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# Professionals' understanding of partnership with parents in the context of family support programmes

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## ABSTRACT

**Partnership has become a dominant concept in current thinking about the parent–professional relationship within a variety of interventions aimed at child welfare, including family support practice. However, despite the burgeoning policy and research attention, the meaning of partnership in practice remains unclear. Based on interviews with professionals in a family support intervention in Flanders (the Dutch-speaking part of Belgium), this paper offers an insight into professionals' daily interactions with parents. The analysis reveals a tension between professionals' commitment towards parents on the one hand, and the way professionals take up this commitment in an expert role on the other. Consequences for professionals' relationships in child and family welfare interventions are discussed, as well as some implications for the realization of proper partnerships that acknowledge the power imbalances that exist in such partnerships.**

## INTRODUCTION

Over the past two decades, a lot of research and policy attention has been paid to the relations that professionals (should) have with parents in different settings aimed at child welfare. These settings range from institutions accessible to all citizens (e.g. early child care, preschool and school context; cf. Payne 2002; Alasuutari 2010) to interventions in the context of children *in need* and more coercive child protection interventions in the context of children *at risk* (cf. Roose *et al.* 2012b). They include family support practices that are particularly addressed to parents and that can be identified by their preventive purpose and their aim to promote strengths in family members (Gardner 2003). Different terms are used to refer to what is considered the most desirable relation between parents and professionals, such as *collaboration* or more *equal* relationships. Several scholars (e.g. Corby *et al.* 1996; Pinkerton & Dolan 2007; Alasuutari 2010; Broadhurst & Holt 2010) refer to the recognition of *partnership* as a dominant concept in current thinking about the parent–professional relationship in child welfare practice. Several scholars have welcomed this concept for its underpinning values such as sharing power, consensuality and equality (e.g. Corby *et al.* 1996; Bundy-Fazioli *et al.* 2009).

Others, though, have highlighted the ambiguity of the meaning of those terms in practice. Calder & Horwath (2000, p. 267), Sheppard (2005, p. 745) and Broadhurst & Holt (2010, p. 99), for example, have respectively described *partnership* as an 'elusive' concept, a 'hazy' concept and a 'buzzword'. Scholars such as Healy (1998) and Roose *et al.* (2012b) even contest the idea that partnerships in child welfare practice can be actually realized due to the imbalances of power so inherent in professional interventions in the private sphere of the family life. Even though scholarly research has already been done on what does or does not work when realizing equal relationships (see, e.g. Thoburn *et al.* 1995; Morris & Shepherd 2000; MacNeill 2009; Darlington *et al.* 2010), partnership seems to be a discourse, rather than a practice. This discourse, however, may obscure what really happens within different child welfare practices. Partnerships are 'developed in various ways in different contexts' (Alasuutari 2010, p. 150), and therefore 'the partnership construction can take on different forms

in practice' (Roose *et al.* 2012b). This observation indicates a need for more insight into how professionals working in different contexts understand partnerships with parents, or, to put it differently, on how they work with parents in their daily practice.

Based on these insights, this paper reports on the findings of a qualitative study on how professionals build relationships with parents through their daily interactions within a particular family support programme in Flanders (Belgium), namely *Centra voor Kinderzorg en Gezinsondersteuning* (Centres for Childcare and Family Support, hereafter CKG). Given the fact that the development of family support programmes has become a key aspect of current international policy agendas (Boddy *et al.* 2009), and given the fact that family support has been linked with partnership (Sheppard 2001; Pinkerton & Dolan 2007), the question of how partnership is understood within family support programmes seems to be all the more imperative to explore. Flanders is, then, an interesting case as it exemplifies both the broader European development towards a family support perspective to improve children's well-being (Roose *et al.* 2012a) and uses the currently dominant idea of partnership as the most desirable parent–professional relationship (OECD 2001).

In this paper, we first set out our research context and method, after which we present the main findings of our study. Based on our findings, we will argue that there is an important tension between the commitment of the professionals towards the parents on the one hand, and the way professionals consider themselves as experts during the intervention on the other. Implications for further research and practice are given.

