adapt the healthcare services that are provided to future first-time parents in the municipality. Future parents are part of the hypercomplex society. As there is an enormous amount of information, advice and guidance available in connection with becoming a parent, it can be difficult to decide what to listen to and what to ignore.

Many future parents have a well-developed network, yet no idea let alone experience of what challenges, joys and worries the parental role will bring. Even if they do have a good network of friends and family, most people today lead very busy lives; the grandparents are still working and prioritise their own interests in their spare time. Many people have never held a newborn baby in their arms until they hold their own for the very first time. There is therefore a lot to take on board and a lot to learn, and there are few if any role models to follow. There is considerable interest and motivation amongst future parents when it comes to creating the best possible circumstances for both themselves and their future children.

Evaluations from both international and Danish studies have shown that a preventive approach in the form of the creation of parent groups for first-time parents starting before the birth has a good preventive effect on family stability, parent well-being, and the well-being and development of the child. Starting up a preventive group project aimed at couples expecting their first child and starting before the birth of the child can give parents an opportunity to improve their parenting skills and enjoy the role of parent more, as well as preventing family problems which in the longer term can be both resource-intensive and difficult to repair. It can be difficult to predict and assess in which families parents are likely to experience difficulties with their role and therefore be in need of additional support in order to safeguard the child’s development and well-being when adopting an individual-oriented perspective. There are both ethical and professional problems associated with identifying and thereby stigmatising a particular group of parents in advance, and it is difficult to recruit parents to initiatives that are aimed at special groups.

**Parent support work**

Support initiatives aimed at parents as early as the pregnancy stage have a decisively positive effect on the child’s weight at birth and the number of complications, and thus also on the child’s health at birth. By targeting the initiatives at the factors that lie behind inappropriate behaviour, instead of at individual risk factors, it is possible to promote the child’s general health and well-being to a greater degree. This process is supported through universal preventive parent support work, which involves offering initiatives to new parents based on the relationship between the child and its parents, as well as the parents’ resources.

The parent support work must therefore help parents to promote their child’s positive and healthy development as well as developing the parents’ ability to act in relation to both their own health and that of their child.

In Greve Municipality, we in the Healthcare Service have worked on the provision of support for parents through the project “Mother and Father – for the first time”.

The goal of this project is to support and develop the parents’ capacity to care and act with the aim of establishing a strong bond between parent and child and developing and maintaining healthy habits for the whole family. The aims of the project are therefore:

- To give first-time parents the opportunity to participate in a group programme;
- To establish networks within the groups;
- To provide the parents with the tools needed to deal with critical situations at an early stage;
- To provide professional support and guidance at an early stage, thereby preventing dissatisfaction and inappropriate development in the individual child;
- To support and guide the family, so that they are able to make

1 L. Lier, M. Gammeltoft, IJ Knudsen: “Early mother-child relationship”

2 The Leksand model. [http://www.leksand.se](http://www.leksand.se)
healthy choices for both the children and the adults

The unique aspect of this model is that the work is aimed at both the future father and the future mother. The couple participate in the project together and attend the same meetings.

When the child has become a little older – about a year – good experience will have been gained concerning the provision of supplementary services for fathers and their children.

**Overall organisation**

“Mother and Father – for the first time” is a working method that is strongly based on interdisciplinary collaboration.

One of the fundamental ideas is that both internal and external, as well as public and private, professionals provide the professional basis in the work relating to the method.

When the project was carried out in Greve Municipality, there was a health visitor who acted as anchor for the group. This was made in view of the fact that the healthcare visitor would in all circumstances have contact with the family when the child was born.

The health visitor has a broad interdisciplinary internal network within the municipality, as well as knowledge and experience of communication paths and collaborative relations.

Links with external collaboration partners will also be established in the primary sector, e.g. with the GP, and with collaboration partners within the region.

**Recruiting the families who will participate**

A pivotal aspect of the method is linked to the meetings before the child is born, so it is vital that the group is established as early as possible during the pregnancy.

Here, the midwives are key collaboration partners, as they are in contact with the couples at an early stage and able to invite the couples to take part in the project.

It is vital that the midwives are motivated into setting aside time to tell couples about the opportunity and that they distribute material about the group to the couples in the form of a leaflet which gives the couples a chance to find out more about what is on offer and decide whether or not they wish to take part.

When the couple has been offered the chance to take part in the project, it is the project leader who takes responsibility for the further organisation regarding group start-up, information on the meeting place, dates, etc.

**Composition of the group**

The families that take part in the groups come from all walks of life. This means that families from every social class participate.

It is actually one of the fundamental ideas behind the model that the group will use the resources that are available and that the participants all have something to learn from each other. A learning community thus develops within the group.

The idea is that the group will provide each other with a network in both the short and the long term, through which they can develop and exchange experiences and thoughts, enabling them to acquire new skills. This helps to enable the participants to support their child’s healthy and positive development.

In addition to being from every tier of society, the participants in the group can also be of many different nationalities.

Danes with a non-Danish ethnic origin can participate if they are able to speak enough Danish to get something out of the programme whilst at the same time not restricting the group process and the discussions that take place.

The method is an obvious opportunity to reinforce integration, as throughout the programme there will be a focus on how people as parents can support their child’s development as much as possible. Throughout the programme, there will therefore be opportunities to discuss values, upbringing, attitudes towards children, family life, couple relationships and so on. In this way, all the participants gain a greater insight into the thoughts and attitudes of other people, as well as an excellent opportunity to sweep away prejudices and misunderstandings.

**Topics for the meetings**

Participants in “Mother and Father – for the first time” take part in 12 meetings, split between three meetings before the birth and nine after the birth. A wide variety of topics are touched upon at these meetings.

There will be many different ways in which to combine the topics, as well as many ways of tackling the meet-
ings. This will depend on both the participants and the professionals.

Some examples are given below of topics which were brought up during the “Mother and Father – for the first time” meetings.

Before the birth, there are topics that concern the impending birth, as well as things that relate to the birth itself. Examples of topics which were brought up are:

- **Expectations of parenthood & preparation for the birth:**
  The preparations that the couples can make for the birth are discussed at this meeting.
  Mutual expectations are also discussed, with an emphasis on the roles of the father and mother.
  Here, the meetings can touch upon topics that are practically-oriented, but more emotional topics such as sexuality can also be considered.

- **Law – finance and/or insurance:**
  Parental authority and its importance, as well as the key legal issues concerning parenthood, are discussed at this meeting.
  The family’s financial prospects and challenges can be discussed, and the insurance policies that you should take out when you become a family may also be considered.

- **The child in the family:**
  The child’s development and well-being. How can parents “talk” with their child? How can parents read the signals that a new-born baby gives out? And how should parents react to these signals? Here, it is important to draw the participants’ experiences into the discussion. When are people (un)sure about what they are experiencing?

- **The early days as a parent:**
  Parent dynamics and the roles of parents. What kind of mother/father do the participants want to be? What has surprised the participants? – Here, we can talk both about what “new” aspects of themselves the participants have become aware of since they became parents and what aspects of their partner they have been surprised by.
  It will also be relevant to discuss the participants’ views as regards what is good for the child, what can help to support its development, and what personality traits of the child should be encouraged.
  At some of the meetings, it may be appropriate to follow up what was discussed at the last meeting and also to expand on the discussions with new angles and aspects.
  It can be a good idea for the participants to give examples from their everyday lives and to create a forum where there is scope to air prejudices and discuss values and norms.

**Making a special effort**

“Mother and Father – for the first time” was carried out in Greve Municipality, but at a time when resources are scarce, it has not yet been possible to launch the method as a permanent initiative. However, there are signs of political interest in “Mother and Father – for the first time” once again and the Child and Adolescent Committee has asked for a brief overview of what it would cost to run a number of groups a year for this programme in Greve Municipality.

There are currently many other services available for parents who are in need of support and guidance. These are services which are both preventive and, for some people, more therapeutic. In all cases, the focus is on the provision of assistance at as early a stage as possible and on drawing on as many interdisciplinary resources as necessary.

The healthcare service in Greve Municipality is working on special initiatives aimed at vulnerable young mothers, families with children who were born prematurely, families with twins and also families of non-Danish ethnic origin. Work is also carried out to seek out post-birth reactions without using additional resources.

**References**

http://www.leksand.se
Interdisciplinary knowledge gathering for the rate pool. The Healthcare Service and other early interdisciplinary initiatives. Danish National Board of Health, 2008
The Non-governmental organisation as a player within the family centre – a vision of collaboration  

*Milla Kalliomaa*

This article describes the special role which organisations and volunteering play in the operation of family centres. The special role of organisations is based on the voluntary work they organise. Organisations, or the third sector, integrate with the fourth sector, which consists of families and social networks between people. Partnership-based co-operation between municipalities and NGOs faces the challenge of moving from parallel, partly overlapping production of services towards co-operative planning and implementation of family centre operations. The Mannerheim League for Child Welfare is a nationwide organisation which, in the context of family centres, concentrates on developing peer group activities and family cafes.

The Finnish family centre model is based on co-operation between many contributing players, aimed at enhancing child and family welfare. Family centre work by organisations, municipalities and other partners have the joint goal of providing support for parenting and children’s growth and development at the earliest possible stage. In organisations, such as the Mannerheim League for Child Welfare (MLL) and Folkhälsoan, development of family centre work has focused on different forms of peer support, parent groups and open activities.

The idea of family centres was introduced in Finland nearly thirty years ago, when the first family centre was founded by the Mannerheim League for Child Welfare in Rovaniemi in 1987. Following a model set in the United Kingdom, the aim was to bring together municipal child health clinic services, MLL’s temporary childcare services and parent groups. Due to the economic recession in the 1990s, this kind of family centre was never realised (Kalliomaa, 2004). Thereafter, the focus of MLL’s family centre work has been on developing peer support groups and open activities for families with children. Family cafes in particular have gained favour with families. There are currently hundreds of family cafes throughout Finland, operated by Folkhälsoan, the Mannerheim League for Child Welfare, and other players.

MLL’s current family centre operation is mainly based on volunteering. Nationwide and regional development is financed by Finland’s Slot Machine Association (RAY). Municipalities also provide financial support for the regional direction of family centres. Nationwide operation includes various peer support groups, family cafes, children’s clubs and support persons for families with children. In addition, MLL’s district organisations offer temporary child care help to families with children. Family centres are operated by MLL’s local associations and their volunteers. District organisations, whose personnel have the task of supporting co-operation between local associations and the municipality, are responsible for directing the operations of family centres.

Municipalities hold the main responsibility for family centre services and develop their operations in co-operation with organisations, congregations and other local players. Indeed, the role which organisations play in the co-operation between family centre partners is characterised by creating and strengthening mutual support between families, through volunteering and offering an easily approachable, low-threshold environment. To achieve this, an organisation
requires structures and resources for supporting volunteers, and must guide their work and forge co-operation within the multifaceted family centre network.

Volunteering and the fourth sector
Due to the voluntary work which they organise, organisations play a central role in family centre operations. It could be said that the third sector enfolds the fourth, which consists of families and social networks between people. Volunteers rarely engage in direct participation in municipal services or the activities of municipal professional working communities. The reason for this is understandable. Voluntary work is directed by a different operating logic to paid work. Several co-operative projects have shown that, when seeking the participation of volunteers, a community is required which volunteers can join on the basis of their own terms and values, and through which they can receive help from the organisations’ workers.

