Chapter 2
Professional Context, Research Site and Partnership

The Importance of Services for Children and Families

This chapter describes the professional practices under examination throughout the book, and the site at which my empirical work took place. The role that services for children and families play in addressing major social problems linked to disadvantage and inequality is explained. Relevant features of contemporary public policy in Australia are presented to illustrate local inflections of international agendas around services for children and families, rehearsing the idea of partnership, which is taken up in more detailed at the end of this chapter. I then focus directly on the Unit itself, describing the professionals who work there, and the families they support. Evidence demonstrating the difference a stay on the Unit can make to families is then outlined. The description of the Unit as the site of research continues with discussions of its spatial and temporal characteristics. The next section introduces the idea of partnership within the context of global (health) service reform, and provides details of the Family Partnership Model (FPM), the approach adopted by Karitane and many other services globally. The chapter concludes by linking partnership to questions of pedagogy and professional learning in practice.

This book is based on an ethnographic study of the Residential Unit run by Karitane in Carramar, Sydney. Every week, up to ten families become resident on the Unit, receiving support from a multi-professional team with issues relating to parenting of children under the age of four. Issues relating to children's sleep, settling, feeding and behaviour patterns are important, because they are woven into the broader fabric of family wellbeing, child development, and social participation. Supporting families with young children is key to addressing problems of social disadvantage and inequality: acting early to help give all children the best possible start in life, while acknowledging that many parents face significant challenges in doing so. Understanding this context is crucial as it frames the broader

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purposes or ends around which the professional practices documented in this book are oriented—a central feature of a Schatzkian (2002a, b, 2003) approach to understanding practices (see Chap. 2).

Many child and family services, including the Residential Unit, offer support with what might seem like mundane, even trivial, issues. These include how much children sleep, how they go to sleep (settle), when and where they sleep, how, how much, what, and when they eat, toddler tantrums and how they play and interact with siblings and other children. These form the 'bread and butter' focus of professional practices on the Unit and in many services for children and families. Others focus specifically on more complex issues, including speech and language development, coping with chronic illness and disability. Whatever the particular focus, such services are at the front line of state-led interventions to provide support to families who need extra assistance.

Socioeconomic disadvantage—people's access to material and social resources and their ability to participate in society (ABS 2013)—is strongly linked to children falling behind early on, which has long-term negative impacts (DEEWR 2009; Maggi et al. 2010). There is conclusive international evidence that the first five years are pivotal in children's learning and development (Kilburn and Karoly 2008). In Australia, the Productivity Commission (2011) therefore advocated a focus on disadvantaged children and families who would benefit most, and delivering cost savings to the nation. The priority is to minimise the gap in outcomes for children affected by disadvantage.

All Australian States and Territories and the Commonwealth are therefore committed to ongoing funding for family support services (Productivity Commission 2011). These services take a range of forms and include universal approaches that engage with all families, regardless of their status. Others are targeted to families affected by poverty, social isolation, low literacy, drug and alcohol abuse, or mental illness. In such cases, children's and parents' wellbeing is often deemed to be at risk, and intervention is offered with the aim of strengthening protective factors, and breaking cycles in which disadvantage is passed on to new generations. Focusing on parenting in early years offers significant benefits because this is where economic returns are highest (Heckman 2006, 2012; Conti and Heckman 2012; GLA 2011). Cost-benefit analyses show early childhood parent education programs can more than pay for themselves by reducing future costs associated with poor developmental outcomes: for every $1 invested in early years, between $2 and $17 can be saved later on (Kilburn and Karoly 2008). The economic case for early intervention is incredibly strong.

Many services capitalise on the huge influence parents can have on child development and wellbeing (Heckman 2012), aiming to build families' resilience and social connectedness. Examples include home visiting, toddler clinics, residential services, telephone advice lines and peer support programs. Day care, preschools, kindergartens, playgrounds and crèches are, of course, also important, but are not a focus here. In the latter, professionals work directly with children, while the focus in this chapter is on services where professionals support parents.

Parenting is known to have a significant influence on children's physical, social, emotional, linguistic and cognitive development (Bronfenbrenner 1979, 1986, 2005; Reeves and Howard 2013). Furthermore, it is known that providing support for families can mitigate vulnerabilities and strengthen protective factors, including secure parent-child attachment (Harnett and Dawe 2008). This is important given that large numbers of children face circumstances of disadvantage that threaten their physical and mental health, educational performance, and subsequent economic and social opportunity (CDC 2007; Maggi et al. 2010). Disruptions in secure attachment between young children and parents, ineffective parenting and relationship breakdowns can not only have immediate negative effects on health and wellbeing, but can effect future development and perpetuate social inequality and disadvantage. If unaddressed such effects can be perpetuated across generations (Stanley et al. 2005).

However, the effects of social disadvantage can be reduced and social mobility boosted through educational support to ensure effective caregiving by parents and help families to meet their goals (Ermisch 2008; Kelly et al. 2011). The Millennium Cohort Study found that family routines, psychosocial environmental factors, and learning in the home are all potentially important in close gaps in income and other measures of social disparity (Kelly et al. 2011). The importance of parenting practices was central to the *Harlem Children's Zone* project, in which support for parents was folded into a multi-stranded approach that also addressed schooling and neighbourhoods (see Tough 2009). Its 'Baby College' was created in light of Geoffrey Canada's conclusion that if one wants to change the lives of Harlem's poor children, then starting at kindergarten was too late" (Tough 2009, p. 58). Parents are not to blame for these larger social problems, but parenting is without doubt an important lever for change in promoting social mobility and mitigating the long-term effects of disadvantage experienced in the early years (Paterson 2011).

The evidence in favour of helping vulnerable children by supporting parents and developing strengths in families is incredibly strong (Heckman 2012; Johnson and Kossykh 2008; Kilburn and Karoly 2008; Shonkoff and Phillips 2000). An 'ecological approach' seeks to strengthen the whole family system, fosters social connections, and is sensitive to particular issues each family faces (Bronfenbrenner 2005). This is taken up in this book with respect to the idea of partnership, specifically the FPM (see below). The physical and mental well-being of all family members significantly affects outcomes on a range of measures, highlighting the importance of addressing parents' experiences of anxiety, depression and other mental illness (see CSSP 2003). The next section shows how arguments and evidence relating to the need for and value of early intervention in general, and partnership-based approaches in particular, are now reflected in relevant Australian policy.

Relevant Features of Australian Policy

One of the fundamental values underlying state support for parents concerns the desire among governments to ensure their youngest citizens have the best possible start to life. I will now outline how this is articulated in policy in contemporary New South Wales (NSW), the Australian State in which Karitane is based. Details provided here will provide further explanation of the links between parenting challenges and the wider social issues discussed above. Nationwide, the Melbourne Declaration on Educational Goals for Young Australians (2008) aims to promote equity and excellence by reducing the influence that socioeconomic disadvantage has on educational outcomes. Policy in this area is closely tied to protecting children's safety and wellbeing as a fundamental priority. In Australia is this is currently articulated at a national level in the Council of Australian Governments' (2009) *Protecting Children is Everyone's Business* framework. More recently, the Australian Research Alliance for Children and Youth (ARACY) facilitated the development of the National Action Plan for Child and Youth Health and Wellbeing, or *The Nest* (ARACY 2013). This was a response to statistics placing Australia in the middle third of OECD countries on half of a range of indicators relating to child safety, development, health and wellbeing, and the bottom third for a quarter of those indicators. Parenting behaviours are identified as a key focus, particularly with respect to parents' role in ensuring children are loved and safe.

Keep Them Safe (KTS) was the NSW Governments five-year (2009–2014) plan, introduced in response to the Special Commission of Inquiry into Child Protection Services in NSW. It was active during the period of study undertaken for this book. KTS aimed to ensure that 'all children in NSW are health, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential' (NSW Government 2009, statement by Linda Burney, Minister for Community Services). Specifically it pursued a number of outcomes for children and young people, as listed in Table 2.1 (see Cassells et al. 2014 for the report evaluating this initiative).

Outcome 4 in Table 2.1, referring to physical, emotional and social needs, points to the importance of basic but not necessarily simple issues relating to

Table 2.1 Intended outcomes of keep them safe

No	Descriptor
1	Children have a safe and healthy start to life
2	Children develop well and are ready for school
3	Children and young people meet developmental and educational milestones
4	Children and young people live in families where their physical, emotional and social needs are met
5	Children and young people are safe from harm and injury
6	Children, young people and their families have access to appropriate and responsive services if needed

sleep, nutrition, freedom from pain, distress and anxiety, opportunities to play, socialise, feel loved and so on. However the best possible start to life for children depends crucially on the health and wellbeing of their parents. The *Child and Family Health Nursing Professional Practice Framework* (NSW Department of Health 2011) identifies the importance of addressing parents' needs. It recognises that there are many determinants of physical and mental health that are specific to or acute in early childhood and early parenting, and that these apply to both children and parents.

'Protective' factors or conditions can mitigate the effects of challenges and disruptions in families, and can be strengthened through timely access to relevant health, education and community services (Harnett and Dawe 2008). Among these factors is the presence of a secure attachment between a child and his or her primary caregiver; this is key to an infant's social and emotional wellbeing (Bowlby 1988). A child with a secure attachment to his or her mother will regard her as a safe space and look to her when they feel distressed. If a parent experiences sustained fatigue, emotional strain, and social isolation, this attachment may be at risk, and there may be direct effects on child or parental physical and mental health, including onset of perinatal mood disorders such as post-natal depression. Child and family services aim to counter this risk by building resilience, promoting parenting confidence, self-efficacy and social connectedness.