## RESEARCH CONTEXT

In Flanders, child protection and child and family welfare services are closely interlinked and together form one pyramid structure (see Desair & Adriaensens 2011). The rationale is that family support interventions, which are situated at the lower level in this pyramid structure, should precede – and attempt to avoid – more coercive child protection interventions, which are situated at the top level of the pyramid (Roose 2006). CKG centres form a particular type of service at the far end of structural services for family support and are therefore located just below the top level of the pyramid. They are framed as preventative, voluntary and temporary: Preventative, as they are aimed at averting more severe problems later in life and accordingly more serious interventions; voluntary, because families can go to the CKGs at their own initiative, even though CKGs also intervene in families mandated to receive court-ordered services; and temporary, as the CKGs' interventions can vary between a few days and a maximum of 6 months. CKGs work with families with children between 0 and 12 years, but with a particular focus on 0–6-year-olds. In each of the 23 centres, interventions might comprise of one (or a combination) of the following types of intervention: (i) (semi-) residential care for children (day care as well as night care, 24/7) along with support for the parents that might include parenting skills training or referral to more specialized interventions, e.g. in case of financial or relational problems; (ii) parent training modules; and (iii) individual home-based services.

Decisions about which kind of intervention will be offered in a particular case, is based on the assessment of that particular case and the principle of subsidiarity. If necessary, it is possible to switch from one type of intervention to another (e.g. from home-based service to [semi-] residential care). In general, court-ordered interventions comprise residential care for children. Some parent training modules make use of evidence-based programs such as Triple P (see Sanders 2003) or STOP 4–7 (see De Mey *et al.* 2009) and even though other forms of support are not evidence-based at this moment, it is the intention to evolve to an evidence-based practice (Van den Bruel 2002). The involvement of parents in any kind of intervention by the CKG (semi-residential, parent training or home-based services) is made obligatory by the decree of the Flemish parliament of 2002. The parent–child relationship is the main focus of the CKGs interventions (see Vlaamse Regering [Flemish Parliament] 2002). However, parents who address these centres can have a variety of problems in the area of child raising, e.g. behavioural problems of the child, a lack of parental knowledge and skills to establish and maintain a *good* relationship with their child, mental health problems or substance abuse by the parent, or temporary material problems such as housing problems. The purpose of the intervention was to maintain the child within or reintegrate the child into the family.

A graduate-level multi-professional workforce provides the direct work with children and families. Most of the staff in residential care have a degree as a child care worker at the level of secondary education or at a bachelor level. Parent training and home-based services are predominantly provided by bachelors or masters in social work, psychology and special education. The latter two also play a key role

 

in advising and supporting this workforce. Besides them, (para)medical staff are also often part of the workforce.

## RESEARCH METHOD: DESIGN, DATA COLLECTION AND ANALYSIS

The study's aim was to gain more insight into the relationships that professionals build with parents in family support settings aimed at child welfare. Data were obtained from 23 semi-structured interviews, one interview in each centre. In five centres, the interview took place with one professional of this centre. In 18 centres, several professionals participated in the interview (varying between two and six professionals). In total, 58 professionals from all 23 CKG centres were interviewed during the winter of 2008. When selecting our participants, we strove for as much variety as possible on the following four criteria: (i) *their seniority* (varying from less than 1–40 years); (ii) *their position in the centre* (22 participants were board members; 17 participants were involved in direct work with families; 16 participants were involved in supportive tasks towards the staff providing direct work with families; and 3 participants performed administrative or logistic tasks); (iii) *their qualifications* (11 were child care workers, 9 were social workers, 7 had a degree in special education, 6 had a master's degree in psychology or educational sciences, 6 had a medical-oriented qualification, 1 was a schoolteacher, 1 had no qualifications and for the remainder this information is not known); and (iv) *gender* (17 of the respondents were male and 41 were female) (Table 1).

As we were not interested in the discourse on partnership as such, participants were not asked direct questions about how they defined their relationships with parents. Instead, questions focused on the content of their interactions with parents. The central question asked in the interviews was: During which phases in the intervention process do you have contact with parents and what do you do during these moments? All interviews were recorded with the participants' permission and lasted for 1–2 hours.

The interviews were transcribed and thematically analysed. This process involved coding and categorizing units of information (Lincoln & Guba 1985). The constant comparison method (Glaser & Strauss 1999) was applied in order to identify specific characteristics in professionals' actions with parents. This process resulted in the identification of three main forms of interaction: (i) informing; (ii) instructing; and (iii) motivating. In the next section, we present the main findings. To underpin these findings, we have added quotations from the interviews (our translation). The numbers (1–23) refer to the CKG centres; the letters (a–g) refer to the participants within each CKG centre.