For many people, voluntary work is a path which begins with participation in peer support activities and that continues with meaningful volunteer work, suited to the volunteer’s current life situation, within an organisation. A volunteer is often motivated by the experience of having being helped and consoled by others. This is something they would like to pass on.

It is important to create an environment in which volunteers can both learn and obtain support in their work. Volunteers have the right to narrow down their task and volunteering hours as they see fit. They commit to ethical principles, such as respecting other people, appreciating children and childhood, and dependability, confidentiality and equality. In return, they have the right to support and guidance.

Support structures for voluntary work consist of basic training provided for each task, continuing education, peer meetings for volunteers, and guidance offered by a worker at the organisation. They also comprise adherence to consistent practices in various activities (e.g. in family cafes). Organisations’ pivotal partners in volunteer training include state-supported study centres offering liberal adult education, such as the OK Study Centre and the Svenska studiecentralen operating in Swedish.

Volunteers
MLL volunteers, such as group leaders, family cafe volunteers or support persons, are not required to have a vocational education and are not paid for their work. Volunteering is considered valuable, as the additional education and experience gained in such activities complement volunteers’ professional skills. Indeed, one-third of peer group leaders report that the benefit to their professional lives is a motivating factor. However, even more important motivators for becoming a peer group leader include willingness to help others (48.7%) and to share one’s own experiences (42.3%).

In voluntary work, motivation is supported by volunteer peer meetings, training and feedback, organised by the organisation. Voluntary peer group leaders describe their motivation in the following manner:

“Without the support of peer discussions, I don’t think I would lead another group”

“Finding a collaborator to run the peer group and become a second group leader was truly motivational” (Halonen, Sourander & Viinikka 2010)

Families
Families usually find their way to MLL’s family activities after hearing about them at their child health clinic (32%). In almost as many cases, a friend or acquaintance has told them about MLL’s family work and the participation possibilities offered. Nearly every parent participating in peer groups refers to the need to talk to other parents facing the same situation as the reason for partici-
pating. Six out of ten participants join a group in the hope of finding new friends. These hopes are often fulfilled, with nearly 70% of participants reporting that their social network has grown stronger and that they have made new friends. The second most important effect of group participation was that participants felt better when they had the opportunity to talk to other parents. Participants felt that the group contributed to their well-being (35.8%). Over a third felt that this helped them to settle into the area (Halonen, Sourander & Viinikka 2010).

Participants in groups led by volunteers feel that the most significant parenting support is provided by friends, spouses and relatives. Child health clinics are first on the list of professional help, occupying fourth position on families’ help networks after the persons mentioned above. It is therefore worthwhile investing in early support, bolstering families’ own resources. Families know how to benefit from mutual support and openly report that participating has provided them with new strength (Halonen, Sourander & Viinikka 2010).

According to the preliminary results of the family cafe survey currently underway, parents think that children finding company is the most important element in attending a family cafe. Strengthening of the parents’ social network is viewed as the second most common effect.

A family cafe reaches a very wide variety of families, whose educational background can be divided fairly evenly into three groups. A lower academic degree is the most common educational background, while vocational school is the second most common, almost matched by the number of higher academic degrees. Approximately half of all visitors visitors feel that their subsistence is secured and their social networks are functioning. Many worry about subsistence and the scarcity of social networks. Over one-third of family cafe visitors often feel weary or fear that the family’s income is insufficient to cover its needs.

Two-fifths of those who have taken the survey report that the family cafe helped them to settle down in a new location. They also referred to the cafe as the place at which they heard about services for families with children. The survey currently being conducted suggests that family cafes offer help and support to families whose socio-economic statuses may differ but who have a certain life situation in common. Open responses from visitors provide encouraging feedback to local associations and the entire organisation.

**NGOs support for and management of family centre work**

NGOs co-operate closely with municipal family centres. Such co-operation is hampered by the fact that the volunteer-based family centre work of local associations is insufficiently integrated with the rest of the service network. MLL has 566 local associations, which are independent, registered associations. These associations plan their activities as they see fit and according to the needs of participating families. There is not always even time to co-operate with the municipality. Such co-operation is also beset by volunteers’ perception of an imbalance in their relationship with the municipality’s professionals (Carpelan 2007).

Concrete co-operation requires co-operative planning; municipal organisations do not have a tradition of planning their services together with families. Co-operation with the broad field of organisations also takes time. In a report on partner-
ships, municipal players viewed their co-operation with organisations as highly important, but also felt that no working time had been allocated for this (Carpelan 2007). This is the key development challenge in managing organisations’ family centre activities.

In 2009, MLL began a development project with the goal of renewing professional guidance of voluntary work and responding to the challenges posed to co-operation between municipalities and organisations. This project aims to implement a regional control model for family centre work throughout Finland by the beginning of 2014. Instructors hired for the project by the organisation are social services, health and education professionals. Together with municipalities, they have the task of assisting local associations. Each worker operates at the junction of the public, third and fourth sectors. Municipal workers can reach a worker during office hours, in order to negotiate on issues or plan meetings. The worker meets families in open meeting places and events, and visits family cafes organised by volunteers. He or she also assumes responsibility for directing demanding voluntary work, which includes e.g. support person work for families with children, for which training and a longer-term commitment are required of volunteers.

The organisation’s worker helps its volunteers to recognise situations where a parent, who is a member of a parents’ group or visits a family cafe, needs to be referred for professional help. Lengthy periods of dejection, relationships in crisis or exhaustion require professional help. In such cases, the family in question is referred by the group or family cafe for further help.

The organisation’s worker ensures that families are familiar with the entire service path and that municipalities are aware of what organisations offer to families. Families need support from organisations and municipal services ranged side by side. This service path model is illustrated in the figure (1) attached to the end of this article. The figure reveals that, in addition to voluntary work, organisations offer professional services. In most cases, such services are based on outsourcing service contracts with municipalities.

**Vision for family centre co-operation**

In Finland, the family centre model is still taking shape. In some municipalities, this model is based on network co-operation between services in different locations and mainly focuses on family training. Some municipalities assemble various municipal services and open activities, provided by organisations under a single roof. Sometimes, family centres run by municipalities and organisations operate side by side and may even offer similar services for families with children.

Regardless of the model, since around the turn of the millennium, municipalities and organisations family centre thinking has directed the development of services for families with small children. A set of services has been under development, based on multi-professional co-operation and a multiple player model, with all players sharing the goal of supporting families at the earliest possible stage. The forerunners of the family centre model have referred to a paradigm shift, which has brought families to the centre of services. Families are viewed as proactive experts in their own welfare, capable of creating and receiving help through their peer relationships. In the family centre model, volunteers and families themselves are recognised as players, as well as municipal professionals and organisation workers.

In practical everyday life, much remains to be done in order to achieve the goals mentioned above. Co-operation between municipalities and organisations continues to be
mainly based on purchased services, a model in which the municipality purchases while the organisation sells. A partnership model, based on collective service planning and realisation, is seen less often. Especially rare is a situation where families’ mutual networks, family cafes and groups, all organised by the organisations, actually form one of the municipality’s set of services. The parties usually operate side by side but not together. This is partly due to the fact that the organisations have not publicised open activities run by volunteers. Another explanation can be found in the municipalities themselves. Within municipalities’ own development projects, municipal open services may have been established next door to an organisation’s family centre. Development projects therefore face the danger of taking a suffocating, over-organised approach to families’ own activities. A voluntary leader may be crowded out by a professional.

There are also some exemplary local models in which a municipal family centre combines an open municipal child daycare centre, the organisation’s family cafe, stand-in grandparent activities, events organised by volunteers and municipal child health clinic and family services in the same building. Working in the same place brings the organisation’s and municipal workers closer together and makes cooperative planning more natural. In the Vauvaperhe (‘Family with a baby’) project of MLL’s Southwest Finland District, a model was created for a service chain. Based on this model, new family centres are being developed in the area in co-operation with the municipalities.

Organisations need to invest more in the professional management of family centre operations and co-operation with the municipalities. They also need to improve their follow-up and assessment – systematic information should be generated on families’ needs and experiences of the support they receive. Organisations may rely too much on the idea that their services are more human, value-based and intimate. Continuous assessment should be harnessed to investigate whether people actually feel this way.

Co-operative development and political commitment would be made easier if the family centre were defined more clearly. Families do not perceive the service network as a low-threshold family centre. The network model should be developed into a set of operations which is easier to grasp. Shared locations and environments should be created, of the kind which families perceive as family centres. Multi-professional co-operation ought to be concretised, and further professional education is needed to create a new breed of service thinking. MLL and Folkhälsan have especially good experiences of shared training for organisational and municipal workers. Such training has been provided in MLL and Folkhälsan’s co-operative project entitled Vahvuutta vanhemmuuteen (‘Strength to parenting’), which seeks to lay a path from municipal family training, through guided family groups, to the organisations’ open activities. During the project’s first year, co-operation has already begun in 55 municipalities.

The vision underlying the proposed changes is based on genuine co-operation and planning and working together. Municipal resources are also needed to support the organisations’ voluntary family activities. Each euro invested by a municipality in an organisation is highly productive. According to a recent economic survey, every euro invested in supporting voluntary work yields six euros in return (Ruralia Institute, University of Helsinki, 2011). The most important yield, however, takes the form of human welfare, experienced by families as they offer and receive help.

Municipalities have no need to reinvent the wheel. The family cafes of MLL (439) and Folkhälsan (38) are a resource which should be brought into closer co-operation with child health clinics and family centres. Parents visiting family cafes emphasise the significance their participation holds for the children in particular. The connection between family cafes and open daycare centres should be reinforced. This would ensure that the environment better meets the needs of children of various ages. An open child daycare centre could provide a natural environment for both a volunteer-run family cafe and children’s play and interaction in a pedagogically planned and guided environment. This would also give children in home care access to early childhood education and care.

Local solutions vary considerably, due to the strong autonomy of municipalities in Finland. For this reason,
it would probably not be worthwhile to even plan a single, shared family centre model. It is essential that the organisations, other local players and municipalities engage in joint planning as the nature of their work changes. Co-operative planning ensures that the open services of the municipality do not overlap with the organisations’ operations, and that families in different life situations find the right kind of support. This vision outlines a new, shared working culture and a flexible path for families, from peer support to services and vice versa.

**The Mannerheim League for Child Welfare** is a nationwide non-governmental organisation which promotes the welfare and inclusion of children, adolescents and families with children, by developing different forms of support and by influencing decision-making. The organisation has over 92,000 members and its operations are based on active volunteering within its 566 local associations, and on a nationwide network of 13 districts. Its associations and districts are independent associations which organise various family-supporting activities. They are also responsible for their own finances and operating. Activities are guided by the organisation’s common strategy and national programmes. About 8,500 people throughout Finland volunteer for work which strengthens families with children. In open activities, over 900,000 contacts are made each year with children, adolescents and parents.

**NGOs** are an essential part of the Finnish welfare state. They develop services, produce information on people’s needs, and create environments in which people can participate and help each other. In comparison to other Nordic Countries, NGOs operate exceptionally widely in Finland. The Register of Associations holds about 120,000 associations, and the number of social and health associations alone is 13,000. Volunteer hours across the entire field of organisations are not annually surveyed in Finland, but in 1996 their number totalled 123 million hours. Among the Member states of the European Union, Finland is in the second highest category in terms of volunteer activity (Volunteering in the European Union, 2010).
Folkhälsan is a non-profit social and healthcare organisation founded in 1921. The organisation employs about 1,800 people in health services, research, education and health-promotion. 100 local associations and a total of around 17,500 members operate throughout Swedish-speaking Finland. Hundreds of volunteers support children and families, for example by assisting in schools, and acting as family cafe leaders, support for women in labour (doulas), or by participating in or organising swimming schools and other events. Folkhälsan seeks to encourage people to care about their and other people’s health, by both offering practical activities and influencing societal development. Its health-promoting activities are divided into four fields: volunteering, families and relationships, lifestyle questions (physical activities, food, rest, youth work, sexual health), and language development and communication.