Ian Harrison (the Visiting Perinatal Psychiatrist at Karitane), quotes Donald Winnicott's (1964) well-known aphorism, 'There is no such thing as a baby'. What was meant by this was that descriptions of a baby are nearly always actually descriptions of a baby and someone: infants are essentially part of a relationship (Harrison 2007). This captures the focus of child and family services such as the Residential Unit at Karitane on relationships between children and parents. This relationship is the primary context for development in the early weeks and months, and remains a key part of a child's social, physical and mental environment for several years.

The principle of early intervention appears recurrently in policy documents, and is a key feature of the *NSW 2021* plan covering all services for the State of NSW (NSW Government 2011). This identifies child wellbeing as a priority area, and commits to focused early intervention to prevent the worsening of problems faced by people in already tough situations, supporting some of the most vulnerable members of the community. *NSW 2021* recognises overwhelming evidence that the experiences of childhood have enduring effects throughout life (NSW Government 2011). It advocates a partnership-based approach to supporting families, which will be discussed in more detail later in this chapter.

So, the case for intervention to support parents with young children is strong. This does not imply treating parents as hopeless or helpless. Nor does it constitute unasked-for government intrusion in private family matters. Further extracts from the letter sent to Karitane by Fiona, mother of Fabi (see Chap. 1; reproduced in full later in this Chapter), show how she had tried many different approaches and sought out multiple forms of support before her stay on the Unit"

> Asking for advice almost perpetuated the problems and my negative feelings. I Googled about getting your baby to sleep, read books, talked to family and friends and basically received a load of confusing and conflicting messages. I, like I'm sure many mothers, had lost so much confidence from my lack of sleep. I felt like I was failing every step of the way… (extract from a letter received by Karitane, August 2011).

There is much that can be done to minimise this risks and give the healthy, happy and safe start to life that young people deserve, and that society owes it youngest members. *Keep Them Safe* states:

> Every child is part of our community and all children should be cherished and valued. Their care and protection goes to the heart of our society's wellbeing. Parents and families are their best carers and protectors The community and government support them in this role and there is no more pressing priority. (NSW Government 2009, p. 1)

This book explores the practices and learning in practice that unfold as professionals go about their everyday work in one service for parents with young children. It is to the specifics of this setting that I now turn.

The Residential Unit of Karitane

Karitane is one of several organisations in New South Wales, Australia, that provides a range of services for parents with young children. It runs two Residential Units; this book focuses on the one in Carramar, established in 1996, which deals with more complex cases and families with children up to four years of age. Up to ten families from across the state become residents each week, arriving on Monday and departing on Friday. I will introduce the professional staff, and then give a sense of the families whom the Unit supports. After presenting evidence demonstrating the impact a stay on the Unit can have, I outline its more basic spatial and temporal structures. This is offered by way of giving relevant context about the site of the ethnographic study upon which this book is based. Consistent with the practice-based thread that runs throughout this book, I use the term 'site' both in a standard methodological or ethnographic sense of where fieldwork was conducted, and in the Schatzkian (2002a, b, 2003) sense, taken up by Nicolini (2011) of site as a particular instances of practices bundled with material arrangements. As a site of this kind, the Unit can be understood as a *clearing*, a space where particular phenomena can be shown up, and made sense of (see Nicolini 2011). The phenomena of interest here are the broad questions and key framing themes outlined in Chap. 1, relating to professional practices and learning, underpinned by contemporary sociomaterial theorisations.

All information about the Unit's staff, layout and routines is correct as of the time of fieldwork in 2011. Several changes in the workforce composition, architecture and scheduling have occurred in the interim. The present tense is used in describing the Unit for stylistic purposes, but refers specifically to the period of study. I begin my detailed description of the Unit by considering the professionals

whose work forms the focus of this book, and continue with a focus on the families who attend each week.

Professionals and Clients

The Unit is staffed by a combination of health and childcare professionals, and hotel services, administrative, maintenance and security personnel. During the period of study the team comprised thirteen Registered Nurses (RNs), seven Enrolled Nurses (ENs) (three with parentcraft qualifications, one with a mothercraft qualification), two Mothercraft nurses, one Nurse Unit Manager (NUM), one Clinical Nurse Specialist (CNS), two playroom coordinators qualified in childcare, two social workers, one clinical psychologist (who left mid-way through the study and whose position was replaced with the second social work role), two visiting medical officers (VMOs)—a paediatrician and psychiatrist. The nursing staff and playroom coordinators are dedicated solely to working on the Unit, while other health professionals share their time between the Unit and other services at Karitane, or other institutions. A clinical nurse consultant (CNC) located within Karitane's education services provides regular support and training for the Unit's staff, and sometimes offers relief in case of staff illness. All these team members are female, except the VMOs. They range in age from 31 to 61 years, with two thirds of the group being under 40.

Seven have been working at the Unit since its opening in 1994, with a further six having been in continuous service since 1996 or 1997. The professional workforce is notable for its stability. Seven nurses work full time, with the remainder part time, their contracted hours ranging from eight to thirty hours per week. The playroom coordinators job share, with one working Monday to Wednesday, the other covering Thursdays and Fridays.

In addition to this core team, the Unit has two dedicated administrative personnel, one of whose roles includes collating data from client satisfaction surveys, with the other responsible for typing and storing medical records. The hotel services team perform catering and room preparation (laundry etc.) duties for families. A masseuse visits the Unit twice a week, offering affordable massage for clients and staff, and a hairdresser visits once a week, for families. A Sister of Charity also visits on Friday mornings to run a self awareness group for parents. A security guard patrols a number of buildings overnight, and visits the Unit to escort staff to the cark park when they finish the afternoon shifts (around 10 pm), and to be with parents who wish to smoke (they have to do so outside the building).

Turning now to focus on clients, the Residential Unit offers support for families with children under the age of four years across the state of New South Wales. The service is free to families, although there is a small boarding charge to cover meals. The state pays for the service, but private health insurers often meet costs for clients with appropriate insurance cover. The Unit functions 51 weeks of the

year, and with approximately 10 families per week in residence, supports around 500 families each year. Karitane also has a second Residential Unit in Camden, and Tresillian, a similar organisation, offers similar services also in NSW. Residential Units are provided in other states and territories in Australia, meaning that across the country each year thousands of families with young children are supported through services like the one studied.

The Residential Unit is not a universal service delivered to all families, but a tertiary service delivered to those where specific need is identified. Families are referred to the Unit, either by a local doctor (GP) or other professional in the community. Some families will have had prior contact with Karitane through its other services but for many this will be their first and only engagement. During the period of study the time between referral and residence on the Unit varied from a few weeks to several months. This waiting period, and the number and kind of families in residence each week takes into account the number and age of children, complexity of cases, parental availability, and an assessment of urgency.

The residential services are quite well known among families, and often parents actively seek referrals from their doctors or other health workers. Many have been experiencing challenges for some time, and feel they have tried everything: a week on the Unit is often seen as a last chance lifeline. As a norm Karitane accepts all families referred to them, distributing them between the Carramar and Camden Units according to age of child and complexity of case. However, some conditions of entry are maintained, ensuring that staff and clients are safe, and that parents are in a position to take on the challenge and benefit from what is offered. Parents who are actively using illegal drugs or who have just stopped using will normally have their place held until they are free from the effects of substance abuse or its withdrawal. On one occasion during the study, a single father was referred to the Unit, but he did not have stable accommodation, and the difficult decision was taken to defer his referral until there was a suitable home environment to which the process of support could be oriented. Chapter 6 explores the close, sometimes 'haunting' connections between the spaces of the Unit and those of families' homes.

The Unit operates a well person policy that applies to staff, children and parents. Given the confined environment, viruses and infection can spread very quickly, and signs of colds, coughs, flu and other illnesses are watched for closely. If parents or children arrive with such symptoms, or develop them during the weekly cycle, they are asked to leave. Depending on when in the point of the week this happens, they may be offered a rescheduled week at a later date.

The families who come to the Unit experience parenting challenges typically relating to difficulties with settling, frequent night-waking, catnapping, breastfeeding, solid food intake, or toddler behaviour and tantrums. The 215 families in residence during my time on the Unit displayed a remarkable diversity of characteristics: living in urban, suburban, regional towns, and isolated rural homes; with nuclear and extended families, single parents; first-time mothers, older mothers with several children; families who had used IVF or double-donor processes; Australian-born as well as migrants from South East Asia, Europe, Africa, South America, the Indian Subcontinent and the Middle East (no Aboriginal or Torres

Strait Islander families were resident on the Unit in the weeks I was there). Everyday practices on the Unit are conducted in English, but translation services are provided if needed. A number of measures and indicators are used on the Unit in order to assess the client intake each week. A brief examination of these data during the period of study is useful in giving a flavour of the overall client population.

The Edinburgh Postnatal Depression Scale (EPDS)[1] is used as part of admission to screen for anxiety and depression among parents. It produces scores between 0 and 30, with higher scores signalling greater levels of depression. The mean, mode and median score for all clients during the period of study was 10, while 30 % of mothers scored 13 or higher—a key benchmark, taken to indicate that mothers are likely to be experiencing a depressive illness. Item 10 asks about thoughts of self harm, and during the period of study 21 clients (8 %) indicated having had such thoughts, with 3 % noting they occurred sometimes of quite often in the past 7 days. These figures show that anxiety and depression are common among parents who stay on the Unit. The admission process includes routine screening for domestic violence, and 11 parents (4 %) reported being victims of some kind of domestic violence, including verbal abuse. On average one week in three during the fieldwork period there was at least one parent present for whom these additional complexities and vulnerabilities are present.