**Table 1** Characteristics of the participants ($n$ = 58)

| | |
|---|---|
| Seniority | Between less than 1 year and 40 years |
| Position | Board members (22 participants) |
| | Direct work with families (17 participants) |
| | (Semi-)residential care or parent training (11) |
| | Home-based services (4) |
| | Combination home-based with other forms (2) |
| | Supportive tasks towards staff working with families (16 participants) |
| | Administrative or logistic tasks (3 participants) |
| Gender | Males (17 participants) |
| | Females (41 participants) |
| Qualifications | Child care workers (11 participants) |
| | Social workers (9 participants) |
| | Special education (7 participants) |
| | Master of psychology or educational sciences (6 participants) |
| | Medical-oriented qualification (6 participants) |
| | Schoolteacher (1 participant) |
| | No qualification (1 participant) |
| | Not known (17 participants) |

## FINDINGS

### Phases of the interventional process in which parents are involved

When professionals reported on their daily interactions with parents, they mentioned the following phases of the interventional process: (i) providing information about the interventional process, legal rights and rules of the centre; (ii) assessment of parents' and children's needs; (iii) developing a support plan including goals and methods, (iv) implementing the support plan; (v) reviewing parents' and children's progress; and (vi) closing the intervention. As the main objectives of the intervention are improving parents' pedagogical skills and their ability to establish and maintain a strong bond with their child in order to enable them to keep/reintegrate the child in the family, professionals explained that developing a support plan is mainly focused on determining goals that are in line with

 

these objectives. The implementation of the support plan comprises activities with this particular focus. With regard to the final phase of the intervention, professionals further explained that in cases in which the decision is made to place children out of home (e.g. in foster care), this final phase is focused on preparing parents and children to take this step.

So according to the participants, parents seem to be involved in several phases during the interventional process. Moreover, when analysing our data, it was remarkable how frequently the participants used the word 'together' to express how parents are involved during the intervention process. However, the interviews also revealed that there are activities in which parents are clearly not involved. In all 23 CKGs, staff meetings are organized on a regular basis. During these meetings, decisions are made about access to the centre and about the most appropriate form of intervention – (semi-)residential care, parent training or home-based services – as well as about the future situation of a family, including the question whether other, more permanent professional help is needed and whether or not the child can stay at/return home. Remarkably, our findings show that parents do not seem to be involved in these decisions.

> 'In fact, we make some kind of analysis of the problem and we decide in the team. Then, we make an agreement with the parents about the form of support that is most appropriate. When we have made a report, parents can read this. We give them an account of the support plan that is developed here [in the team].' (4a)

> 'If this [leaving a home visit with the feeling that a child is safe at home] is not the case, we come together as a team, with the other professionals involved in this family, the psychologist, and assess the safety of the child.' (5c)

> '[On establishing a link with the juvenile court or the Committee for Special Youth Care] It happens that we think that the safety or good care is no longer guaranteed by the parents. In this case we work towards an extended intervention in another setting. This happens together with the parents. The idea for the need of a more intensive intervention, to refer the case to the Committee for Special Youth Care, is not always together with the parents. Sometimes, professionals have had the idea already for a longer time. They cannot see the children going home. Then, we discuss this with the parents [. . .]. When the parents cannot agree, we make a decision in favour of the safety and the well-being of the child. At last, we take the final decision ourselves.' (18b)

So having contact with parents or involving parents during different phases in the intervention does not necessarily mean that parents are also involved in the decisions that are made by the professionals in these phases, nor – as the last quotation suggests – that such an involvement is always deemed desirable by the professionals.

### Forms of interaction: how professionals interact with parents

A further analysis of how professionals interact *with* parents in all phases of the interventional process in which professionals claimed that parents are involved suggested that these interactions can be brought back to the following three forms of interaction: (i) informing; (ii) instructing; and (iii) motivating.

#### *Informing*

One form of interaction, which was clearly present in how participants reported their daily contacts with parents, is giving information to parents. This form of interaction refers to providing information about the interventional process, their legal rights and the rules of the centre.