References


Is preventive work cost-effective?
Effectiveness and costs of preventive services for children and families

Ismo Linnosmaa, Antti Väisänen, Eero Siljander and Jukka Mäkelä

Introduction: This article discusses issues related to the economic evaluation of preventive services for children and families. A concrete example is presented in the form of child welfare and its financial evaluation, chosen because child welfare costs have sharply increased throughout the new millennium. The number of children placed outside the home increased until 2009. Especially rapid growth has been seen in the number of 16–17-year-olds outside the home.

We begin the article by describing the aims of services for children and families. We discuss the concept of preventive measures and, with the help of two examples, demonstrate the possible result if early intervention fails, alongside the costs of such an outcome. In terms of effectiveness, we take a closer look at services for children and families which might reduce the risk of a child being placed outside the home. We then examine the concept of cost-effectiveness and current research data on the effects and costs of prevention. In conclusion, we discuss the possibilities and problems involved in preventive measures.

Starting point: securing the welfare of children and families with children

Although the majority of Finnish people are better off than before, part of the population is becoming socially marginalised. There is a danger of social marginalisation, poverty and social deprivation continuing down the generations. Many services for children and families aim to secure the most equal starting points possible for children. Early intervention in problems and support for the everyday life of families with children enhances family life and the safe development of children. Sometimes, situations become so grave that they endanger the provision of a safe environment and balanced development for the child, in which case it may be necessary to resort to child welfare.

1 We thank Aija Puustinen-Korhonen and Marjatta Kekkonen for their constructive comments on our manuscript.
Placing a child outside the home is a child welfare measure of the last resort. It can have long-term effects on his/her life, affecting, for example, his/her education and career (Heino and Johnson, 2010). Placing a child outside the home is also expensive for society.

Among other things, the Child Welfare Act 417/2007 lays down provisions on preventive child welfare, support for parenthood, support interventions in community care, and placing children and adolescents outside the home. The Act determines the circumstances in which the threshold for child welfare support measures is considered to have been crossed. Child welfare measures as such cannot be eliminated, without changing the unfavourable development conditions which make such measures necessary. Rather, demand for child welfare can be affected by means of preventive measures and child welfare community-based services. Since placement outside the home is a drastic measure from the viewpoints of child and adolescent welfare and municipal finances, means of preventing such placements are required.

Family centre work is a new method of organising preventive measures. It increases families’ opportunities to receive both peer and professional support at an early stage, when their own resources still are reasonably sufficient. This is an ideal stage at which to increase the child’s possibilities of faring well, since a change of direction at an early stage significantly affects the situation later in life. The origins of a possible need for child welfare at a later stage begin to develop long before the actual concern has emerged.

Family centre work is an example of a universal social policy service. An
activity is termed universal when it is targeted at all members of a given group, such as families with children, while the aim of targeted measures is to improve the life situation and welfare of a selected group, for example a certain high-risk group. Primary prevention is universal and all children and adolescents in Finland are subject to it. Meanwhile, secondary and tertiary preventive measures are targeted at a certain child or family, whose problem or risk has been recognised.

A significant element of prevention consists of recognising high-risk groups and allocating resources to the most vulnerable population groups. Child welfare can be used as an example, since there appears to be a clear connection between family poverty and the need for child welfare. Consequently, it can be seen that financial subsidies allocated to the poorest families have preventive effects.

Failure to take preventive measures leads to the culmination of problems and major costs
Services for children and adolescents can also be seen to have a broad role in supporting lives and development, as well as preventing problems. Below are two examples of the possible consequences of failed prevention or insufficient early intervention, and the resulting costs to society.

Trends in child welfare use and costs
In Finland, problems experienced by families experiencing ill-being amongst children and adolescents are particularly reflected in the growing number of municipal child welfare clients. Cuts in services during the recession of the 1990s also affected services for families with children, such as domestic aid. Poverty among families with children had been decreasing over a long period, but began to increase in 1995 and continued to do so until 2005 (Salmi et al., 2009). These factors were expressed in a growing need for child welfare. The number of children placed outside the home grew steadily from 1991 all the way to 2009. During this period, the figure almost doubled to more than 16,600 children and adolescents. With respect to teenagers in particular, the number of children placed outside the home has been growing steadily throughout the 2000s. This is probably explained by growing ill-being among young people (Kuoppala and Säkkinen, 2009). The same trend can also be explained by the increasing mental health problems faced by young people and insufficient availability of mental health services for children and adolescents (Child Welfare Act 417/2007).

In 2009, almost a billion euros was spent on child welfare services. Of this sum, almost 600 million euros were spent on out-of-home care services (Sotkanet), which entailed yearly costs of about 40,000 euros per each child placed outside the home (Kumpulainen, 2010). Child welfare costs are clearly increasing at a faster pace than in other social and health services, excluding the costs of services for older and disabled people. Such growth in expenses is explained by increased use of services and higher unit costs, but also, first and foremost, by the institutionalisation of all services. (Kuoppala and Säkkinen, 2010). An increasing portion of children placed outside the home are placed in child welfare institutions, a trend clearly reflected in growing costs. The daily cost of institutional care is four times that of foster family care (Väisänen and Hujanen, 2010). Municipalities are being faced with difficult decisions due to high costs. Indeed, children are in danger of inequitable treatment between municipalities due to the municipalities’ varying financial situations. All in all, the economic incentives to reduce the out-of-home placement are great.

Early intervention and the costs of antisocial behaviour and social marginalisation in young people
Early intervention is a working method based on which the child’s school, social services and families cooperate to prevent antisocial behaviour and social marginalisation, through timely recognition of problems in young people's lives and in their educational progress (Työministeriö, 2004). It is possible to intervene at an early stage in such problems, steering the young person’s development in a positive direction before more serious and expensive action is initiated by the authorities.

Antisocial behaviour and social marginalisation in young people may incur expenses for society. A follow-up study conducted in the United Kingdom (Scott et al., 2001), surveyed the costs of antisocial
behaviour in young people and adults aged 10 to 28. The study noted that a young person with behavioural problems costs society three times as much as a young person belonging to the average population, when costs are assessed in terms of public expenditure on public services. Most costs caused by antisocial young people are incurred in the form of police and judicial services (about 60% of total costs), while the education sector (about 20%) accounts for the second greatest cost levels and child welfare comes third (about 10%). Health service costs were significantly smaller. When the costs of public services are taken into account, at its highest the total cost can amount to almost 70,000 pounds at 1998 prices (Scott et al., 2001), or around 100,000 euros at current prices. One international study (Healey et al., 2004) noted that workforce participation, the employment rate and the income of young people exhibiting antisocial behaviour are lower than those of the whole population at both 18 and 32 years of age, i.e. long after the period of youth. Young people in whom antisocial tendencies are observed at an early age tend to spend longer periods unemployed and have a criminal record. Culmination of such antisocial behaviour can lead to social marginalisation from education and working life.

The National Audit Office of Finland has estimated that a young person in a state of permanent social marginalisation from the labour market costs society around one million euros (Valtiontalouden tarkastusvirasto, 2007). This figure corresponds to the cost of youth unemployment to the national economy. According to Nilsson and Wadeskog (2008), this million-euro price tag measures only around half of the actual costs of social marginalisation. This is because, in addition to production losses, the socially marginalised are associated with greater than average use of services such as the police and the judicial system, employment authorities, social welfare and social security.

Kajanoja (2000) has also estimated the costs of social marginalisation. According to his calculations, permanent social marginalisation causes a loss to national income of around 700,000 euros and an increase of 450,000 euros to the public economy, at current values. Loss of national income has been calculated according to the lowest wage group, with the employer’s additional expenses added. The impact on the public economy consists of lost tax revenue and increased service expenditure. However, Kajanoja (2000) points out that these calculations are likely to underestimate the total costs of social marginalisation.

The need for child welfare, and social marginalisation amongst young people, are extreme examples of the possible consequences of allowing young people’s problems to accumulate. Although the situation is nowhere near as grave for most children and young people, appropriate and timely prevention and early intervention may also improve the lives of “ordinary” children. Clearly, some problems are only noticed at a later age and cannot always be solved, but this does not eliminate the clear need for preventive measures. Family centre work can be used to combine professionals from multiple sectors to co-operate for the benefit of children. Family centres also support families and parents, while encouraging parents to participate in various activities. This makes it easy to approach problems and enables early-stage intervention. Although, in its current form, family centre work focuses on early childhood, services available in the centres include social and family work services, home-help services, child welfare services and non-institutional adolescent psychiatry services (THL, Kasvun kumppanit).

Family centre work represents a new method of organising preventive services for children and families. However, no direct research evidence exists on the effectiveness and costs of this, although indirect evidence is available on its effectiveness.

---

2 The base figures from the year 1996 were 3 million marks in losses to national income and a 2 million mark increase in public expenditure.
Cost-effectiveness

Basic concepts in the evaluation of cost-effectiveness
The concept of cost-effectiveness can be defined with the help of the concepts of inputs, output and effectiveness (see Fig. 1).

Input denotes the resources used in service production, such as workforce, equipment, machines and production materials. In municipal child welfare services, a focal production factor can be found in the input of a social worker and, for example, family worker, but service production also requires physical capital such as premises. If social workers decide to place a child in a professional family home instead of a foster family home, production factors include input and the necessary premises, as well as factors needed to maintain the premises, such as energy. Input use is often measured based on production costs.

Combining different kinds of inputs creates an output comprising the amount of services and goods produced. For example, child welfare services include social work case management and guidance, support interventions in child welfare community care (e.g. family work and family rehabilitation) and substitute care services which can be realised as institutional care, professional foster care or foster family care. Nonetheless, services as such are not the actual outcome. Instead, the use of services can hopefully contribute towards achieving positive effects in terms of clients’ welfare.

Sintonen and Pekurinen (2006) define effectiveness as a change in final output which is in accordance with the goal of the action taken. To define the effectiveness of services, information is needed on both the length and quality of life (Williams, 1985). In the case of child welfare, the child’s well-being is a natural candidate as the life quality variable (see e.g. Knapp, 1984).

Fig. 2 depicts the effectiveness of a child welfare service. For example, this service may involve placing the child outside the home or taking the child into care. In the example, the child care service is effective because the welfare of a child who is provided with the service is greater than that of a child who is left without. The effectiveness of the service can be measured with the help of area E. Effectiveness takes into account both the change in welfare at any given moment, and the duration of the effect. It should be noted that service use does not always result in the desired outcome – service effectiveness can remain small or even negative in value.