Staff also use the Karitane Parent Confidence Scale (KPCS) on admission and discharge. The KPCS is a tool used to measure how confident parents feel on a range of issues, and gives an outcome score between 0 and 45 (see Črnčec et al. 2008). During the study, the mean, mode and median score on admission for all parents who completed the survey was 34, the lowest score being 4 and the highest 45. Clients' confidence as parents varies greatly on their arrival.

From one week to the next, the client intake changes considerably—in some weeks high depression scores are more prevalent, in others parents express greater degrees of confidence. The range within each week varies, too: on some weeks, the group of parents cluster around similar EPDS and KPCS scores, in other weeks there are dramatic differences between them. See Hopwood and Clerke (2012) for a detailed analysis of these weekly variations.

The issue of deciding which members of staff are assigned to each family is not a trivial one. Professionals working on the Unit have a range of backgrounds, interests, experience and qualifications. The NUM and In-Charge nurses seek to exploit this when allocating nurses to families for each shift (other health professionals and the playroom coordinators are not allocated to work with specific families).

[1]The Edinburgh Postnatal Depression Scale (EPDS) is used to assess a parent's mental health. It is used for both mothers and fathers on the Unit, including those with older children (up to 4 years of age) and who therefore lie outside the traditional 'postnatal' period. Its use with these groups is validated. The scale consists of 10 items, each with 4 possible responses, scored 0–3. The maximum score is thus 30, and the minimum is 0. All items ask respondents to check the answer that best reflects how they have felt in the past seven days. Items relate to symptoms of clinical depression including feelings of guilt, sleep disturbance, suicidal ideation, low energy, and being unable to experience pleasure in activities usually found to be enjoyable.

For example, some nurses have qualifications and particular interests in lactation, and are thus matched with families who have identified breastfeeding issues as something they wish to work on. Other nurses are more experienced in working with toddlers, and are allocated to families with older children whenever possible. However, the process of allocating staff to clients is complex and mediated by a range of other considerations.

Where possible, attempts are made to provide families with a consistent set of relationships with nurses. However nurses will not always work with the same families throughout the week. This can reflect decisions aimed at protecting staff from over-exposure to highly complex and demanding cases in a short period of time, or ensuring more junior staff also have opportunities to work with challenging families, teamed with a more experienced colleague. Varying the staff assigned to families can also expand the expertise to which families have access, and bring fresh ideas to sticky problems. Spatial considerations also play a role, too, with attempts made to allocate nurses to families in adjacent rooms, or at least rooms in the same corridor. This makes staff more visible and readily available to families, and makes listening out for cries, or parallel settling of more than one child at once, much easier. The role of multiple professionals working with any one family creates challenges in providing continuity and coherence of support. Chapter 9 explores the professional learning in practice that makes this possible, while Chap. 10 details several forms of pedagogic continuity—ideas that are stable and infused across many practices and interactions. Having introduced the professionals who work on the Unit and the families whose lives it aims to change, I will now turn to focus on this change in more detail.

The Impact of Professional Support on Family Life

This section reconnects with the first part of this chapter, which discussed the importance of services for families with young children. It presents both quantitative and qualitative evidence pointing to the kinds of outcomes that may result from a stay on the Unit. In order to monitor the progress made with families each week, comparisons are made between parents' scores on the KPCS (see Črnčec et al. 2008) at admission and discharge. Hopwood and Clerke (2012) examined these data in detail and key outcomes of their analysis will now be presented.

The mean KPCS score at admission for the period of study was 34 (see above), and by discharge this had risen to 40. The overall picture is clearly one of increased parental confidence—this is important because the primary aim of the Unit is not to produce changes in children's sleep, feeding or behaviour (although these are often accomplished), but rather to develop parents' confidence and skills. The KPCS is validated to demonstrate a clinically significant improvement in confidence when an increase of 6 points is gained (Črnčec et al. 2008). This applied to 45 % of clients during the study period, and the overall mean change of 5.7 is very

close to this. In many non-residential services, such a change might be expected to take several weeks or months, so the change achieved on the Unit in a Monday–Friday period is remarkable. It should be noted that a change of +6 is not possible for parents whose confidence at intake is above 40 (the maximum possible increase is +5). Sometimes the scores remain the same, or even go down (6 % of cases). This does not necessarily represent failure or regression: parents may not have fully acknowledged the challenges they were facing, or may learn more about the skills involved in parenting, the persistence and emotional control that will be required of them, and on the basis of a more complex understanding, appraise the task ahead of them and their confidence in relation to it differently.

Information about client satisfaction and progress on goals is also collected, and during the period of study 95 % of parents either agreed or strongly agreed that the (i) felt supported during their stay; (ii) staff helped them to work towards their goals; (iii) they feel more knowledgeable about caring for their child; and (iv) they feel more confident in caring for their child (see Hopwood and Clerke 2012 for more detail).

A sense of the difference a stay on the Unit can make to families can perhaps more powerfully and personally be gained through the many letters and thank you cards sent by parents to Karitane. These have an advantage over the quantitative data outlined above because they convey changes over a longer period of time, sometimes months after families visit the Unit. This is important, because many of the issues that staff support parents with are not resolved completely during the five-day stay. Instead, a longer journey is begun, setting families on a trajectory towards greater wellbeing through enhanced parental confidence and resilience. Two of the more extensive and detailed accounts changes in family life came from Amelia and Fiona, whose letters are reprinted in full below, beginning with that from Amelia, mother of Jayne.

> Karitane helped to change our family life significantly. I was suffering with postnatal depression brought on by sleep deprivation as my little girl was a very bad, unsettled sleeper. This impacted terribly on my relationships with Jayne, my partner and my ability to cope on a day to day basis.
>
> Upon arrival at Karitane we were welcomed and settled into our room and immediately we started by setting our goals. Obviously I wanted to get Jayne to sleep for longer periods during the day and night, but I was also keen to sort out the problems I was having with breastfeeding, and ideally return to full breastfeeding. It was clear to the staff that Jayne was suffering from potential reflux issues, so we introduced a food thickener and were then diagnosed by the paediatrician and put on medication. Having support whilst feeding helped me to regain my confidence and continue breastfeeding and to enjoy this fantastic opportunity to bond with my little girl. This support was followed up with clear, consistent, reinforced messages, something that I had struggled to get from day one. I had given every bit of advice a go, even conflicting ones! The support of staff with feeding and resettling techniques was terrific and by day two we were already showing improvements in sleep patterns, breastfeeding and a routine that just worked so easily.
>
> By the end of my week's stay at Karitane, I was ready to go home. I couldn't wait to see if the resettling techniques were going to be as effective once we got home and into the routine. I was feeling supremely confidence that I could now cope, having spoken to a very understanding and helpful counsellor who provided information and a plan for

> future support. Now two weeks post Karitane, life is great and I am really enjoying every moment with my beautiful little girl. I am confident that I know what her routine should be, when to resettle her and when not to intervene. Breastfeeding has become an enjoyable time when we bond together and is no longer a struggle. Jayne now sleeps for two hours twice a day plus an afternoon nap, and I am only getting up to feed her once during the night. I am much less sleep deprived and let's face it, a happier person to live with, so my partner says! I really can't thank all the staff at Karitane enough for their guidance, support and expert advice as well as understanding. You truly made a difference to my family's life. (letter from Amelia, received, July 2009)

Amelia's letter highlights the significant impacts that Jayne's unsettled sleeping was having on her relationships with Jayne and her partner. The outcomes include changed child sleep patterns, but most apparent is the sense of Amelia's renewed confidence and improved wellbeing for all family members. It is also important to note the role of the counsellor (one of the social workers on the Unit), and the outcomes relating to other forms of support that Amelia plans to draw on in future.

We have already met Fiona, through extracts of her letter presented in Chap. 1 and earlier on in this chapter. However, her testimony is worth reproducing in full, to capture how seemingly mundane issues of sleep and settling were having such a profound effect on her family. Her letter also indicates important features of the approach taken by professionals on the Unit, and again gives a rich, personalised sense of the seeds for positive change that can be sewn through a week in residence.

> There is just SO much that I want to say and I truly don't know where to start. The most exciting thing is that I am actually writing this to you all as my baby sleeps in his cot… in the middle of the day! I never would have imagined this would be possible! I feel like a new woman. A better mother. A happier person. My decision to go to Karitane when I did was the best thing I have done as a mother, and has truly helped me get my life back on track.
>
> Before my week at Karitane I was so incredibly down, flat, emotional, anxious, nervous, exhausted… the list goes on. I didn't know myself or how to be myself anymore. I felt like I was under a heavy grey cloud and everything around me had turned from vibrant beautiful colours to black and white. I so desperately wanted to not feel this way, but I had no strength or energy to change things.
>
> Asking for advice almost perpetuated the problems and my negative feelings. I Googled about getting your baby to sleep, read books, talked to family and friends and basically received a load of confusing and conflicting messages. Classic lines like "You've made a rod for your own back", and "Well". When I was raising kids we just got on with it!"… One minute you feel validated as if you are nurturing your baby and loving him in the best way, then the next piece of 'advice' totally unempowers you, and makes you feel that you are actually doing more harm than good… The so-called 'baby whisperers' on morning TV shows (catching sleep deprived mums at their most vulnerable and fragile time!) who proclaim your baby isn't 'normal' if he or she is waking in the night and you must at all costs let them self-sooth: "7 pm until 7 am, in their own bed, nothing less", says the unidentifiable woman on the TV with her flawless make-up and perky boobs!. Who do you listen to? What is the right answer and how can I 'fix' this so that I don't hurt my baby but at the same time I can feel normal again?