> 'Then we explain how we work, that we have to make a home visit at least once a week because we are obliged to do so. Then we run a checklist step by step: who we are, what we do, that the intervention is just temporary, [. . .], that it is all about parenting support and not, for example, about financial problems.' (8b)

> 'We start with providing parents with a lot of information about the way the organisation functions. They receive a welcome brochure. We also inform them about their legal position.' (5b)

Professionals also inform parents when final decisions are made. As the interviews suggest, making final decisions mainly comes down to informing parents about what was decided by the professionals, e.g. during the phase of closing the intervention:

> 'I cannot remember that I've ever contacted the Committee of Special Youth Care without informing the parents. I've always respected that parents should get a minimum of information.' (5c)

> 'When we see that the safety of the child is not 100% guaranteed, it is our duty to inform parents about our assessment. [. . .] You say: "[. . .] you have to know that we will take this one step further, and there will be a chance that the Committee of Special Youth Care will intervene." ' (17a)

#### *Instructing*

Next to providing information, professionals' interactions with parents also include a lot of instruction. In

 

this particular form of interaction, the instructor defines the goals and uses his knowledge in a systematic way to let others, who lack this knowledge, know what is objectively true or right. The interviews suggest that during the assessment of parents' needs and the development of a support plan, the professionals consider themselves as having the competence to define goals. Although parents can say what their problems are, it is the professionals who define the goals of the intervention:

> 'We rephrase the question for help into what the CKG can offer in a particular case because this can be very different from what the applicant wants us to do. [. . .] Together with parents, starting from their question for help: 'What do you want us to do? What do you want to accomplish? [. . .] But these are not always the right goals that we will work on later. During the intervention you gradually rephrase these goals into the ones you have to work on.' (19a)

> 'We take up engagements together, we develop an action plan together, that we will follow together, [. . .] then you say: "Madame, although you cannot recognise this as a problem at the moment, we ascertain this and that as stress factors, things on which we need to work together." ' (17a)

One of the participants explained how professionals' knowledge about defining the 'most appropriate' goals is legitimized by science and not based on the professionals' individual interpretations:

> 'For the support of parents we map the needs by use of a support plan: an analysis of the problems in the family according to the child, the parents, the professional. This concerns an analysis of the child-parent interactions etc. [. . .] We conclude what we will work on. [. . .] It's not about what we think a child needs, it's based on scientific knowledge. [. . .] No, it's not the parent who determines the goals for what will happen during residential care.' (18b)

Instruction is not only part of the interactions with parents during the assessment of parents' needs and the construction of a support plan, but also happens during the implementation of the support plan. Professionals try to change parents' behaviour through instructions about what exactly could have caused the problem and which parental skills are appropriate to solve this problem, taking into account the specific context of the parents. Rather than giving information or advice – which is a form of interaction that presupposes the possibility of different options (Giesecke 1990) – professionals tell parents what seems, according to them, to be the most obvious underlying reasons for the problem as well as showing parents what is believed to be the best possible way to act:

> 'Pedagogical support can be given to stimulate the development of the child. When you notice that the parents cannot cope with this, you teach them how to stimulate the development of their child. We start from the behaviour of the child and ask the parents how they interact with their child. When you assess that the stubborn behaviour of the child is linked to the developmental phase the child is in, you can explain this to parents and make them understand that it is normal as well as how they can respond to it.' (5c)

> 'In residential care parents learn by modelling. They come to bath their child or they learn how to make a bottle and nourish their child. When we know that the mother lacks those competences we will involve her in taking up these tasks.' (2b)

Some participants explicitly claimed that giving information or advice is insufficient. Their statements suggest that they doubt parents' abilities as well as their engagement towards their child:

> 'Providing information . . . , then parents are not able to translate this into practice.' (5e)

> 'Concerning parent participation, we explain to parents that we teach them how to do it [interacting with their child] but they have to get to work with it. [. . .] We can teach them by modelling. We give them the feeling that they are the ones who are responsible and have to take up and accomplish their tasks as a parent.' (5e)

### *Motivating*

Next to providing information and instructing parents, a third way that professionals interact with parents is motivating parents. In this particular form of interaction, professionals try to stimulate parents to get things moving and to make parents take the opportunities they get from the professional in order to accomplish a fixed plan or objective. Of course, the activities mentioned earlier – providing information, developing a plan, defining goals and letting parents know what is best for them – can all be motivating. However, the interviews suggest that professionals consider motivating parents as a core task. Or as one of the participants (5e) said: *'It is a process of motivating parents.'* Motivating parents is part of different phases of the intervention. Professionals motivate parents to engage themselves to accept the help that is offered, to accept the rules of the centre and to follow the plan in order to accomplish the goals that are part of it.