The cost-effectiveness of preventive measures
Evaluating the cost-effectiveness of preventive measures is difficult due to the fact that the benefits of such measures are usually realised only in the future. Chronologically, a preventive measure precedes any positive effects it may have. In such a case, variations in effectiveness are usually also explained by other factors influencing the child’s welfare, such as his or her education. A research-related challenge in evaluating the effectiveness of preventive measures lies in distinguishing the measure’s effectiveness from changes in the child’s welfare which are due to other factors (see Fig. 3). This is probably the main reason for the scarcity of direct research evidence on the effectiveness of preventive measures.
In economic evaluation literature, additional effectiveness $E_B - E_A$ and additional costs $C_B - C_A$ are termed incremental effectiveness and costs. On the other hand, the cost calculated for an effectiveness unit is termed the incremental cost-effectiveness ratio and calculated using the formula $\text{ICER} = (C_B - C_A)/(E_B - E_A)$.

**Decision-making in the evaluation of cost-effectiveness**

When cost-effectiveness is assessed, two or several alternative measures of services are compared to each other. In child welfare, these can include, say, enhanced community care services and the child's placement in a foster family. Different measures are often used to pursue the same goal, which is usually that of securing or improving child welfare. Alternative measures all have a certain effectiveness and scant financial resources are required in order to put them into practice.

Fig. 4 depicts a situation in which a social welfare decision-maker has decided to implement two, mutually exclusive alternatives in organising a child's care. In alternative A, the decision-maker chooses enhanced community care, whose expected effectiveness is $E_A$ and costs $C_A$. Under alternative B, the decision-maker chooses to place the child in a foster family. Care in a foster family is expected to yield efficiency $E_B$ and costs $C_B$. For the sake of simplicity, let us assume that the costs and benefits of the two alternatives are known to the decision-maker.

Which of these two alternatives should the decision-maker choose? In economic evaluation literature, a similar decision-making situation is depicted as shown in Fig. 5, in which the costs and effectiveness of community care are compared to those of care in a foster family. In the figure shown above, the effectiveness and costs of community care are positioned in the middle.

If the costs and effectiveness of placing a child in a foster family are in area I, the placement costs more than community care and it is less effective than child welfare community care. In such a case, for the decision-maker community care is a better alternative than foster family care. Whereas, if the costs and effectiveness of placing the child in a foster family are located in area IV, foster family care is a better alternative than community care, since the costs of placing the child in a foster family are smaller and the effectiveness greater than in the case of child welfare community care.

Areas II and III are more challenging from the viewpoint of decision-making than areas I and IV. Let us begin by examining a situation in which the costs and effectiveness of foster family care land in area II. In this case, foster family care costs more than community care, but is also more effective. Now the decision-maker needs to evaluate how much extra he/she is willing to pay for additional effectiveness $E_B - E_A$ generated through foster family care. If the additional cost calculated for each alternative is $C_B - C_A$,
The effectiveness unit \((C_B - C_A)/(E_B - E_A)\) is lower than the decision-maker’s willingness to pay, placing the child in a foster family is a better alternative than community care. If the additional cost surpasses the decision-maker’s willingness to pay, community care would be a better alternative. (See e.g. Sintonen and Pekurinen, 2006)

If the costs and effectiveness of placing the child outside the home are located in area III, community care will yield greater effectiveness but it will also cost more than placing the child in a foster family. The same decision-making rules as in case II apply to this situation.

**What is known about preventive work?**

Can family centre work reduce the subsequent need for child welfare or other specialised services, that is to say, is it an effective form of primary prevention? No direct answer to this can be found based on research. However, the theoretical basis of family centre work can be demonstrated through research. A child’s survival through the various challenges of life, without developing serious symptoms, is a process involving multiple factors. Some of these factors arise from the child’s own profile of abilities or special difficulties, and his or her temperament. Most factors, however, are related to how the adults close to the child respond to the child’s needs and support his or her development.

Parenthood is an important variable, any lack of which in the child’s or adolescent’s current situation leads to a growing need for child welfare:
in child welfare, society assumes part of the parent’s primary responsibility for the child’s development. Nonetheless, insufficient parenting is not only connected to parents but also to the broader context in which the community provides parents with the support they need. This basic assumption of a communally-borne burden of parenthood is characteristic of the way human beings care for children. It is also indispensable in light of human maturation, which is exceptionally long and wearing on the parents’ resources.

Although children are a huge blessing, even an ordinary childhood demands an immense amount of time and mental and emotional resources from parents. In a situation in which the child faces developmental challenges or the parents are otherwise under a notable burden, the need for wider resources is obvious. The more naturally support is available, the easier it is to receive. Consequently, child health clinics and the related home-help services, home visits and family work as well as parent groups are all forms of work which can be assumed to help parents when there is a need, but not too great a need, for support. In a family centre, support services can be organised in a way which allows the maximum number of players working with families with children to offer their services and forms of support, all within the same environment. Such an organisational approach may increase the usability of services and the effectiveness of early prevention.

The greatest existing source of evidence on different forms of primary prevention relates to home visits made during pregnancy and the child’s early years. According to a longitudinal study of international significance conducted in Finland, supervised home visits by nurses during the child’s early years significantly reduced mental disorders and outwardly visible behavioural disorders in young people (Aronen and Arajärvi, 2000). Although the study did not directly evaluate child welfare measures, outwardly visible symptoms in young people were usually among the factors creating a need to take the child into care. Consequently, as home visits reduce the number of symptoms, the need to take children into care is likely to decrease among this population. In a Swedish study evaluating the economic effects of interventions, it was concluded that, purely on the basis that they reduce depression, the cost-benefit ratio of home visits is twofold compared to ordinary cost-effectiveness limits used in healthcare (one DALY, or a disability-adjusted life year, was obtained with 25,000 euros, while the acceptable cost-effectiveness limit is considered to be 50,000 euros in Sweden) (Breberg, 2007). Similarly, in the US, the Nurse-Family Partnership programme (Eckenrode et al., 2010) has been deemed an effective way of reducing social marginalisation in socially high-risk families.

These home visit studies have been conducted in child health clinics categorised as universal. The effectiveness of home visit work has also been studied amongst a group of young people, namely the group in which the number of children taken into care
has grown most in Finland. In the US, the most heavily researched intensive home visit work method is multi-systemic therapy, MST. In Finland, for example the Nopsa family work conducted by the Social Services Department of the City of Helsinki has been piloted based on the same principles. Nopsa family work intensively addressed families through home visits, in a situation in which a young person is under an immediate risk of being taken into care. In 2009, Nopsa work involved 110 young persons, of which only 19 were later placed outside the home. Earlier on, a social worker evaluated all of the young people involved as being in immediate need of entry into care, but this was the eventual fate of only 17% (Hovi and Mansikkasalo 2010). Consequently, within only two years, Nopsa work has proven an effective way of preventing young people from being taken into care.

Another form of preventive work closely associated with family centres is peer support. Peer support is usually understood to take place between people in a certain type of situation, such as the parents of small children meeting in a family centre’s family cafe. Peer group activities can also incorporate professional guidance for supportive parenthood, a form of work comparable to many effective international programmes with a proven track record of cost-effectiveness, such as the Incredible Years programme (O’Neill et al., 2010). The more systematically parent groups are used to support the parenthood of parents whose children have behavioural disorders, as in structured and evaluated programmes (Incredible Years, ICDP/Vägledande samspel, COPE, etc.), the more directly this will prevent developments which result in a need for child welfare.

Family group conferences are an example of effective secondary prevention, because they usually lead to a solution other than taking the child into care. In family group conferences, parents can aim at a solution alongside their own close family and associates, which is then approved or rejected by a social worker (Heino, 2003). This form of work requires a change in professionals’ attitudes rather than their work input, since responsibility for the actual conference lies with the family and their close acquaintances. Family group conferences have proven able to solve various, dead-end situations, such as the threat of the child’s being immediately taken into care.

Investments in the service network may also prevent children from being placed outside the home. Väisänen and Linnosmaa (2011) ask whether the number of municipal social workers affects the number of children placed outside the home. This study began from the hypothesis that if the number of social workers in a municipality is large, it is possible to monitor the welfare of children and families in an effective manner and to take measures at a sufficiently early stage to prevent children being placed outside the home. Early detection of family problems may lead to increased use of community based services and decreased the number of placements outside the home. The researchers observed the ratio of municipal social workers to the number of children within the municipality placed outside the home during the following year. According to the results, employing a social worker reduces the number of children placed outside the home in the following year. Hiring one social worker in the previous year (in 2001 and 2003) reduced the number of children placed outside the home by an average of 0.37 children in 2002 and an average of 0.38 in 2004.

Why no investment in prevention?
Many factors influence decision-makers’ commitment to preventive work. The most important of these is uncertainty about what is viable. Many measures and programmes which are said to prevent a later need for more expensive investments, but no direct evidence is available on their effectiveness. Collecting direct evidence is genuinely difficult. As in this article, it is therefore necessary to rely partly on indirect evidence. For example, this has been done in Imatra, where the total costs of specialised services in various sectors had risen steeply throughout the 2000s. There, home visits by child health clinics were supported by a new team. In just one year, a downward turn in the costs of expensive specialised services was seen at macro level (Imatra, 2011).

This highlights another problem related to investing in preventive work, namely sectoral thinking. Since sectors hold budget responsibility, preventive work ought to create savings in the sector in question. However, the situation may be such
that an investment in healthcare reduces costs in the social sector, or that supporting the group formation of school classes with education sector resources prevents costs in specialised healthcare. It is difficult to envisage a solution to this problem without multisectoral management of preventive work. It is equally difficult to resolve the issue of thinking and decision-making being closely connected to budget, council or election periods. When investments are made in child and family welfare, a wait of several years is often unavoidable before the results of the investment show. The savings in the Imatra and Helsinki Nopsa cases were seen quickly, in the following budget year, but in practice this still involves a transition period during which expenditure exceeds savings. Since future savings can be significant, surmounting this problem should be an important topic in economic research.

The key question is whether decision-makers believe that preventive work is possible and useful. Do they believe that, even in difficult situations, development of child and adolescent welfare can be supported in a way which reduces the need for cumbersome and expensive activities. This problem, too, is best overcome by means of research and providing decision-makers with research data. For example, it is important to be familiar with developments which can lead to a need for child welfare and which could be transformed into greater ability to cope at an earlier stage. This is the only way to plan sensible, universal and specialised preventive measures which are also cost-effective.
References


Bremberg, S., 2007, Hälsoekonomi för kommunala satsningar på barn och ungdom, En metod för att uppskatta nytan i förhållande till konstnaden för olika insatser, statens folkhälsoinstitut


Nilsson, I., Wadeskog, A., 2008, Det är bättre att stamma i backen an i ån, Institute of Socio-Ecological Economics


Valtionalouden tarkastusvirasto, 2007, Nuorten syrjäytymisen ehkäisy, Toimintakerrostus 146/2007, Valtionalouden tarkastusvirasto


Väisänen, A., Linnosmaa, I., 2011, Exploring the demand for child welfare services: Do social workers have a preventive role? Working paper, Center for Health and Social Economics, National Institute for Health and Welfare


Acts and provisions:

Online publications:

THL, Kasvun Kumppanit: http://kasvunkumppanit.thl.fi/fi_FI/web/kasvunkumppanit-fi

Sotkanet: http://uusi.sotkanet.fi/portal/page/portal/etusivu

Family centre entails changes in professional skills and knowledge
Knowledge advancement concerning family centres

Vibeke Bing

Knowledge advancement concerning a new practice

The composition and completeness of family centres is a new practice that was formulated in a partnership between various professional groups and thanks to interaction with parents and children. If we consider what knowledge favours a development towards a new practice, Vanderbroucke (2008) believes that the ranking of the suitability and strength of study designs within the known evidence pyramid must be turned upside down. In these cases, case studies and qualitative data are the most suitable design, whilst randomised controlled studies (RCT) are considered to be the least suitable. Despite this, evidence of the effects of family centres is still sought. However, no studies of these effects are available, nor are they appropriate for such a relatively new initiative. Controlled effect studies are intended to assess whether previously researched and proposed methods actually achieve the effect they are expected to give. In the case of family centres, knowledge which contributes to observations and clarification from an internal perspective has advantages compared with studies which can demonstrate the effects of the family centres. The best knowledge that is currently available concerning family centres is based largely on observational studies, case studies and qualitative data whose aim is to provide new knowledge through findings and explanations.