I think many mothers feel overwhelmed with the desire to be the best mothers we can because of the intensely deep, all-consuming love we have for our most precious little ones, and the social pressure to get *it* right, whatever *it* is!

I, like many mothers, had lost so much confidence from my lack of sleep. I felt like I was failing every step of the way. Failing my baby because I could not get him to sleep on his own, failing my partner because I had no time or energy for him, and failing myself because I just didn't know who I was any more.

I was personally really nervous about coming to Karitane, and put it off for some time because I imagined it was a cold and clinical hospital environment with a corridor full of stiff, old fashioned white apron-clad matrons with clip boards who would make me ignore my baby crying in a sad distressed state. This, I *knew* I just could not do! I had experienced very kind baby health nurses coming to my home instructing me on the way to get my baby into his bed, and after they shared with me their knowledge, I would politely smile and say what I thought they wanted to hear, until they left and I would hold my baby close to my breast and say to myself disbelievingly, 'How am I supposed to do that on my own in the middle of the night when I'm exhausted?!'.

I knew I needed to be in a controlled environment for a period of time where I could see that there were ways to achieve my goals of getting my baby to sleep happily in his own cot. I needed support over a period of time, through the day and the night and the following day again to actually put these techniques into practice, with someone by my side encouraging me that it was working, or if it wasn't to let it go and try again next time!

What an amazing experience it was to find that all I had to do was trust. Trust in the three most important people in this story! Me, my partner and my baby. Karitane helped me to learn to trust in both myself and my partner. To realise that we are indeed, and have been all along, really great parents!

It was not always easy. I did struggle some days, and get frustrated, but the way the staff took the journey with me at Karitane was so personal, gentle, practical and manageable. The skills you learn are easily transferable into your own home, and the ideas stay with you as you strive to keep hold of the positive new energy you have found. Most importantly, you learn to take one day at a time.

The entire experience, though daunting at first, is so well put together, you feel guided and supported yet free within your own space to mother as you choose to. Techniques are gently and personally tailored to the way that you have already been working with your baby so you feel that you values are respected, but along every step of the way you are educated and informed as to how you could improve on what you are doing or change what you have been doing, such that you set about the process of achieving your goals.

I also think that the key to the success of the Karitane experience is that it does not misrepresent itself as a 'quick fix'. You realise that if you want to make changes, you must be the change you hope to see. Karitane teaches you *how* to do it on your own. They showed us that you will always have a tough time in every day and a tough day in every week, but you need to learn to let go, try again, give yourself credit where credit is due, to see the big picture and keep a sense of humour.

Since returning home, Tom, Fabi and I have done really well. Our baby is sleeping in his cot at night (and even in the day!) and his daddy can put him to bed awake now too! Fabi may still wake up to twice a night, but we know how to deal with it now, and how to read his cues. As his mum I have so much more energy in the day to ENJOY my baby!! My baby is not textbook, but what good part of life ever is! Sometimes in life I think we just need someone to help us turn the mirror back towards us to remind us of the strength we have inside (it is a heavy mirror to turn alone when you are so tired!). (letter from Fiona, received August 2011)

Fiona's articulate account speaks volumes for itself. I wish to draw attention to a number of its features. First, Fiona creates a palpable sense of how non-trivial Tom's sleeping behaviours had become, and how they affected the whole family. She also points to problems, in her view, with many of the sources of (supposed) advice and support that are handed down from (so-called) experts, leaving mothers like her feeling inadequate, failures as parents. Fiona's mention of 'all-consuming love' and 'desire to be the best mothers we can' put in personal terms the idea, mentioned above, of giving all children the best possible start in life, and the assumption in partnership (see below) that all families have strengths. Indeed such love is a key basis for adopting an unconditional positive regard for parents, irrespective of other challenging features of their circumstances and behaviours. Finally, Fiona captures not only *what* impact the Unit can have, but *how* this is done, through respectful support that builds confidence and resilience without leaving parents feeling judged as failures. Indeed Fiona's closing comments show how her stay on the Unit helped her recognize her strengths.

Neither Amelia nor Fiona thanks Karitane for 'fixing' their children for them. Both describe changes in their own wellbeing and their skills, capacities and strengths as parents as key in their journeys of change. The Unit receives thank you cards from parents most weeks, and after being displayed on the nurses' station for a few days, these are placed in a large collection in on one of the corridor walls. I will now present quotations from a selection of these, received during the time of study, in order to further convey the impact the professional practices that are the focus of this book can have. This begins with a letter from Yana, received seven months after her stay.

> To all the very special angels that work at Karitane Residential. My daughter and I were lucky enough to stay with you in October 2010 and it really changed our lives!! For me I took so much knowledge and skills away with me and I really feel I am a more confident mother! She is her happy self and now sleeping perfectly! Thank you all so much for the wonderful job you are doing. (letter from Yana, received May 2011)

> To the wonderful staff of Karitane. Thank you for your kindness and dedication you have all shown us throughout the week. With your support you have enabled us to begin our journey to better days! It has been a life changing experience. Happy Nurses' Day! (letter from Chang, received May 2011)

> Amani and me have been home for a month already. Thank you for your work and effort. Amani can sleep in her bedroom now. And she can play quite well in the playgroup now. Last Friday was the first time we went back to the playgroup. She played with the kids while I was sitting far away talking with other mums. At that time my tears were really coming out. Every hard day and night we stayed with the helpful and warm-hearted nurses was showing on my mind. Everything changes better and better. We keep going with what we learned about sleeping, playing and settling. Thank you for giving that supported feeling. We just feel we are not alone in looking after Amani, because of all of you. (letter from Adiba, received July 2011).

The letter from Adiba shows how it took several weeks after her stay on the Unit before she felt ready to return to her local play group. This return was not only indicative of changes Adiba saw in her daughter, but also shows how the Unit can help parents (re)connect with social support in their communities. Amani's

behaviour had led Adiba to stop going to the play group, but now she is back, and benefitting from contact with other mothers. It is worth noting, too, how Adiba describes keeping going with what she learned. The idea that these changes are brought about through *learning* is central to this book. And the process of keeping going strikes at one of the key forms of pedagogic continuity that connects many practices on the Unit: Be consistent! (see Chap. 10).

So far I have described the social make-up of the Unit and shown the positive difference that a five-day stay can have for families. However, my introduction to this fascinating practice setting is not yet complete. Given the analysis that follows, it is important to familiarise readers with the spatial and temporal characteristics of the Unit and the practices within it. The following sections provide a basic foundation for theoretical engagement with questions of spatiality and temporality that follow in Part II.

The Spatial Structure of the Unit

Karitane is spread over numerous buildings across several suburbs of Sydney, including a multi-service complex in Carramar, a suburb to the west of Sydney's city centre. One of their two Residential Units is located here, along with a Toddler Clinic, Jade House (day stay for mothers experiencing perinatal mood disorders), 24-h Careline (telephone-based), research and education offices, meeting rooms, a café, and a multi-purpose room used for conferences and public gatherings such as breastfeeding or infant massage events. The complex is set back from a quiet road, and has a large car park. To one side there is a community health centre, and to the other is an ambulance station. The surrounding area is largely residential, consisting of single-storey detached buildings. A few kilometres away lies Fairfield, a suburb with a busy shopping centre, known for the ethnic diversity of its population. There is a large park further down the road past the ambulance station, with a children's play area, stream, woodland, open grass, and sports fields.

By day the area feels quiet, safe and pleasant. At night, however, the character changes considerably. The park is dark and is not deemed safe due to several attacks on pedestrians. Nearby car parks have been used for drug trading. The Unit is locked down during hours of darkness, and serviced by night security personnel. The contrast between day and night in terms of practices is one of several foci in Chap. 5.

Figure 2.1 shows the basic architectural features of the building. I will now explain salient spatial features with reference to this illustration. This provides a foundation for Chap. 6 in which the spaces of the Unit are understood as fluid, sociomaterial accomplishments resulting from dynamic forms of connectedness in action. The layout of the client rooms and nurseries has been changed since I completed by fieldwork, but Fig. 2.1 accurately conveys the arrangements that were in place at the time.

Two glass sliding doors next to the intake office (Fig. 2.1) lead to a reception area, with a reception desk on the right. On the left is the room from where