Based on the interviews, building trusting relationships seems to be an important strategy used by the professionals to motivate parents. The participants explained how they first listen to the parents' story and try to gain their trust:

> 'In most cases, the first question is: "According to you, what is most important to start with?" Even when you think their

 

house should be cleaned because this can make it easier for the child with ADHD. But parents say: "He should be able to be more quiet." So, you start from there but over time you show them that it's important for the child that everything is structured to help him be more quiet. Like that, you get to your goal but you start from the parents' problem because then, they will be motivated. They will not be motivated when they don't think it is important. When they say, 'Yes, more structure can be important', at that moment you can ask how you can work on it together to offer more structure.' (18a)

'We are frequently confronted with parents for whom imposing something does not work anymore. Families living in poverty do not accept that. [. . .] Someone who is poor will not accept that you are an expert and follow what you are suggesting. First, you need to install a bond. First, they need to trust you.' (18a)

However, not all participants invest in building such a trusting relationship as in their opinion, this is too time-consuming.

'We have chosen for a rather confronting and direct style. No longer – like it happened a lot in the past – let the whole process last for years without making any progress. [. . .] You as a parent have to make the decision if you want to go that way, yes or no, and this needs to be functional in the sense that it has to lead to a solution and not towards foot-dragging, which is frequently the case in interventions. When no progress is made, it has no meaning and then we are clear about that: "When you don't choose this, it's your responsibility and then we can use our time more efficiently on someone else." ' (16b)

Next to building a trusting relationship with parents, different styles and strategies are used to motivate parents, such as pointing out what is in it for the parents or presenting the predefined goals as a mutual interest of professionals and parents, or by confronting parents with their present behaviour and their responsibility towards their child.

'When the parent does not agree with our proposition, residential care, then we explain that we think it is in their best interest. In this case we assess how we can take this on together with the parent. You have to persuade the parent why you think taking the child into residential care is necessary. When parents hear they can visit their child every day, that they are welcome here from 8 till 8, many of them are relieved and realise, I will be able to see him every day, to put him to sleep every day, to nourish him, so my parenting task will not be taken over completely.' (17a)

'Then we contact the parents and we say that normally they are supposed to visit their child and that this was the agreement; we ask why they don't stick to the agreement [. . .]. We discuss with them that it is important for their bond with their child.' (1b)

Others try to motivate parents by putting the goals in a social perspective or by setting up smaller steps during the review process.

'Putting things in a social perspective, it's something you've got to do when you need to talk people into it . . . When you need to persuade parents to take care of their child's hygiene before bringing him to school, then a social perspective is useful. You say: "When you are not taking care of his hygiene, other children in school will smell it and laugh at him." That kind of message, they understand.' (3a)

'Part of the support could be: "OK, it didn't work out this week, maybe you see a possibility to make it work next week?" or "Why did it not work out, what can we do in order to make it work next week? Because when we make appointments or you get a task in order to accomplish a certain goal you want to reach, then you need to try to make it happen." ' (18a)

The participants made clear that they motivate parents not only in order to make parents accomplish the plan, but also with a view to having parents take up their responsibility as a parent. For that purpose, professionals try to engage parents to take up parenting tasks themselves and clearly avoid taking over these tasks:

'We do not take over the role of the parents. We make parents take some decisions themselves, because they will also have to take these kind of decisions and actions when their child is back at home and no further intervention is offered. We make them clear that they are still responsible for their child.' (11b)

'Parents are motivated to take these steps but we are not going to solve these problems for them.' (16a)

'Part of our job is that we make parents realise that the ball is in their court. We make the parents responsible.' (2a)

Furthermore, some statements of participants suggest that professionals have certain expectations towards parents including their interactions with professionals. They are expected to cooperate:

'[. . .] motivation and cooperation of parents . . . for us, this is the basis of our intervention.' (5g)

'Although it [the intervention] is voluntary, it's not non-committal anymore. We take up engagements together. [. . .] Parents who function perfectly as partners, they try to use all the advice they are offered to get out of the situation . . .' (17a)

## DISCUSSION

We started this paper with the observation that there is a need for clarification of what partnership between professionals and parents actually means in practice. Focusing on a particular family support programme

in Flanders, our research aimed to gain more insight into the concept of partnership by interviewing professionals about their daily interactions with parents. Our findings reveal two important issues in relation to these daily interactions.