Family centres are an organizational form that is filled with learning. A working group learns about the parents’ daily life, captures each other’s knowledge and is influenced by it and changes its working method. The dynamic means that the work can be revised and the level of knowledge and the quality of the work are gradually raised. The working method used by the family centres is not static. Over the years, new research observations have been added to the work. The initiative has benefited from knowledge concerning the way in which the foundations for health are laid during pregnancy, the development of the brain and attachment, relationships and infant research. Values and political messages today are not the same as they were yesterday. The Convention on the Rights of the Child and equal treatment are requirements that leave their mark on practice. If the aim was once to prevent the failure of care, the aim today is to provide more scope for self-esteem and good relationships.

The context of the family centres

As part of strategic public health work, family centres are expected to contribute to the reduction of differences in health. In all the Nordic
countries, both child poverty and relative poverty have increased in recent decades. The gap between rich and poor has increased. With differences in income come differences in health, and a recurring question is whether the family centres, with their expanded resources, reach out to the socio-economically vulnerable or whether they are only visited by the well-heeled.

A family’s general quality of life is after all the factor that has the biggest influence on the health of young children. The family centres form part of a context, and their importance must be interpreted with regard to the way in which children and families live their lives (Bing, 2003). Nordic children tend to live their lives between home and school. From a fairly young age, they spend a lot of their time at nursery and school amongst other children and professionals. Mothers and fathers are well-educated and both are in paid employment. The family members therefore spend their time each day in different arenas. Fathers, like mothers, are becoming increasingly involved in their children’s lives and have to make an effort to balance their working life and family life. The statutory parental leave has therefore become an exclusive period for parents and children, time that they own together.

The way in which the link with an open nursery at a family centre benefits the parents of young children has been evaluated in a qualitative study of six family centres (Abrahamsson et al, 2009). The study shows that it is the open nursery which makes the family centre more accessible. Parents say that when they are there, they learn about children and parenting. They expand their social contact network and get a chance to relax in a secure environment where they know that social support is in reach. The staff is important, as professionals create structure and a friendly atmosphere, so that parents feel welcome. They get support to enjoy and bond with their children. When Lindskov (2010) interprets family centres in relation to modernity, she describes the parents’ perception of the initiative. At family centres, parents receive professional advice from experts. They also say that they can share experiences with other parents and thereby learn about child-rearing and parenthood. According to the parents, the task of the staff is therefore to facilitate the meetings. Family centres are also used as play centres, where children can socialise, play and sing with adults and other children. The staff prepares and organises everything. Finally, the family centres act as a living room for socialising and social interaction. According to parents, the role of the staff is therefore to be a good host with the task of inviting guests and making sure that everyone is happy.

In other words, the professional role is changing. Staff are expected to perform a broad spectrum of roles. The professional role will vary depending on whether one is acting as an expert, hostess, play leader or circle leader. As a member of staff, you must continually switch between all these roles. The new professionalism involves consciously adapting oneself to physical and psychological distance and depth. At a universal level, easy-going contacts are established which lead to individually adapted initiatives. Interviewed parents testify that they received the right help at the right time thanks to this availability and the fact that they got to know the staff at an early stage. For the staff, the collaboration clarifies the professional roles, and knowledge is increased through the proximity to other professional groups. The everyday contact with all the ever-present young children reinforces the child perspective (Abrahamsson, 2009).

So, are all social groups reached by the family centre’s resources? The answer is yes. A study of all the parents who visited the open nurseries at 16 family centres in Västra Götaland shows this to be the case. The visitors accurately reflected the socio-economic structure of the population in the area where their family centre was located. Information from the 437 parent visitors also showed that the family centres are of particular importance for immigrants. There is therefore an argument that family centres have the potential to contribute to social inclusion and greater equality in terms of health.
References


The competence, commitment and co-operation of employees are of crucial significance for the quality of the services that are provided for children, adolescents and their families. It has long been a requirement within the healthcare sector that professionals should work together not only in order to make services more efficient, but also because children and parents with problems have many needs and different competence are required in order to help them. It is therefore vital that the various professionals are able to work together with regard to solutions, so that those in need of help receive the best possible service in a timely manner and have the opportunity to participate. A number of evaluations have been carried out of the Plan for Advancing Mental Health Care (Research Council of Norway, 2010). Amongst other things, these evaluations indicated that a number of improvements have been made, such as the provision of more municipal health personnel. However, in the opinion of both users and health personnel, there is room for improvement with regard to collaboration between professions and services (Andersson and Ose, 2007; Sitter, 2008). Other studies from the health sector indicated that the lack of collaboration could have serious health consequences for patients, in addition to reduced levels of satisfaction with services (Fewster-Thuente and Velsor-Friedrich, 2008). The collaboration between professions and services is thus viewed as an important resource within mental health work by those who will receive the services, personnel within the healthcare and care services and the Norwegian authorities.

Working with other people is both rewarding and stressful. Several studies have suggested an increased risk of burn-out amongst health and pedagogical personnel (Maslach, Schaufeli and Leiter, 2001). On the other hand, such jobs also provide opportunities to help others and to have a valuable and meaningful job with opportunities to work with other colleagues. We have therefore decided to look in more detail at employees who work at Family’s Houses in Norway and the way in which they assess their work situation and the collaboration that takes place within Family’s Houses (Adolfsen and Martinussen, 2010).

**Study participants**

All the employees of the six original Family’s Houses in the pilot project were invited to participate in a questionnaire survey. A total of 71 people (91% of which were women) responded to the survey. This represents a response rate of 51%. The majority of participants were married/living with partners (90%), and a large proportion had children under the age of 18 living at home (66%).

**Results**

The questionnaire presented various statements regarding what it is like to work at a Family’s House. Responses to the questions were given using a five-point scale, ranging from “to a very little extent” through to “to a very great extent”. Table 1 presents the proportion that were in agreement with the statements to a great or very great extent.

Participants were also asked to describe what was positive or beneficial about the Family’s House organization and what was challenging. Several participants mentioned that readily accessible low-threshold services were beneficial for users and that the model
had led to increased user participation. As regards challenges and disadvantages, the use of time and the considerable number of meetings were mentioned, along with the fact that this meant less time spent with users. Other challenges were that the collaboration did not work as expected, and that the employees found that maintaining professional secrecy was challenging. A considerable number (50%) considered it to be easy to obtain assistance from other departments, and that there was mutual respect between the departments (60%). The employees were also asked what was needed in order to do a good job. Of the suggested alternatives, training/courses and guidance were mentioned as being either important or extremely important (around 73%), whilst better collaboration was considered to be either important or extremely important by 66%.

Burnout and engagement were also surveyed amongst the employ-

### Tabell 1

*Professionals’ views of working in the Family’s House*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family’s House has helped to improve the opportunities for informal collaboration between the different services.</td>
<td>85%</td>
</tr>
<tr>
<td>I am satisfied with the way the work is organised at the Family’s House.</td>
<td>83%</td>
</tr>
<tr>
<td>I have developed a more extensive professional network by working in the Family’s House.</td>
<td>83%</td>
</tr>
<tr>
<td>Family’s House has helped to improve the opportunities for informal collaboration between the various services.</td>
<td>82%</td>
</tr>
<tr>
<td>There has been a stronger focus on the mental health of children and adolescents since the establishment of the Family’s House.</td>
<td>71%</td>
</tr>
<tr>
<td>I have become aware of how other services work in my municipality through working at a Family’s House.</td>
<td>65%</td>
</tr>
<tr>
<td>The courses in which I have participated in during the establishment of the Family’s House have been useful for my job with children and adolescents.</td>
<td>64%</td>
</tr>
<tr>
<td>I feel that my service has gained added competence as a result of the establishment of the Family’s House.</td>
<td>58%</td>
</tr>
<tr>
<td>The Family’s House has led to changes in the way in which my service works in relation to children and adolescents.</td>
<td>53%</td>
</tr>
</tbody>
</table>
The employees generally scored lower than a comparative group on two of the three aspects of becoming burnout (exhaustion and cynicism) and higher on engagement (Adolfsen and Martinussen, 2010).

**Conclusion**

The majority of employees were therefore very positive about working in a Family’s House and thought that this had led to a more extensive professional network and better opportunities for both formal and informal collaboration between the services. The Family’s House model was reported as being favourable due to the ease of access for users and greater user participation. The challenges associated with the model concerned the use of the professional secrecy, and the fact that a considerable amount of time was wasted on meetings, which resulted in less time being spent with the users.

**References**


Contact information: Gørrill Varvik Vedeler (gorill.vedeler@uit.no), Monica Martinussen (monica.martinussen@uit.no), Frode Adolfsen (frode.adolfsen@uit.no) and Anette Molto Thyhraug (anette.thyhraug@uit.no), Regional Centre for Child and Youth Mental Health and Child Welfare, University of Tromsø, NO-9037 Tromsø, Norway.
Good practice dialogues as a tool for sharing expertise

Jukka Pyhäjoki and Mimosa Koskimies

Everyday skills and ways of acting are often termed tacit knowledge, a term coined by philosopher Michael Polanyi (1940). According to Polanyi we always know more than we are able to tell. The better one knows something, the less one is able to explain such knowledge. Traditionally, proficiency in a certain skill or profession – and the related knowledge – has been transferred from master to apprentice. Today, systematic sharing of skills and knowledge between one generation and an individual and another, or between communities, is rare in working life. Various pressures at work often overwhelm common opportunities for reflection and sharing. Tacit knowledge, everyday skills and good practices remain “inside” people. This either leaves no time to exploit them, or people are unable to do so. However, tacit knowledge involves huge potential for developing the working methods of a community and interaction between people.

As part of the target-oriented development of a community, utilisation and sharing of tacit knowledge is based on the desired state and needs of the community in question. Joint reflection upon and analysis of work and functioning practices take time, requires a location and space as well as special methods. Moreover, structures are required that support dialogicality and dialogical management of processes.

Communities can use good practice dialogues (Gp-dialogues) to pinpoint and share good practices and working methods that relieve worries and keep them at bay. The objective is for people to become more aware of their own and the community’s tacit knowledge, and those aspects of their practices and operating methods that work well. Together, they should also share and develop practices and the operational culture. The aim is to create new ways of developing work and well-being at work, of enhancing participation by children and parents, strengthening open co-operation and promoting a dialogical, networked operating culture. Benchmarks for reviewing one’s own activities and developing services in Gp-dialogues always include openness, inclusion and early co-operation. The goal is for these to feature in work and in everyone’s ways of acting and interacting with others.

For instance, good practice dialogues can be arranged for supervisors, work communities, between work communities and between work communities and key partners, such as children, adolescents, parents, and employees in other sectors. Reflecting on good practices, and sharing and developing them together in dialogue and dialogically, is also good practice in itself. Implementation of good practice dialogues, as part of the functioning of a community, promotes a service culture that supports inclusion and fruitful encounters.