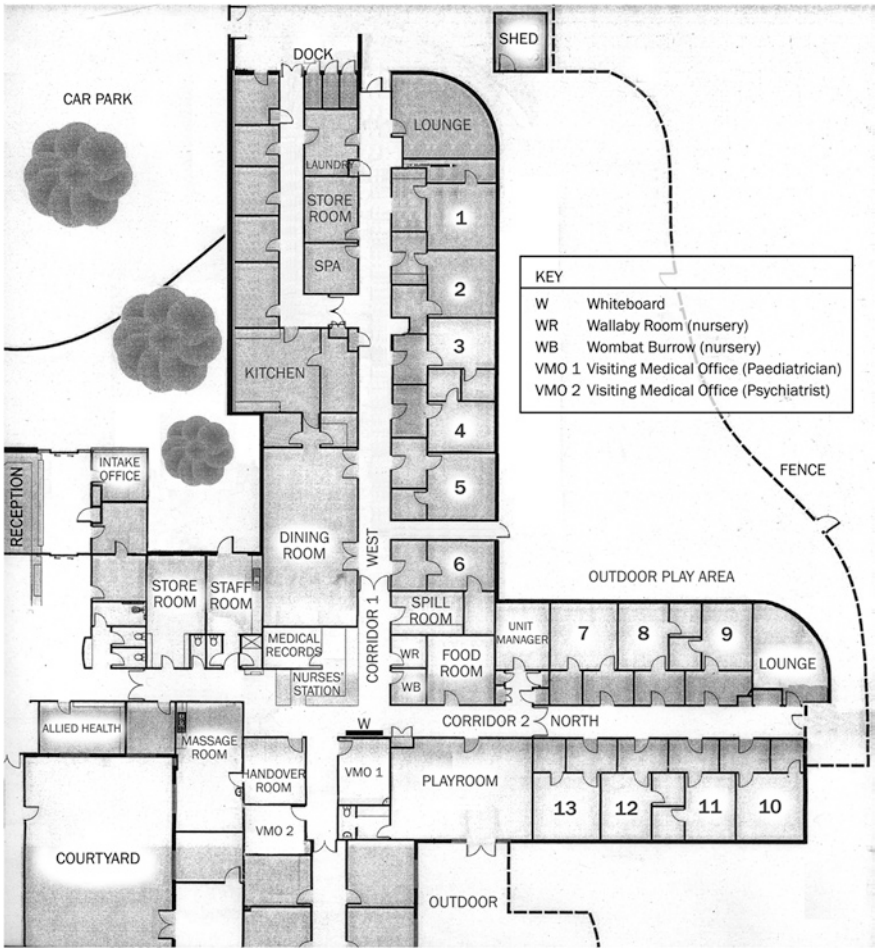

Fig. 2.1 Architectural layout of the residential unit at the time of study

nurses make initial phone calls to families who have been referred to one of the Units (intake calls). The next set of sliding doors require a security tag to open them, which all staff have. The receptionist uses a remote button to open these doors for clients. Through these doors is the main lobby area. This has a large, colourful mural depicting Jack and the Beanstalk on one wall. Other walls have Aboriginal art, a painting of a mother and child, framed awards and certificates, information boards, a cabinet displaying a range of items including baby soap and a DVD about settling infants. In one corner there is a brightly coloured plastic toy attached to the wall, with buttons to press, wheels to spin, mirrors etc. There are two sofas, ample natural light, and no music; noises of children's play or cries seep in from other parts of the building. A number of doors lead out

from this atrium, including a breastfeeding room, therapy rooms (some for the Toddler clinic, others for clients to meet social workers), toilets and baby-change facilities. To the right are the entrances to Jade House, offices, and staff areas behind the Toddler Clinic. To the left is a corridor that leads to the Residential Unit.

The Unit is constructed in a large L-shape, at the nexus of which is the nurses' station and main whiteboard. The west corridor has six client rooms along the right hand side (rooms 1–6), and a client lounge at the far end. On the left lie the client dining room, spa, a store room, and the laundry room. Running parallel is a smaller corridor only accessed by staff, housing further storage facilities and the kitchen. Along the right hand side of the north corridor are the playroom and four client rooms (10–13), on the left the food room, Unit Manager's office, three client rooms (7–9) and a second client lounge. Around the nurses' station there is a cluster of more rooms: the handover room, offices for the paediatrician and psychiatrist, a massage/hairdressing room (called Kangaroo Pouch when used as a nursery overnight), two dedicated nurseries (Wallaby Rock and Wombat Burrow), a spill room, staff room, locker and storage room (used to store cots and beds), and a medical records office. From the nurses' station at the corner of the two corridors, the sounds of children at play, or infant cries are often heard.

There are two outdoor spaces specifically contained within the perimeter of the Unit. One lies at the end of the west corridor, and has a short track for children to drive play-cars around, and a playhouse. The other is linked to the playroom, and is largely covered to provide shade. Both have fences around them to prevent children running out onto nearby roads.

Each family is allocated to at least one client suite, two if they require separate nurseries for multiple children. These suites all have a nursery, which immediately adjoins the corridor and has a baby-changing shelf, sink, and cot or bed. There is a larger room with a double bed, sofa and armchair, wardrobe, and adjacent en suite bath and toilet facilities. The plain walls and muted colours of bed linen and curtains give the sense of a comfortable but basic hotel room. Lights in the main room and nursery have dimmer controls, and there is a panel enabling parents or staff to adjust the volume of soothing music that is piped on a constant loop from a central music player. A phone by the main bed enables outside calls, but also internal calls to and from the nurses' station.

Temporal Structures of the Residential Unit

What has been presented so far is rather akin to describing a school without mentioning timetables and terms. Indeed there are cycles and routines on the Unit that resemble the ways schools are temporally organised. The outline below describes only the most basic and stable temporal structures, as a prelude to the more nuanced discussion in Chap. 5. Introducing these features here is consistent with

Schatzki's (2002a, b, 2003) notion of site, wherein temporality is seen as a crucial dimension.

The Unit functions on a five-day cycle and is closed on weekends. This was not always the case, as it used to run on a seven-day cycle. During the period of study families arrived on a Monday and departed on a Friday, though again, this was different in the past, when staggered admission meant clients came and went on different days. The present system gives a strong overall temporal structure to many practices on the Unit, based on this weekly cycle. The synchronised arrival and departure of clients as a group gives each day a particular character within a shared cycle. This does not mean that things progress for families at the same rate, or that a rigid daily routine is imposed on all practices. On the contrary, the opposite is true, but nonetheless there are traces of a diurnal progression within the stable weekly cycle. Mondays are admission days, Fridays are leaving days.

Many temporal structures of the Unit reflect staff shift patterns and staff-led practices. The nursing team covers all hours from Monday morning to Friday afternoon, organising their work into three shifts: 'morning' or 'a.m.' from early morning until after lunch; 'afternoon' or 'p.m.' from early afternoon until late evening; and 'night' which bridges the two. These overlap to allow nurses to perform handover (see Chap. 5, Fig. 5.3, and Chap. 9, Table 9.1). The number of nursing staff is highest from Monday, Tuesday and Wednesday, when families need most support. On Thursdays and Fridays there are fewer nurses, as families are encouraged to take more of a lead in care for their children (see Chap. 10 for a discussion of this in terms of temporalities of scaffolding and withdrawal). Precise numbers of staff vary, reflecting the number of families in residence each week, but there is always one nurse in an In-Charge role, and between one and four other nurses. Each shift except the first one on Monday morning begins with a nurse receiving handover from a colleague, and towards the end of each shift, nurses give handover to the next shift team.

The two playroom coordinators (whose aliases in this book are Anh and Thi[2]) share the job, one working Monday to Wednesday, the other Thursday and Friday. The paediatrician makes short visits on Mondays and Wednesdays, the psychiatrist on Wednesdays. At the time of study a psychologist and two social workers worked part time on fixed days each week, with a combination of open appointment schedules and routine group activities within these. The masseuse visits on Mondays and Thursdays, the hairdresser on Wednesdays, and the Sister of Charity on Fridays. Administrative and hotel services staff cover daytime hours from Monday to Friday, with catering staff arriving before breakfast and leaving after evening dinner.

Families bring their own routines, including bed and meal times. Indeed as we will see in Chap. 5, many families come to the Unit seeking changes in these temporal structures, and so many practices on the Unit can be understood as working on or with time. While the approach is generally responsive to families' present

[2]All names used throughout this book are aliases.

and hoped-for rhythms, clients are encouraged and on occasion required to coordinate some of their activities with temporal structures of the Unit. Meal times, for example, are limited to the periods serviced by the kitchen at breakfast, morning tea, lunch and dinner. Precise timings of events are rarely specified in advance, with the exception of appointments with allied health, medical staff, the masseuse or hairdresser, but even these are assumed to be tentative and likely to change. Group activities may or may not happen depending on demand from families, weather, staff availability etc.

Nonetheless, each day has a particular distinctive feel, and a relatively secure if not stable, sequence within it (see also the discussion of the Unit's routines as producing and following a timetable in Chap. 5, Table 5.2). Mondays are dominated by the arrival of clients. Up to ten families come to stay on the Unit each week, and normally they arrive in a staggered sequence between around nine o'clock in the morning and two in the afternoon. Two nurses conduct an admission interview with each family, which may last between 60 and 90 minutes (since the time of fieldwork this has been changed to only one nurse per admission interview). Families are given a tour of the Unit, sometimes with other families if they are available at the same time, and again these are staggered throughout the day. The paediatrician visits the Unit, meeting with as many families as possible. This is a formal requirement as the Unit is technically a hospital, and children must be admitted by a doctor. The paediatrician returns later in the day if required.

As the morning shift draws to an end, staff arrive for the afternoon shift. A welcome group is held in the dining room between three and four o'clock in the afternoon (see Chap. 5). After the welcome group, afternoon shift nurses meet with families to discuss and begin work on families' goals.

On Tuesday morning there is usually a toddler group (for parents) and a music and storytime activity for children and parents. In the afternoons a group focused on toddler play builds on the morning group, and staff hold a briefing to discuss important issues or concerns. In the evening the playroom is used to offer a relaxation session for parents.

Wednesdays have a different character again. Often signs of progress are being noted, but still there may be unsettled periods for children, and difficult times for parents. Weather permitting, staff accompany parents and children on a pram walk to the nearby park. The paediatrician returns for follow-up appointments, and stays for the lunchtime case conference. The case conference is also attended by the psychiatrist, the current In-Charge from the Unit, a representative from allied health, and a nurse who has been working on intake of new clients. During the day parents may have appointments with the psychiatrist, allied health professionals (social work, psychology) and/or the visiting hairdresser, and in the evening fathers are encouraged to attend the 'other half' group, led by a social worker.