First, the interviews show that there is a difficult tension between the professionals' commitment to involve parents and their expectations of parents' (lack of) capabilities to act in the best interest of their child. On the one hand, the interviews reveal that professionals value parental involvement and engage themselves to interact with parents during different moments in the intervention. This commitment is not only reflected in the participants' frequent use of the word 'together' during the interviews, but also in the way they explained how parents are involved in the intervention process. Much attention is paid to informing parents about the intervention and their legal rights, to teaching parents the proper skills to enhance the well-being of their child(ren) and to motivating parents to apply the professionals' instructions.

On the other hand, though, the interviews show that even though parents are involved in different phases of the intervention process, they seem to be excluded from these moments in which (final) decisions are actually taken. This is in line with the finding of Corby *et al*. (1996) that even though parents are better informed, their involvement in the decision-making process is still limited. By limiting the role of parents to objects that are consulted about their problems and/or are informed about decisions taken by the professionals, parents are approached as passive recipients rather than partners in a reciprocal relationship in which 'decisions are made jointly' and 'each partner is seen as having something to contribute' (Tunnard 1991, p. 1).

Second, in all three forms of interaction – informing, instructing and motivating – professionals initiate the interactions. Professionals mainly approach parents from their own views of parents, parenting and family support, which are shaped by the concepts used by their services. Interactions with parents seem to start from the idea that parents lack the knowledge, capacities or even the will to autonomously take care of the well-being of their child. Therefore, professional knowledge is needed to define the appropriate goals and to select the most appropriate methods to solve this problem. Consequently, the professionals stressed more what they expect from parents, rather than emphasizing the reciprocity in their relationship with the parents. Moreover, the professionals' strategies to motivate parents seem to be mainly aimed at accomplishing the goals that they have unilaterally set for the parents. Even when professionals value a trusting relationship with parents, this is grounded in the idea that such a trusting relationship will be useful to achieve their own goals of the intervention. This seems to be in line with Beresford (2000), Poste & Beresford (2007) and Roose *et al*. (2009) who stated that parents are involved to make them less resistant towards the changes that professionals deem necessary. However, as Roose *et al*. (2012b) argued, such an instrumental view refers to an understanding of partnership as 'a divided responsibility' and can hardly be considered *democratic*.

All these suggest that there is a tension between the professionals' commitment to work together with parents on the one hand, and the way professionals take up this commitment in an expert role on the other hand. While the former might refer to the underlying values of partnership (such as equality and consensuality), the latter shows that partnership is in fact realized in a context of inequality: the purpose of the intervention was to maintain the child within or reintegrate the child into the family and to prevent more coercive child protection measures, such as foster care or more permanent residential youth care. Referring to equality in a context of inequality is, however, rather paradoxical and results into an instrumental understanding of partnership, stressing the importance of parental involvement for the realization of the desired outcomes of professional interventions.

Several important implications for research and practice emerge from our findings. Following Säfstrom (2013), we argue that given the issues mentioned earlier, it might be more fruitful – both for researchers and practitioners – to not look at partnership as realizing equality as such, but as searching for equality within a situation of inequality. What is crucial for family support programmes, then, is that professionals working within family support programmes not reduce parental involvement to an instrument for improving their 'assessment of eligibility' (Morris & Shepherd 2000, p. 170), or to an outcome that has to be realized (Roose *et al*. 2012b). Instead, they need to shift their focus to critically challenging the institutional context within which they work and that shapes their relationships with parents. To accomplish this task, previous research by Morris & Shepherd (2000) can be inspiring, yet, future research is needed to explore in more detail how the democratic character of partnership can be defined

 

not only on the level of the relationship between professionals and parents, but also on a socio-political level. From this perspective, it is necessary to regard the discussion on partnership with parents not merely as a methodological question (how to motivate parents to engage in a pre-structured process with well-defined objectives and methods?), but also as an inquiry into the democratic character of family support programmes and the democratic foundation of child and family care. This kind of research should contribute to the question of how professionals can be enabled to reflect on how interventions are and can be structured as well as support professionals in critically challenging their own role and the role families are/can be given in this. In addition, it seems important that future research builds on previous studies that explored parents' own views on child and family social work interventions (e.g. Corby *et al*. 1996; Spratt & Callan 2004; Palmer *et al*. 2006; Buckley *et al*. 2011) as this might be helpful to gain more insight into how parents experience the role of child and family professionals as well as into how parents define partnership.

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