Tacit knowledge highlighted and shared – implementation of dialogues

Good practice dialogues constitute an opportunity for the dialogical development of work or other communities. Dialogues pinpoint situations, related to everyday work, or, where children and adolescents are concerned, connected to life in general or school attendance, that involve no worry. They also identify situations that involve various degrees of worry. In addition, personal skills and those of the community are shared: what already works for me/us, what am I/are we good at, what should we enhance, in what areas do we want to develop further? In such dialogue, it is essential that while one develops one’s own work and interaction, for instance with customers, one also develops the ways in which community members work together as a community. In Gp-dialogues, people interact with others, listen to and meet community members, colleagues,
children and adolescents, and other parents. They also form a multivocal reality together, while strengthening the sense of community.

The core of the good practices dialogue process comprises two interactive dialogue forums. A first meeting identifies well-functioning and worrying situations related to the activity. The second shares good, everyday practices and ways of acting that keep worry at bay, arising from themes based on these situations. In addition, face-to-face advance planning with management and personnel is important to good practices dialogue processes. Aspirations and objectives for the dialogue process are negotiated in planning sessions. At the end of the process, agreement is reached on how the community and management intend to continue processing good practices and development themes in the future.

Zones of subjective worry (see illustration) provide support in reflecting on situations. A method developed by the National Institute for Health and Welfare, “zones of subjective worry” is a tool for developing co-operation between children, adolescents and families, and employees working with them. “Zones of subjective worry” is a figure of speech, a metaphor describing the degree of worry and working conditions. The phrase also represents an attempt to form a language facilitating discussion of comprehensive experiences. With the help of these zones, an employee can analyse the degree of worry he or she feels, the sufficiency of his or her personal scope for action, and the need for additional resources. Children, adolescents and families too can use such zones to assess their personal degree of worry and need for support. The zones are not intended as a tool enabling employees to interpret situations in a similar way. Rather, the aim is to promote the possibilities of people and various actors to develop an interest in mutual differences. Neither are the zones intended for the classification or registration of children, adolescents or families (Pyhäjoki & Koskimies 2009).

Gp-dialogues constantly function at the interfaces of private and public knowledge. How might we manage the public sharing of individuals’ tacit knowledge so that it is sufficiently detailed, but not too general? And vice versa, how can we put general knowledge into a form, and convey it in a way, which touches individuals and gains traction with them? Such bridges have been constructed through good practice dialogues, by combining and applying various cooperative learning tools, including the learning café and open space methods, and other variants. In the development process for Gp-dialogues, it has proven essential to form a functioning basic model, on whose basis leaders can tailor and modify different variations, as necessary. Tailoring and modification are both the Gp-dialogue’s strength, and the prerequisite for its functionality. A guide will be completed by the end of 2011 on the purpose and use of good practices dialogue processes, and leadership of dialogues (Koskimies & Pyhäjoki & Arnkil 2011).

So far, good practice dialogues have been arranged and developed in intensive co-operation with staff and managers of services for children, adolescents and families in the cities of Nurmijärvi and Rovaniemi. In Rovaniemi, good practice dialogues have been employed in activities such as the Napero project, which developed a family services centre.

**Figure 1**

*The zones of subjective worry*

<table>
<thead>
<tr>
<th>No worry 1</th>
<th>Minor worry 2</th>
<th>Considerable worry 3</th>
<th>Major worry 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No worries at all</td>
<td>Feelings of worry or wonder</td>
<td>The worry is considerable</td>
<td>Worry is extremely great</td>
</tr>
<tr>
<td>High confidence in own possibilities</td>
<td>Running out of own resources</td>
<td>Unable to resolve situation using own resources</td>
<td></td>
</tr>
<tr>
<td>Thoughts of need for additional resources</td>
<td>Need for additional resources and greater control</td>
<td>Immediate change in situation required</td>
<td></td>
</tr>
</tbody>
</table>

Arnkil Tom & Eriksson Esa 1998
and in developing co-operation with organisations. Within municipalities, the National Institute for Health and Welfare is training leaders of good practice dialogues as part of the development of early open co-operation.

Written feedback is collected for all rounds of good practices dialogue. Giving, receiving, joint handling and utilisation of feedback are integral to dialogicality and the creation and development of a dialogical operational culture. Several hundred instances of feedback have been collected so far. Such feedback is extremely positive and enthusiastic. Employees have an intense need and willingness to discuss and perform their work, coupled with a desire to share and develop their competence together.

According to the experiences of participants, Gp-dialogues are practical and make everyday work easier. They are regarded as a safe way of raising ideas and concerns, while being found to enhance a sense of community, motivation, well-being at work, and dialogicality. Such dialogues are also viewed as a light, fast way of bringing out tacit community knowledge and the operational culture of the community. According to supervisors themselves, they are able to make direct use of the results of Gp-dialogues in the preparation of development plans. People often have fun in good practice dialogues, even if dialogicality is no easy, comfortable option. A dialogical encounter always requires participants to pause, commit themselves, tolerate uncertainty, show confidence and proceed in a process-based manner.

**Dialogue process for practices that ease the worries of children, parents and class teachers**

The following is a description of how the good practices dialogue process was utilised in developing the school operational culture together with children, parents and teachers. Children’s worries and good practices for alleviating such worries, and the issue of how adults at home and school can combine to support and contribute to children’s growth and development, lie at the core of the process.

Seventh-grade students at Isoniittu School in Nurmijärvi considered their worries, and good practices for alleviating them, by class, led by their teachers. Work began with reflection on their worries, with the help of the zones of subjective worry. Using these zones, the children recorded the kinds of issues related to school attendance, teachers, friends, hobbies, home, family, etc. that made them happy and feel good, as well as those which caused small, considerable and/or major worries. A summary of these anxieties was prepared.

Next, in small groups the children considered good practices relevant to the situations they selected within each zone of worry. Using these zones, the children recorded the kinds of issues related to school attendance, teachers, friends, hobbies, home, family, etc. that made them happy and feel good, as well as those which caused small, considerable and/or major worries. A summary of these anxieties was prepared. Finally, situations and practices were reviewed in mutual discussions. The children were told in advance that parents and class teachers would also examine their worries and practices at a future parents’ meeting, and consider how they might best support the children in facing these concerns. After the parents’ meeting, the results, plans, feedback and messages to the children from parents and class teachers were reviewed with the children.

Later in the autumn, a parents’ meeting themed “Good practices for alleviating the worries of children” was arranged for the parents. In the invitation, parents were asked in advance to record worry-free and worrisome situations in the zones of subjective worry. The parents and class teachers began by familiarising themselves with the summary of worries and good practices created in connection with the children’s Gp-dialogue. In small groups, they then reflected on the worries identified by the children and what kind of support they might give to help the child act in such a way that could alleviate the child’s worries and make him/her feel better. Small groups of parents and class teachers considered and exchanged experiences of good “everyday” “small” acts and activities which might ease children’s fears and comfort them. Themes included friendships of children and adolescents, coping, sufficient rest and good nutrition, preparing for exams and doing homework, use of computers/the internet, spending money and family relationships. Group discussions were reviewed and debriefings conducted together. Finally, the parents presented their own impressions of teachers’ discussions, focussing on what particularly pleased and concerned them about the discussions.

As a concrete next step, it was agreed that an event would be arranged for the parents at which various methods
of providing learning support would be presented. Secondly, it was decided that a joint discussion would be arranged, on buying and consuming sweets and soft drinks during school hours. In addition, a message on the evening’s discussions was agreed, for communication to the children.

The teacher leading the Gp-dialogues with children mentioned that the students greatly appreciated separate enquiries being made about their concerns. This made it easier for them to open up about their worries. The children pointed out that while reflection on worries and good practices was enjoyable and easy, implementing such practices in one’s personal life was not always so straightforward. For instance, a number of sound exam preparation methods had been collected (begin preparing in time, go to bed early, spend only limited time during the day surfing the Web) but pupils did not always comply with these. According to the teacher, children were eager to participate in consideration of good practices, concentrated well on listening to proposals by classmates, and discussed them in earnest.

Feedback from parents and teachers indicated that gathering children’s worries and practices was considered a wonderful, useful and important exercise. The opportunity to hear their children’s ideas was rewarding, interesting and thrilling. It was considered extremely positive that children were the genuine starting point, with everyone given the chance to participate and share their worries. The parents meeting was deemed extremely useful. Exchanging ideas and experiences with other parents and class teachers was considered interesting and valuable. According to parents, fruitful discussions and getting to know other parents were the best aspects of the evening. They mentioned the exchange of everyday practices, experiences, ideas, tips, viewpoints and peer support as particularly useful. Parents found it extremely important and relieving to find out that others, too, had similar worries. They hoped that these practices would continue and that parental meetings of this kind, in which even children could participate, would form part of the school’s working culture.

**Conclusion**

The creation of new, communal knowledge requires the transformation of tacit individual knowledge into understandable shared knowledge. Personal knowledge and experience must be shared in a reciprocal process with others. The foundation for creating new collective and organisational knowledge lies in individuals, and their interaction within a group and the working community.

The first steps in creating new knowledge involve bringing out tacit knowledge, sharing competence and creating new understanding (Von Krogh 1998). It is the task of management to provide the time, place and space for learning by the community. Good practice dialogues are spaces and processes for learning that create new knowledge, skills, meanings and interpretations. These spaces support the professional growth of participants and strengthen the competence of individuals. A successful dialogue requires a context where people can speak safely about their competence, worries and development needs in a positive atmosphere. Developing such spaces, or dialogue forums, for sharing competence is essential. There, people can be and are heard, and can share everyday best practices.

**References**


A picture of future competence needs in family centres

Heidi Backman and Alexandra Nordström

What does the future hold within the field of children’s and family services? What competencies will be needed under various possible future scenarios? What would happen if we did not actively develop the provision of services and what would a social disaster mean for the services that are aimed at children and families? What consequences would the digitalisation of society have and what consequences would there be if a family centre were to be provided in every municipality?

This article is based on a project carried out by the Finnish National Board of Education during the period 2009–2011. The project working group consisted of representatives from the fields of day care, healthcare, social work and culture. The group developed four scenarios that describe the provision of children’s and family services looking 10–15 years into the future. The first scenario that was prepared was a “business as usual” scenario, where the current trends within the day care sector continue even if the outside world changes; the second scenario is a disaster scenario where the welfare and care systems are dismantled. The following text presents a description of the third scenario in particular, multi-professionalism and smorgasbord, a scenario in which the children’s and family centres are developed.

Multi-professionalism and smorgasbord – children’s and family centres are developed

In Finland, the economy is steady and the employment situation is good. This has led to an increase in immigration and the proportion of people in paid employment, as well as an increase in the demand for day care provision. Society can afford to invest in public sector care provision. The ageing population is leading to an increase in demand for care services, but the birth rate is not declining; it is instead rising in line with immigration, which is resulting in an increase in demand for various forms of services for children and families.