On Thursdays nurse staffing levels are reduced, and the atmosphere changes as staff focus is on completing discharge summaries, although they continue to provide support for parents if needed. An infant massage group often takes place in the afternoon, and toddler arts and crafts activities are offered in the playroom. A 'connecting with your child' group had been led by the psychologist, but this was

not continued after she left midway through the period of study. Parents may make an appointment for a massage, and the relaxation group is repeated in the playroom in the evening.

Soon after breakfast on Fridays, families begin to leave the Unit, particularly those with a long distance to travel home. For those who remain, the Sister of Charity offers a self awareness group, and lunch is provided before the last families leave. Staff begin preparing documentation and rooms for the next week.

Mention must be made of nights, which are not times of uninterrupted slumber! Indeed many families come to the Unit precisely because night-time for them is far from restful. There are no group activities or meals to punctuate the night with routines, so night practices are much less structured than those of the daytime. Nonetheless, the work of responding to waking children and supporting parents in resettling them, is often at its most intense in this period. Practices of the overnight period are discussed further in Chap. 5.

There remains a crucial feature of practices on the Unit that must be explored at this preliminary stage in order to complete the scene-setting. I raised the issue of partnership earlier in this chapter (and in Chap. 1), and it is to this that I now turn.

Partnership—A New Relational Approach to Professional Practice

One of my key aims in this book is to explore questions of professional practice, learning, knowledge and expertise in the context of contemporary forces that are reshaping relationships between professionals and service users in a range of contexts. The Residential Unit is a rich site (in both everyday and theoretically laden terms) at which to examine the idea of partnership between professionals and, in this case, families (see Hopwood 2015, 2016; Hopwood and Clerke 2012; Hopwood et al. 2013a, b). In line with state-wide policy for New South Wales (see above) Karitane has adopted the FPM (Davis and Day 2010; Day et al. 2015) as a specific approach to its work with families. As a site of theoretically informed ethnographic study, it can thus serve as a *clearing* (Nicolini 2011; Schatzki 2003), where light can be shone on broader questions through detailed analysis of empirical material. In this section I will first outline the wider changes that locate this particular study within a contemporary global landscape of professional practice reform. I will then focus on partnership approaches within child and family health services, before presenting details of the FPM itself. I conclude the chapter with a brief explanation of how the notion of partnership gives rise to important, and as yet not fully addressed, questions about the nature of professional practices and learning: questions to which the remainder of this book is devoted, especially Part III.

There are strong drives in many professions towards what have been termed coproduction. For example, there has been significant policy rhetoric advocating citizens' participation in the design and delivery of health services (Dunston et al. 2009). This is seen as a distinct from models of service delivery in which clients

are passive consumers of services provided for or done to them. The idea of coproduction goes beyond consulting service users about their views or experiences (Bovaird 2007). The achievement of 'equal partnership' between professionals and the public has become a key focus for service development (Boyle and Harris 2009). British Prime Minister David Cameron has described circumstances in which the public are trusted to make choices that are appropriate to them, becoming 'doers, not the done-for' (see Boyle and Harris 2009).

These ideas are not particularly new, but they are certainly a key part of the contemporary moment in health and other services for children and families (Cahill 1998; Gallant et al. 2002). As the views and wishes of the public have been increasingly taken into account, dimensions of coproduction have expanded to include active engagement of people in their own care, contributions to decision making and goal setting, increased sharing of information with service users, and varying levels of consultation and participation in service redevelopment. In nursing, ideas of patient-centred (Cahill 1998) or family-centred care (Coyne 1995; Friedemann 1989; Cummings 2002) have gained considerable momentum.

Visions of increased efficiency, equality, transformation, and empowerment, are alluring and seductive. However, questions arise around whether partnership is interpreted and implemented in consistent ways in practice (Bidmead et al. 2002). Some key assumptions are beginning to be unpacked, including in Mol's (2006) stunning critique of the consumerist logic of choice in healthcare. Maconochie and McNeill (2010) discuss children's participation in a parent-baby group, indicating that there is no clear cut-off as to when these responsibilities begin. Could or should be all members of the public be expected to participate in the same way? Some people may, for good reasons, simply want or need professionals to fix problems for them. The philosophy of partnership may not be appealing to all families engaging with child and family services, particularly those who feel they have few reserves left to draw on and just want some help (Coyne 2007).

Fudge et al. (2008) discussion of the promise of user involvement critiques the vagueness of the concept, documenting approaches that range from surveying patients to delivering strong peer support. Professional control may be maintained as to what 'involvement' actually means, with the result that services are far from transformed. Coyne (2008) notes how parents in children's wards can be managed by professionals, disrupting their participation. Such difficulties have been documented by Hitzler and Messmer (2010) who studied decision making in child welfare, finding examples of professional collusion and collaboration in maintaining control—building alliances that make client disagreement difficult, because client involvement is seen as complicating matters. They question whether professionals should insist on client participation when clients are reluctant. Participation in interaction, they conclude, does not safeguard partaking in the decision. As Needham (2007) notes, professionals may experience tension between demands to care and demands to contain or control.

In such instances parents may be more realistically identified as participants in care rather than partners. Wilson (2001) highlights the actions of mothers who 'keep the peace' by avoiding questioning the professional knowledge; inequities in

the relationship remain present but silenced. It cannot be assumed that all parents want or know how to work in partnership with a professional. Wilson (2001) proposes that some parents' actions may work against a partnership approach; they may not see it as appropriate or possible. Crucially, embarking on a partnership requires that parents are able and willing to be partners and that the professional can skilfully create the conditions for an effective relationship to emerge. Keatinge et al. (2002), however, found communication to be a key barrier to establishing and maintaining partnerships between nurses and families. Partnership work requires particular skills, approaches and values that may be already widespread, but cannot be assumed.

Fenwick (2012) identifies three key problems with the way coproduction or partnership have been framed in public policy. The first reflects the sense of a universal model, articulated in general terms, without specific guidance or concrete examples. It is relatively easy to find new adjectives to describe more efficient, responsive, or equal services or practices and thus to entice people with the promise of better things to come. Actually nailing down what this means, and whether it might mean different things in different contexts, is much harder, and often remains a gap in the policy and research literatures.

A second problem identified by Fenwick (2012) concerns emphasis on equality. In what ways are professionals and service users equal? Needham (2006) points out that accountability regimes tend not to see both parties as equal—professionals remain accountable in many ways that do not apply to their clients, in law, to their professional bodies, ethical codes of practice etc. The transfer or share of power cannot be equal because responsibility and accountability are not borne in the same way. In the case of child and family health services, there is always the prospect of professionals being obliged in law (as is the case in Australia) to make referrals to child protection services if a child's wellbeing is judged to be seriously at risk. Where is equality there? I have explored these questions in detail, focusing on signatures and practices of signing on the Residential Unit, within the framework of partnership (see Hopwood 2014d).

Fenwick's (2012) third critique questions whether partnership really involves a transformation of the degree and magnitude proclaimed. Discourses of transformation are used to bolster promises of radically different outcomes. Fenwick's sociomaterial account of coproduction in policing reveals strategies and practices that enrol community members as well as material entities into actions that blur boundaries between professionals and service users. These often reflect longstanding ways of working, rather than a radical break from the past. It is also important to note that the introduction of partnership models in child and family services has often exploited values that were already present among professionals who have long conceived their role as supportive rather than directive (see Fowler et al. 2012a, b, c; Hopwood et al. 2013b; Keatinge et al. 2008).

It is within this exciting yet contested trend in contemporary professional practices, that the Residential Unit of Karitane—indeed all of Karitane's services—has embraced the FPM as a specific rubric for implementing a more collaborative and participatory model of care. I will now turn my focus to partnership models

developed in the context of services for children and families, before looking specifically at the FPM.

Partnership Models in Child and Family Services and the Family Partnership Model (FPM)

Decades of experience and a significant body of empirical evidence have led to the conclusion that many complex problems involving families with children cannot be addressed by treating families as passive recipients of care: engaging them as partners is viewed not as desirable but as crucial (Bidmead and Davis 2008; Day and Davis 1999; Scott 2010). Expert-centred models where professionals parachute into family life, leading in interventions, and solving problems on their behalf, often do not work. They may fail to build capacity or resilience in families, overlook families' strengths, and leave parents feeling judged, poorly consulted, and with little say over their role in change. Strong evidence suggests that parents are much more likely to follow through on actions or professional advice if they feel listened to and involved in discussions, decisions, goal setting, and action planning (Davis and Fallowfield 1991).

While partnership can be articulated in policy, it often remains ambiguous conceptually and at a practical level (Gallant et al. 2002; Hook 2006). Hook's conceptual review revealed the following as distinctive attributes of partnership approaches: Relationship, shared power, shared decision-making and patient autonomy (see below for more detail about how these and other characteristics are taken up in the specific guise of the FPM). A number of models have been developed within the context of child and family services that seek to address this challenge by translating the values and aims of partnership into a detailed framework, often linked to provision of specialised education or training for professionals. These include Family Systems Nursing (Wright and Leahey 2009), the McGill Model of Nursing (Feeley and Gottlieb 2000), Nurse-Family Partnership[3] (Olds 2006), and the FPM (Davis et al. 2002; Davis and Day 2010; Day 2013; Day et al. 2002, 2015; Day and Harris 2013). Family Systems Nursing has become a significant feature of nursing practice internationally, having been implemented in Hong Kong (Simpson et al. 2006), Iceland (Svavardottir 2008) as well as in North America and Europe. It stresses involvement of the whole family in the care process, based on the key assumption that a change in one family member affects all members of a family. This appears to share close links with a model put forward by Casey (1988), called a partnership model, which stressed family-centredness

[3]The Nurse-Family Partnership (Olds 2006) was developed specifically for services supporting teenage mothers and is based on a highly prescriptive set of interactions. The other models generally set out stages, skills and values (see below) without prespecifying the content of each interaction between a professional and family.

rather than child-centredness, and sought to enrol the family as a multiple unit into the care of children. One thing that is shared across partnership models in child and family services is an aim, among others, to build strength and resilience in families. This refers to a family's ability to anticipate problems, persist through challenges, to respond as a family unit, and benefit from support offered through the wider family and community (see Lindahl and Lindblad 2011).