Local authorities have set up children’s and family centres or networks with co-located services for families, based on a lifecycle approach with the child in focus. A single centre offers day care or early childhood education, health services, schools, child welfare services and various forms of special needs support, such as speech therapy. The family centres are being developed into both attractive and flexible workplaces in terms of working hours and organisation, as well as into appropriate creative learning environments for the children. This has helped to make it fashionable (amongst both men and women) to work with children, and the status of the sector has risen. Family centres are multi-professional centres where healthcare providers, social workers, kindergarten teachers, special needs kindergarten teachers, nutrition therapists, family counselors, cultural officers and co-educators work together. This multi-professional approach has made the centres more health-promoting and preventive. Special needs are identified at an early stage and essential initiatives, such as psychiatric care and special needs education, are implemented. Health-promoting initiatives for exercise and diet are integrated into the activities. The advice service makes preventive home visits and social workers seek out clients with the aim of identifying and rectifying problems as quickly as possible.

Society is increasingly becoming service-focused and all sectors are becoming more service-oriented, although day care provision is increasingly becoming customer-oriented. People are expecting better and improved services, as well as more customised services. They want to choose the services they need from a smorgasbord of services. There are also profiled day care centres and, at least in larger municipalities, parents can choose between these different profiles for their child, such as language, art and culture, gender issues, natural science or sustainable development. There is also an increasing need for customer segmentation in order to productively and efficiently develop
different types of service, both digital services and face-to-face services. Families do not always want to visit a health centre when their child is ill; they would rather obtain information via the internet and have an opportunity to obtain advice and guidance from experts at a distance or through peer support groups. Children's and family centres are customer-oriented and they are serving increasingly heterogeneous families and family structures. Parents are offered a variety of flexible day care solutions, such as open day care, overnight and weekend care, as well as services that are charged at an hourly rate. Some families are moving to eco-towns or communes in apartment buildings and working from home or living on a citizen's wage. A large group of parents are demanding locally produced food without additives, are sceptical about vaccination and want to work from home and care for their children at home.

There is an ever-increasing need for professional groups that can guide and mentor families with regard to various issues concerning life management, such as health, well-being and exercise, sleep and dietary issues, as well as financial issues or advice concerning the choice of day care or educational services or leisure activities for children. Many of these services are provided by the private sector. This could involve services that combine child day care and household services, such as cooking or gardening, or healthcare services which can be provided in the home.

The multi-faceted knowledge of the personnel

The importance of pedagogic knowledge is a key feature in the provision of all children's and family services, but it is of particular importance when it comes to early childhood education. However, knowledge of children with special needs, gender issues, inter-cultural issues and media and art are important supplementary competencies. Emphasis is placed on supporting the development of the child's identity and taking an individual and respectful approach to children and families. The personnel should also have knowledge of the learning process, of children in groups, of creativity and of family dynamics. The ability to communicate and cooperate is important with regard to contact with parents, officials and decision-makers within the municipality. The personnel should have the competence to counter, guide and support families and to cooperate with other professional groups as well as the parents, to create and work in networks and to establish learning environments. The effects of digitalisation in society must be taken into consideration and it is important that the personnel is able to learn how to use information and communication technology and new media in a way which supports and does not harm the development of children.

The personnel at children's and family centres are an important linguistic role model for the children, particularly for bilingual children and immigrant children. The personnel must be able to support the development of language skills in different linguistic environments. An excellent knowledge of the national languages and an awareness of the importance of language to the development and identity of the child is therefore important, as is knowledge of bilingualism or multilingualism, home language support and a knowledge of “language showers” and “language baths”. A part of the personnel has an immigrant background and need further training in the national languages. Knowledge of foreign languages, particularly English and Russian, is also necessary. Interpreters are in increasing demand within the day care, child welfare and child advice sectors. Different cultural backgrounds are taken into consideration and the personnel receive support from a cultural interpreter if and when necessary. It is becoming increasingly important to understand different cultures, including one's own culture and its subcultures, in order to be able to communicate with people with different backgrounds. The personnel need to have knowledge of multi-culturalism, intercultural competence and the ability to educate about internationalisation. Due to the increase in immigration and globalisation, the personnel must also have knowledge of what are for us exotic and previously unusual illnesses.

The personnel should have a professionalism that enables them to work in multi-professional networks. Knowledge of professional ethics, confidentiality and secrecy obligations, as well as knowledge of law, is becoming increasingly important. Professional identity and pride, as well as an ability to market one's own knowledge and the sector, is becoming important in all professions within the sector, as well
as an ability to act as a role model for others. The ever-changing nature of society and working conditions means that the personnel should be development-oriented and flexible, possess an inner enterprising spirit and have the ability to reflect and to work in projects. It is important that the personnel is able to plan and evaluate the operation, identify needs and develop new productive and efficient working methods, even in demanding situations. The role of the staff member as a tutor, coach or mentor is becoming increasingly important both in relation to children and families and in relation to colleagues.

Leadership is a skill which, although highlighted in this scenario, is not a distinct part of current training. Knowledge of leadership as regards multi-professional work and work in change is needed, as is a positive attitude towards life-long leadership and visionary leadership. Factors that contribute to the popularity of the sector in the scenario are initiatives aimed at the well-being of the personnel, e.g. the development of a work community and the collaboration that takes place, the tutoring of personnel, support for occupational well-being and mental health at the workplace, as well as methods for stress management. Business knowledge and financial know-how, as well as other administrative skills, are becoming increasingly important as public sector finances become ever-more limited.

In order to provide sufficient competent staff for all regions and areas, there is an increasing need for social workers and healthcare workers who are mobile or who can provide services at a distance over the internet. There is a need for consulting kindergarten teachers, special needs kindergarten teachers and various types of educators and pedagogues, such as gender pedagogues who can act as a mobile resource and as a consultant. In the future, some of these services will be provided at a distance, e.g. through information technology. The need for IT support is increasing in line with the broader utilisation of information and communication technology within operations. The general areas of competence are as follows:

**Communication and customer orientation:** to be able to counter and support different types of families, to work with colleagues and parents in an educational co-operation, as well as the ability to communicate digitally.

**Problem-solving and the ability to be innovative:** to be able to develop one’s skills and working methods in different situations according to the changing demands of society and customers.

**Cultural aspects and language:** to take into consideration in one’s work a child’s monolingualism, bilingualism or multilingualism, as well as families with different cultural backgrounds, including subcultures.

**Education:** to possess fundamental pedagogical skills, including skills within, for example, special needs teaching, gender issues, intercultural issues and media and art.

**Professional role and work culture:** to be able to handle administrative issues, particularly issues concerning leadership or teamwork, and to be able to lead, guide, cooperate, develop, change, evaluate and contribute to occupational well-being in the workplace.

This article is based on the results of the Finnish National Board of Education’s ESF-financed VOSE project, a project which is aimed at developing a national model for the forecasting of future competence needs within all sectors. The results will support the development of vocational education and training, polytechnic and university education, including adult education and training in both the short and the long term. A pilot group within the provision of day care and other children’s and family services has been working on the forecasting model in Swedish since autumn 2009. The educators and pedagogues who participated in the group intend to take the results into consideration in their own work with curriculums and study programmes. The VOSE project will conclude its work on the forecasting model in spring 2012.

**References**

Future challenges
Developing family centres in the Nordic countries

Marjatta Kekkonen, Mia Montonen and Riitta Viitala

Nordic collaboration is essential in order to develop family centres. In this publication, we have attempted to present a complete picture of the development of family centres in the Nordic countries, describe the key themes for family centres and outline future development needs and visions of the family centres. The Nordic countries have a long tradition of collaboration with regard to children and family policy. The development of family centres and the working methods of the family centre are evidence of a good Nordic collaboration that has given rise to major benefits in the form of expertise and knowledge.

The living conditions of families and the prerequisites for parenting are in the same state of change in all the Nordic countries. The work routines, organisational approach and organisational culture of child and family services are changing. The client and family orientation is being emphasised and this is changing service structures and service provision. The preventive work needs multi-professional partnership structures not only in the client work and in the cross-border collaboration between the service sectors, but also between non-governmental organisations. In the future, Nordic collaboration will be needed within the development of the complete range of services offered by the family centres in order to establish a common Nordic thread for strategies for parental support and early prevention.

The results of the evaluations of family centre projects that have been carried out of family centre projects have generally been positive. Despite these positive results, we currently do not know enough about the effects of the family centre initiative and the cost-effectiveness of the prevention work. With regard to future developments, evaluation and research should be intensified with regard to the effectiveness of family centres. We need both cross-sectional information and long-term monitoring when it comes to family centre initiatives within the municipal service system and the economic and human consequences of the effectiveness of mother and child advice, family preparations, open day care provision and the preventive family and social work within the family centre services. In this context, it is vital to formulate and realise common Nordic family centre research.

In the Nordic countries, family centres have generated a lot of very practical knowledge, a wealth of good practice and tacit knowledge over the years, which governs the activities in family centres. In addition to research, there is also a need to compile this experience-based knowledge and good practice. Within the work relating to family centres, a diversified range of education programmes has been implemented diversified range
of education programmes that could be of great benefit for all the Nordic countries. The Nordic countries could also benefit from common threads in a family centre manual. The key contents of this manual should concern the competence development of professionals and other players, new family-oriented working methods, greater involvement of children and parents, and the management of the family centres.

The ultimate aim of family centres is to promote a good childhood through reinforcing parenting skills. The way in which family centres should be developed and the effectiveness of the family centre services should be analysed with greater clarity and evaluated in relation to the views of parents and children, the goals established by the staff and the service structures and activities that have been implemented. The views, responses, experiences and suggestions for improvements of parents and children are of pivotal importance in the development of the family centres. It is therefore important to compile information concerning the experiences and values of mums, dads and children as regards family centres in the Nordic countries.

Finland hosted the Nordic family centre conference in 2010, five years after the first conference, which was held in Sweden. The first Nordic family centre conference was held in Sweden five years previously. These conferences showed that there is a lot of Nordic know-how surrounding the theme of family centres and the issue of health promotion and early prevention. The large number of delegates at the conferences also reflects the level of interest in and the desire to exchange information and become involved in health-promoting and preventive collaboration.

We hope that these joint Nordic conferences, which have already become something of a tradition, will continue to be held at regular intervals in our respective countries in turn. Family centre stakeholders need a forum where they can meet their colleagues and others interested in developing the family centres in their home country and across the Nordic region. We hope that this publication will initiate a dialogue and an exchange concerning family centres at both Nordic and international level.
The Authors

FINLAND

Maria Kaisa Aula
Licenciate of Political Sciences
Ombudsman for Children
Office of the Ombudsman for Children
Finland
mariakaisa.aula@stm.fi
+358-50-530 9697
The Ombudsman for Children promotes the realisation of children's rights in Finland. The Ombudsman acts as a sounding board for the voice of children and a bridge builder for child policy. The Ombudsman raises the awareness of decision-makers and influences social policy by speaking out on behalf of children. The intention is also to promote the development of services that support the welfare of children, young people and families.

Heidi Backman
Master of Politics
Director of Education
Finnish National Board of Education
Finland
heidi.backman@oph.fi
Throughout the period 2009-2011, Heidi has been involved in developing a national model for how to create future skills in different vocations and industries. She has tested the model within the daycare industry, as well as other child and family activities.

Nina Halme
Doctor of Health Sciences
Senior Researcher
Child, Adolescent and Family Services
National Institute for Heath and Welfare
Finland
nina.halme@thl.fi

Mirjam Kalland
Doctorate in Education
Adjunct Professor in Social Work and Family Research at University of Helsinki, Adjunct Professor in Music Education at the Sibelius Academy
Secretary General
Mannerheim League for Child Welfare
Finland
Mirjam's main research interest has been risk and protective factors for children's development and is currently working actively on developing support for parenthood within maternal and children's advisory activities within primary healthcare in Finland. The Mannerheim League for Child Welfare introduced the family welfare centre activities in Finland and currently has over 400 open meeting places for parents.