The FPM is the model that has been implemented in all of Karitane's services. This reflects its formal adoption in 2004 as the preferred approach to child and family services in New South Wales (see NSW Government 2009). The FPM has a considerable international presence, having spread from its origins in the UK across Europe and Australia and New Zealand. In the remainder of this chapter, and indeed anywhere in this book where partnership is mentioned in direct relation to the practices of the Unit, I use the term 'partnership' with reference to the specific set of meanings associated with the FPM.

What is now called the FPM was originally developed in the UK and labelled the Parent Advisor Model (Davis et al. 2002). The Centre for Parent and Child Support (CPCS) was established in 2001, with funding from the Guy's & St. Thomas' Charitable Foundation, to develop and evaluate the FPM. It is the global hub for the FPM, and leads ongoing revisions and enhancements to the Model and associated resources for professionals (Davis et al. 2007; Davis and Day 2010; Day et al. 2015). The CPCS also leads development, implementation and evaluation of a number of evidence-based programs including Empowering Parents Empowering Communities, and the Helping Families program. The CPCS is part of the National and Specialist Child and Adolescent Mental Health Clinical Academic Group of the South London and Maudsley NHS Foundation Trust. Its Child and Adolescent Mental Health Services (CAMHS) Research Unit was established in 2006 to produce and disseminate improved, high quality mental health care for children, young people and families. The Unit works closely with the Parents' Scientific Advisory Group, ensuring user input in research design and interpretation of findings.

Services wishing to implement FPM do so through investing in workforce education. The CPCS produces training manuals, delivers courses directly, and supports a cascade model of workforce development, with the aim of enabling services to deliver training to their own staff. The FPM Foundation Course is typically delivered through five full days or 10 half days over several weeks. It is structured according to detailed training manuals, and covers all elements of the model outlined below. Specific courses for supervisors, managers and facilitators each contribute to devolving the capacity to support and train staff to service providers.[4] At the time of study, nearly all clinical staff on the Residential Unit had done so, the exceptions being a small number of newly appointed staff who were in the process of completing the course. Karitane's commitment to working in partnership is strong, and they have developed an in-house short course so that all

[4]Further information about FPM courses is available from http://www.cpcs.org.uk/index.php?page=family-partnership-training.

staff who have contact with clients in administrative, catering, and hotel services roles share a common partnership-based approach.

The following sections delve more deeply into particular features of the FPM, beginning with the idea of partnership as a helping process, then exploring practitioner skills and qualities associated with the Model, family characteristics, and links to wider service and community contexts.

Partnership as a Helping Process

In the FPM, the process of supporting families is viewed as a *helping* process. Later in this chapter, and particularly in Chap. 10, I will argue there is value in reframing helping as a process of pedagogy in which professionals facilitate parents' learning. However for now, I will remain within the vocabulary of the Model itself. It is worth noting that the FPM literature tends to refer to 'helpers' as not all those supporting parents are professionals (some may be volunteers, for example). However, the term 'professional' covers all those I observed at work and whose practices are discussed in this book. I switch between terms for the sake of variety. Neither the notion of helping nor that of pedagogy and learning have any agenda to usurp or displace therapeutic or caring approaches where these are appropriate, nor to discount the established bases of professional expertise within particular professionals.

Within the FPM, the helping process is conceived as influenced by specific helper qualities and skills, and the characteristics families and parents bring (Davis and Day 2010; Day et al. 2015). Core to the helping process, and the achievement of outcomes, is the establishment of a particular type of relationship between helpers and parents. While it might seem obvious to mention outcomes, it is important to stress that while establishing strong relationships is a key feature of the FPM, relationships are a means to achieving outcomes or change, not an end in themselves. While change requires a strong relationship, practitioners must go 'beyond being nice' (Day and Harris 2013; Fowler et al. 2012a, b, c; Rossiter et al. 2013). The FPM reserves an explicit role for professional expertise and emphasises the legitimacy of professionals challenging parents' views or practices in an appropriate manner and within the context of a trusting relationship (see Chap. 10 for a detailed discussion of how challenge is presented to parents on the Unit, and the professional knowing and learning associated with this). The Model builds on ideas from psychotherapy, counselling and child development and parenting (Rogers 1959; Bowlby 1988; Kelly 1955).

Further to an explicit intention to do no harm, outcomes are conceived in terms of:

1. Helping parents and children identify and build on strengths
2. Helping to clarify and manage problems
3. Enabling parents to achieve key goals and priorities for their children and themselves
4. Fostering resilience (see above) and anticipation of problems

5. Fostering and ensuring the development and well-being of children
6. Facilitating and enabling social support through wider family, social networks and the community
7. Facilitating community development, enabling service support, and improving the service system
8. Compensating for family difficulties where necessary (Davis and Day 2010).

FPM literature specifies a connected and broader concept of the family, paralleling that of Family Systems Nursing, and the ecological notion discussed earlier in this chapter. It stresses that interactions between professionals and parents are situated within a wider service, family and community context.

The process of helping is conceived in FPM in a number of stages, each of which is underpinned by and contributes to the development of a relationship between the helper (professional) and parent(s). This process begins with exploring a present- and future-focused picture, from the parents' perspective. The outcome of exploration is a clear and shared understanding of the current family difficulties as well as their strengths and resources, and identification of key areas for potential change. This may involve challenging parents' assumptions and offering alternative understandings of a situation or difficulty. For example, a common challenge offered by a helper might counter parents' assessments of themselves as poor parents. The next task focuses on goal setting, with the aim being that goals are specific, measurable, achievable, realistic, time-limited, explicit, negotiated and revisited, thereby reflecting parents' priorities and wishes. A strategy is then co-constructed, and on the basis of this particular actions are planned. Following a period of implementation, in which parents continue to be supported in implementing agreed actions, all parties undertake a review. This refers back to the understanding or model of the problem, with a specific emphasis on harnessing the parents' role in using their resources and skills to make changes for their family, and assesses the effectiveness of actions in contributing towards progress on goals and how these relate to wider outcomes. The review may lead to a new cycle based on different understandings, or provide the basis for a new set of goals to be articulated, or alternative strategies to be explored, or may indicate readiness to end a piece of work. Importantly, the model always envisaged an end to the helping process. The FPM does not specify any rigid timeframes for these different stages, nor any fixed number of cycles that may be worked through. As a sequential yet non-linear process, significant fluidity is anticipated in the emphasis and time spent at different stages of the helping process.

A key element of the FPM is its conception as a process of construction rather than delivery of a fixed, rigid structure. Information is treated with a focus on searching for meaning and significance, and all participants' understandings or constructions of parenting and parenting challenges are taken into account. The process reflects prior experience of parents and helpers, and unfolds in a way that is unique, through iterative cycles of testing, clarification and change.

Specific Features of the Family Partnership Model

As mentioned above, both the helper (professional) and parents contribute key inputs to the helping process, as conceived within the FPM (Davis and Day 2010; Day et al. 2015), and in many similar approaches. Partnership relies on several key qualities of the helper: respect, genuineness, empathy, humility, quiet enthusiasm, personal strength and integrity, intellectual and emotional attunement. Importantly, it is not considered enough for professionals simply to possess or embody these qualities; rather the FPM outlines how they can be enacted and explicitly demonstrated in interaction with parents. It is crucial that parents view the professionals helping them as respectful, genuine, purposeful and effective. Day et al. (2015; see also Davis and Day 2010) provide detailed descriptions of what is meant by these qualities and how they may be demonstrated.

As mentioned previously, professional skills are understood to be combined with particular qualities in enabling the helper to work in partnership with families. Again, the FPM literature and training manuals provide details as to what these are and how they can be performed. Concentration and active listening are key, meaning that helpers focus on genuinely listening to what a parent has to say in an open and focused manner, rather than waiting to speak. Active listening can involve bodily gestures such as synchronised nodding, as well as allowing pauses or silences that encourage a speaker to continue. The helper also deploys skills in prompting and exploring, in order to enrich parents' accounts, and summarising in order to demonstrate to parents that they have been listened to and accurately understood. Empathetic responses may include verbal affirmations as well as bodily gestures. Of importance here is to avoid a sense of judgement or pity. Professionals and other helpers can also bring enthusiasm and encouragement, and have a role in enabling change in feelings, ideas, and actions, which at times may require presenting challenges to parents. Negotiation skills are also crucial, and apply to all stages of the process, but particularly goal setting and action planning.

The FPM, like many other partnership models, encourages professionals to facilitate a working relationship that recognises, values and utilises the expertise and skills both parties bring to any interaction. However, this does not equate to a wholesale dismissal of professional expertise, and key helper skills are named as communicating and making use of technical knowledge, expertise and experience. Helpers also bring skills in problem management, and particularly in early stages or when working with families with very few emotional and other reserves, this dimension can enable parents to focus on their priority goals.