Milla Kalliomaa
Director, Organisational and Volunteer Work
Mannerheim League for Child Welfare
Finland
milla.kalliomaa@mll.fi
Milla has been involved in developing and expanding MLL’s family centre activities in Finland.

Marjatta Kekkonen
Master of Politics, PhD, Group Supervisor
Senior Planning Officer
Child, Adolescent and Family Services
National Institute for Heath and Welfare
Finland
marjatta.kekkonen@thl.fi
Marjatta worked on the PERHE project between 2005 and 2007. She has worked as an instructor for the in-service training model of educational partnership for the ECEC and family service personnel. She worked as an instructor for the in-service training model of educational partnerships for the ECEC and family service personnel. She participated in the organisation of the Nordic family centre conference in Finland 2010, as well as being involved in the development of the family centres within the national KASTE programme from 2008 to 2011.

Marju Keltanen
Master of Education
Research Assistant
The Association of Finnish Local and Regional Authorities,
maju.keltanen@kommunforbundet.fi

Mimosa Koskimies
Master of Social Sciences
Special Planning Officer
National Institute for Heath and Welfare
mimosa.koskimies@thl.fi

Ismo Linnosmaa
PhD
Research professor
Centre for Health and Social Economics
National Institute for Health and Welfare
Finland
ismo.linnosmaa@thl.fi
Ismo is responsible for the cost-effectiveness analysis of child welfare services.

Mia Montonen
Nurse, Master of Politics
Development Manager
AB Det Finlandsvenska Kompetenscentret inom det sociala området – FSKC (The centre of excellence of social welfare)
Finland
mia.montonen@fskc.fi
Mia has worked on developing the Swedish family centre in Helsinki. She has worked in different positions of trust in the Swedish speaking Finnish association Familjeparasollet as well as being involved in the founding of the Finnish Suomen perhekeskusyhdistys. In addition to that, she was one of the people in charge of arranging the Nordic family centre conference that took place in Finland 2010.
Jukka Mäkelä
MD, Child Psychiatrist, Trainer-level Child Psychotherapist and Theraplay-therapist, Development Manager for Promotive and Preventive Child Mental Health Services National Institute for Health and Welfare Finland
jukka.makela@thl.fi
Jukka has a long experience in preventative work in the grey area between child protection and child mental health.

Alexandra Nordström
Bachelor of Social Sciences Planning Specialist
Finnish National Board of Education Finland
alexandra.nordstrom@oph.fi
Alexandra wrote her bachelor’s thesis on childhood research and on the questions that are linked to daycare in Finland. She has worked with the Finnish National Board of Education’s project on forecasting future skills needs within daycare and other child and family activities.

Aila Puustinen-Korhonen
Master of Social Sciences Senior Adviser
The Association of Finnish Local and Regional Authorities
aila.puustinen-korhonen@kuntaliitto.fi
www.kommunerna.net

Jukka Pyhäjoki
Family Therapist, Educational Science, Vocational Education, 333 ECTS credits Senior planning officer
National Institute for Health and Welfare (THL) Finland
jukka.pyhajoki@thl.fi

Sirkka Rousu
Doctor of Administrative Science, Social Worker Principal Lecturer, Helsinki Metropolia University of Applied Sciences, www.metropolia.fi
Project manager (on leave), The Association of Finnish Local and Regional Authorities, www.localFinland.fi Finland
sirkka.rousu@metropolia.fi
Since the beginning of 2000, Sirkka has been involved in developing the family centre activities in the Harava project of The Association of Finnish Local and Regional Authorities. During the period 2004–2007, Sirkka participated in the PERHE project, which is a family service programme within the national development programme for the social area. She has also been responsible for a research project that the Association of Finnish Local and Regional Authorities carried out between 2010 and 2011 together with its co-operation partners. The project investigates services and co-operation that apply to children, young people and families as well as how the statutory municipal welfare plans have been met and how the Finnish Child Welfare Act is observed.

Eero Siljander
Licenciate Political Science (Economics) Senior Researcher
National Institute for Health and Social Economics (CHESS), National Institute for Health and Welfare, Finland
eero.siljander@thl.fi

Antti Väisänen
Master of Political Science (economics) Researcher Centre for Health and Social Economics (CHESS), National Institute for Health and Welfare, Finland
antti.vaisanen@thl.fi
Antti is a researcher and is currently investigating cost efficiency in social services.

Riitta Viitala
Psychologist Development Manager
Ministry of Social Affairs and Health Finland
riitta.viitala@stm.fi
Riitta has been involved in the development of the family centres in Finland from the very beginning. First in the control group as a representative of the Ministry of Social Affairs and Health for Espoo’s family centre project 2003-2005, then as a project manager within the National PERHE project 2005–2007. She subsequently developed the family centres within the national KASTE programme 2008-2011.
NORWAY

Anette Moltu Thyrhaug
Public Health Nurse. Qualifying as a Master of Public Health
Adviser
University of Tromsø
Norway
RKBU Nord (RBUP North), Faculty of Health Sciences, University of Tromsø, Norway E-mail: anette.thyrhaug@uit.no
Anette has been a member of the project group for the Family's House at RKUP North since 2007.

Gørrill Warvik Vedeler
Master of Education, PhD candidate
Adviser
University of Tromsø
Norway
RKBU Nord (RBUP North), Faculty of Health Sciences, University of Tromsø, Norway E-mail: gorill.vedeler@uit.no
Gørrill is currently project manager for the Family's House project at RKUP North. She is developing a doctoral study on early parent support anchored in open daycare in the Family's House. Member of the project group for The Family's House at RKBU North.

Monica Martinussen
Master of Psychol. (1989) and Ph.D. (1997)
Professor
University of Tromsø
Norway
Regional Centre for Child and Youth Mental Health and Child Welfare, University of Tromsø, Norway E-mail: monica.martinussen@uit.no
Monica is leader of the research group for preventive and health promoting interventions at the centre. The research group is responsible for supporting Norwegian municipalities in establishing the Family's House commissioned by the Norwegian Directorate of Health. This includes information activities and teaching as well as research linked to the Family's House in Norway.

Frode Adolfsen
Master of Education, Research Fellow Adviser
University of Tromsø
Norway
RKBU Nord (RBUP North), Faculty of Health Sciences, University of Tromsø, Norway E-mail: frode.adolfsen@uit.no
Frode has carried out questionnaires among employees in six Norwegian family centres (Adolfsen & Martinussen, 2010). Member of the project group for the Family's House at RKBU North.

SWEDEN

Johanna Ahnquist
BSc, MPH and PhD
Public Health Planning Officer
Swedish National Institute of Public Health.
Sweden
johanna.ahnquist@fhi.se, tel. +4670199691
Johanna works at the Swedish National Institute of Public Health, gathering and disseminating information on methods and strategies for promoting children and young people's health. The family centre constitutes an important promotional and preventative arena in this context.

Vibeke Bing
Social Worker and Nursery Teacher
Public Health Education via the Nordic School of Public Health (NHV) as well as journalism training.
Development and quality coordinator in Backa Läkarhusgruppen.
Vibeke@vibekebing.se; vibeke.bing@backalakarhusgruppen.se
Phone +46766451147
As an administrative Officer at the National Institute of Public Health Vibeke established a national network of family centres in Sweden and took the initiative to create the Association of Family Centres and was its chairman for many years. She was appointed as a consultant by different municipal authorities and municipalities to help start family centres and in 2004 received the Allmänna Barnhuset's Stora Prize for this work. She has also contributed to several books about Child Public Health and reports and evaluations of the family centres. She completed a course in 2010 at Kristianstad University entitledy “Working at a family centre”. In recent years, Vibeke has been engaged in a European context regarding children's health “parenting support” and child poverty.

Thomas Johansson
Community Public Health Coordinator
Academic education: sociology, psychology, psychology of religion and astronomy.
Municipality of Leksand
Sweden
thomas.johansson@leksand.se
+46 247 801 37
Thomas was involved in initiating and developing the Leksand model from 1996.
One of the cornerstones of the model is early and continuous parental support through different ages. Another is inter-disciplinary co-operation and co-operation between professional and voluntary players. The model has received great acclaim in Sweden, Finland, Russia and recently in Denmark.
School recreational leader/education as well as sociology, psychology, psychology of religion and astronomy.
ICELAND

Sigrún Jóulisdóttir
Social worker, Family therapist, Social Worker, Authorised Psychotherapist, PhD
Professor of Social Work; Family Therapist
Faculty of Social Work. University of Iceland.
Private clinic (part-time)
Iceland
sigjul@hi.is
Sigrún initiated one of the first family therapy centres in Iceland in the early 1980s and started the Center for Children and Family Research, University of Iceland, 2006. She is involved in family politics and social debate surrounding family issues, contributing to the family therapy field through therapeutic educational and training activity and conducts family research.

Elísabet Karlsdóttir
MA, Diploma in Services to the Elderly
Social Worker, Project Manager
Centre for Children and Family Research, Faculty for Social Work, University of Iceland.
Iceland
elisabk@hi.is
Elísabet has worked as a social worker providing social support and advice to families, children and young adults in Reykjavik municipality in relation to social problems in the family such as drugs, financial problems, care and more. She has worked as a lecturer in the social worker programme at the University of Iceland. Her job as leader of the research centre includes family research, particularly in relation to violence against women, co-operation and presentation of research in different contexts.

DENMARK

Anna Jin Rolfgaard
Bachelor of Administrative Sciences
Head of Section
Danish Ministry of Social Affairs
Denmark
+4541851101
anr@sm.dk
Anna’s area of responsibility is young and vulnerable people.

Henriette Weberg
Health Visitor
Leading Health Visitor
Center for Børn & Familie, Greve Municipality
Denmark
hwe@greve.dk
Greve Municipality was the first municipality in Denmark to follow a method in which first-time parents received an offer that was strongly inspired by the Leksand model. Henriette was involved in testing the method and acted as facilitator for the first group of parents. She subsequently devised a timetable for the method, which can be used by other municipalities in Denmark.
Steering group and editorial team

Chair
Riitta Viitala, Development Manager, Ministry of Social Affairs and Health

Project Manager
Marjatta Kekkonen, Senior Planning Officer, National Institute for Health and Welfare

Members
Milla Kalliomaa, Director, Mannerheim League for Child Welfare
Mia Montonen, Development Manager, The Centre of excellence of Social Welfare – FSKC
Sirkka Rousu, Project Manager, as from 21.2.2011
Aila Puustinen-Korhonen, Senior Adviser, the Association of Finnish Local and Regional Authorities
Elina Suontama (previously Siltala), Communications Officer, National Institute for Health and Welfare
Torbjörn Stoor, Managing Director, the Centre of Excellence in Social Welfare – FSKC
George Henrik Wrede, Programme Director, Department for Cultural, Sports and Youth Policy, Ministry of Education and Culture

Editorial team
Marjatta Kekkonen, Senior Officer, National Institute for Health and Welfare
Mia Montonen, Development Manager, the Centre of Excellence in Social Welfare – FSKC
Riitta Viitala, Development Manager, Ministry of Social Affairs and Health
Elina Suontama (previously Siltala), Communications Officer, National Institute for Health and Welfare
Family centre in the Nordic countries
– a meeting point for children and families