The FPM also holds that the process of helping families is also influenced by, and builds on, characteristics of parents and children (Davis and Day 2010; Day et al. 2015). These include the nature of the challenges being experienced by families, which may be chronic, acute, and made more complex via links to other stressors or vulnerabilities. Also considered are barriers to engagement, which can arise due to suspicion or fear, difficulties accessing services delivered outside people's homes, conflict within families as to the need for or relevance of support, and so on. Risk factors include mental ill health, drug and alcohol abuse, domestic violence,

social isolation, and parental histories of neglect as children themselves. Motivation to change can reflect the degree of difficulty, but can be tapped as a powerful resource to draw on, particularly when the helping process itself is challenging. (Chapter 10 discusses the professional learning and expertise involved in judging an appropriate level of challenge and putting appropriate supports in place to match each family's strengths and align with their goals.) Protective factors are taken into account, including wider family relationships and access to social support. Parents' expectations of outcomes are also important, and may need to be explored and perhaps challenged in early phases of the process; of course these may continue to be assessed and revised as things unfold. Socioeconomic circumstances and cultural background also require sensitive and responsive approaches to helping, professional respect for and accommodation of different parenting styles.

In addition to listing the necessary skills and qualities of helpers, and identifying characteristics of parents and children that play an important role, the FPM further seeks to demystify and concretise the notion of partnership by naming a series of key ingredients. These begin with the idea of working together with active participation and involvement; the clear message here is that this goes beyond consultation around satisfaction, framing the entire process as a joint endeavour. The development and maintenance of genuine connectedness underpins other features such as shared decision making and recognition of complementary expertise and roles. Note here the term 'complementary', rather than equal. Professionals are involved precisely because they bring something different and valuable to the table; this is recognised, as is the knowledge that parents have of their families, and the strengths they bring. The aims and process of helping should be shared and agreed, and a climate created in which both parties feel comfortable airing disagreement openly so that issues can be negotiated. Mutual trust and respect must be demonstrated, and this is set out as an expectation and responsibility in both directions: professionals must respect parents, but parents must also be actively supported to trust professionals. The ongoing aim is for openness and honesty to characterise all interactions, bolstered by clarity of communication.

Another significant feature of the FPM concerns the wider service and community context. The Model (Davis and Day 2010; Day et al. 2015) does not conceive of interactions between professionals and families occurring in a vacuum. The service context is important, and key features of this that align with and support partnership are identified. These include reflective practice, clinical supervision and support for professionals to develop appropriate skills, knowledge and competencies. Drive and enthusiasm from practitioners through to managers and service leaders, attitudes and beliefs about service provision, and organisational culture are noted as important. Resource availability, system structure, stability and flexibility can all affect partnership, and the ability of a service to meet users' needs. Finally there must be a strong expectation of outcomes. This may seem obvious, but is a reminder that the purpose of partnership is not to establish good relationships with families, but to bring about change. The important role of community groups, neighbours, religious communities and educational services is recognised, with access to these being a key consideration in partnership work.

Prior Research and Evaluations of the FPM

Research focused on FPM training, particularly the Foundation Course, suggests that it improves professionals' helping ability and listening skills, as judged by professionals and families working with them (Bidmead and Cowley 2005a, b). Similar results were reported in the European Early Prevention Project (EEEP) (Layou-Lignos et al. 2005; Papadopoulou et al. 2005). In Australia, Keatinge et al.'s (2008) interviews with nurses 18 months after they completed FPM training showed that they felt it had built on existing skills and helped them become more reflective about their role as facilitators and enablers rather than as solving problems for others.

There is a considerable evidence base suggesting that services that have implemented FPM secure better outcomes for families when compared to those that have not (see Davis and Meltzer 2007). A randomised controlled trial in the UK compared standard help with 18 months of weekly visits by FPM-trained home visitors (Barlow et al. 2007). Outcome measures of maternal sensitivity and infant co-operativeness favoured the intervention group. The EEPP, spanning five countries, included FPM in a nonrandomised intervention. Evidence of differences favouring the intervention group was apparent at 24 months (Davis et al. 2005). This is not to say that FPM is perfect or guarantees better outcomes. All existing studies note some degree of variation in outcomes. Those relating to enhancing community and social support are often less strong than those relating to within-family changes, for example.

This brief discussion of evaluative evidence is presented in part to illustrate the basis upon which decisions to implement FPM across NSW and other Australian States and Territories are based. Not only does FPM offer a detailed working through of the concept of partnership that is so often advocated on vague terms, but it consistently shows strengths in terms of delivering outcomes. Outlining these studies also reinforces a key element of FPM, which is its constant reference to outcomes, reminding us that partnership is not ultimately about relationships, but aims to establish particular kinds of relationships as part of a process of bringing about change. This reframes the professional role from one of solving problems on behalf of others, to one that instead facilitates learning in families, leading me directly to the next section.

Partnership, Professional Practices, and Learning

This book addresses questions of professional practices and learning. I will now introduce arguments that link the idea partnership with the broad themes and issues mentioned at the very start of this book (see Chap. 1). These were initially presented elsewhere (see Hopwood 2013, 2014a, b, c; Hopwood and Clerke 2012), and will be developed fully in Part III. The argument follows a basic logical

sequence. Partnership means that professionals are not there to solve problems for families, but instead to help develop confidence, capacity, strengths and resilience. This can be understood as a process of helping parents learn, and emphasises the pedagogic dimension of contemporary professional practices in services for children and families. This pedagogic dimension, in turn, has implications for the role and nature of professional expertise, the kinds of knowledge and judgement that practice demands of professionals, and the learning that emerges in the conduct of their work.

Interestingly, the UK Department of Health (1994) noted a 'teaching function' as one of the key ways in which nurses and health visitors contribute to health and health care (see also Graham 2011). Thus the idea that professionals working in health care, including those supporting families with young children through home visiting and other services such as residential units, have a pedagogic role is not new. I argue that the adoption of partnership as an explicit approach to working with service users intensifies this pedagogic dimension.

A body of research, much of it informed by practice theory, has developed in recent years that construes working in partnership as requiring professionals to become effective enablers of parents' (or indeed others') learning. Lee et al. (2012) talk of 'doing partnership' as 'embodied pedagogy', pointing to the close-up work of interactions between professionals, parents, and children. Concepts of professional attuning, and the bodily dimensions of the practice textures produced through partnership work discussed in Part III resonate with Lee et al's approach. Similarly, Fowler et al. (2012a, b, c) explored a home visiting program for mothers with depression in terms of 'reciprocal learning', arguing that not only do parents learn from (or with) professionals during such encounters, but that professionals also orient much of their work to learning about families. Learning in both 'directions' is seen as central to establishing effective partnerships, or what Edwards and Apostolov (2007) call 'co-configuration', and is reflected in the distinctive foci of Chaps. 9 and 10 in Part III. The questioning of expert-centred models has been reframed on pedagogic terms by Fowler and Lee (2007), who critique the notion of knowledge transfer, in favour of a more fluid, pedagogical understanding of the knowledge work going on between professionals and parents. Broader connections between coproduction (in the guise of the FPM) and professional learning are outlined by Fowler et al. (2012a, b, c).

I have joined and extended this line of thinking in my own previous analyses of the ethnographic data that underpins this book (see Hopwood and Clerke 2012 for a basic overview). This includes a description of the rhythmic basis of parenting pedagogies (Hopwood 2014c), and early outlines of the links between partnership, practices, pedagogy and the four dimensions (times, spaces, bodies and things) that provide the overarching framework for Part II (see Hopwood 2014a, b). The account I give of practices on the Unit in terms of pedagogic work is not the account that those professionals would necessarily give themselves. However these are not a foreign notions to the people who work on the Unit, either. They often use phrases such as 'It's a learning thing', or 'We can help you to learn

some new strategies for coping with that'. Indeed the response to verbal presentations and publications provided to staff of the Unit has consistently been one in which professionals recognise the pedagogic features of their work, and feel that the account validates and legitimises much of what they feel is important (albeit expressed in an alternative vocabulary). We have already seen how parents also experience their time on the Unit as one of intense learning (see the letters from parents presented above).

This pedagogic dimension of professional practices infuses them with particular knowledge challenges. In Part III, I will highlight these, and provide a detailed description of the practices of professional learning that have emerged in response to them. This includes (in Chap. 9) practices of personal and collective attuning to families, practices of handover, variously choreographed, and practices that position professionals as intimate outsiders in family life, and those that enable professionals to act amid knowledge that is characterised by uncertainty, ambiguity, partiality, and fragility. Chapter 10 draws out different forms of professional expertise and learning in relation to scaffolding change in families, enacting 'nanopedagogies' that transform mundane or negative moments into meaningful, positive and empowering experiences for parents, and pedagogic continuity (concepts that help to cope with the instability of relationships inherent in work that is performed by professionals from varied fields, and across many shifts. Chapter 10 picks up the notions of epistemic work from Chap. 9, exploring the professional learning that is bound up with helping parents learn, when solutions and the learning required emerge through the process, rather than being known from the start. I refer to this in terms of professional pedagogies of the not-yet-known, and show how understanding partnership practices in this way opens up new questions and elucidates important features of professional learning in practice.

Conclusion

We have entered the world of child and family services, and explored the important role that associated professionals play in addressing problems of social inequality and disadvantage. We have touched upon the contemporary Australian policy context, before getting to know the professionals who work on the Unit and the families who become residents for a week at a time. We have seen evidence of the positive difference such a short stay can make for families, and walked through the basic spatial and temporal features of the Unit. We have seen how the key questions and themes of this book speak to a broader contemporary landscape of professional practice reform, focusing on partnership and in particular, the FPM. Seen in these terms, the Residential Unit provides a fascinating research site—a clearing—at which we can cast light upon questions of professional practice and learning. This elucidation requires sophisticated and distinctive theoretical apparatus, and it is to this that my focus turns in Chap. 3.

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