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"It's our children!" Exploring intersectorial collaboration in family centres

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Abstract

Services providing support for children and families are often described as fragmented and more concerned with the boundaries of their fields of responsibility than collaborating with other sectors. To meet the need for greater collaboration, there is increased impetus for establishing interdisciplinary services, such as family centres. This paper presents the results of a qualitative study based on in-depth interviews and participant observation in 3 Norwegian family centres. The findings provide insight into central challenges in developing new practices within the field of family support; we discuss how intersectorial collaboration is constructed in relation to the core objectives of the family centre, professional competence, and service stability. This study demonstrates that both managers and professionals struggle with prioritizing intersectorial work, which mainly focuses on prevention and health promotion, over and above their traditional sectoral responsibilities. It also illustrates the necessity of articulating intersectorial collaboration as an explicit aim and exploring its implications and examining how this contributes to family centres building supportive communities. Building integrated services is not the ultimate goal of this particular form of service provision but rather the first step towards building interconnected support systems for all children in the community.

KEYWORDS

family centre, family support, integrated services, management structures

1 | INTRODUCTION

The increasing acceptance that the early years of life are crucial for a range of health and social outcomes across the life course (Irwin, Siddiqi, & Hertzman, 2007) has placed early child development and family support high on the political agenda globally. The development of young children is influenced by actions across a broad range of sectors, including health, nutrition, education, and labour (WHO, 2008). To be effective, services at all levels need to be better coordinated and to converge with families in a way that puts the child at the centre (Irwin et al., 2007). In spite of this, few countries have managed to implement the actions necessary to provide holistic early childhood development services (Daelmans et al., 2017).

The challenge of coordinating services is also apparent in the Norwegian context (Meld. St. 24, 2015–2016; Meld. st. nr. 26, 2014–2015). The services that provide support for children and families are fragmented, divided into different sectors that specialize in physical and mental health, education, social welfare or child welfare. Service providers' areas of expertise have developed over decades, resulting in a system in which the services are more concerned with policing the boundaries of their fields of responsibility than collaborating with services in other sectors (Willumsen & Ødegård, 2015). New public policies and legislation (Folkehelseloven, 2011; Helse- og omsorgstjenensteloven, 2011; Meld st. nr. 34, 2012–2013; Meld. st. nr. 26, 2014–2015) are challenging municipalities to break these patterns. Several Norwegian municipalities have chosen to organize family support services in family centres, co-locating services from different sectors. The co-location provides a multidisciplinary setting but does not necessarily provide integrated services or ensure interdisciplinary working. The aim of establishing the centres was to

provide holistic family support, through interdisciplinary collaboration across services and sectors requiring professionals and managers to rethink how they provide high-quality family support. Research on integrated services in Norway has primarily focused on two fields: integrated health care services (Grimsmo et al., 2016; Skråstad, 2014) and coordinated services for people with disabilities (Breimo, 2014; Eriksen, Andersen, & Askheim, 2006; Lundeby, 2008). Internationally, there is little research on how multiagency teams are changing their ways of working (Frost, Robinson, & Anning, 2005). Most studies describing the antecedents of interdisciplinary work have focused on practitioner's interactions and abilities and not on leadership (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005).

In this paper, we explore the practices and perspectives of professionals and service managers in three family centres. This study explores how intersectorial collaboration is constructed in the family centres and provides insights to the challenges and opportunities for developing new interdisciplinary practices within a particular organizational form for delivering family support.

1.1 | The family's house model

The family's house is the organizational form of the family centres included in this study. The family's houses are centres that provide interdisciplinary health and social services for children, adolescents, and their families living in a municipality. The first houses were established between 2002 and 2004 by the Norwegian Health Authorities as part of a pilot included in the national plan for advancing mental health care (Sosial- og helsedepartementet, 1998). The pilot was based on the Swedish family centre model and adapted to the Norwegian context (Thyrhaug, Vedeler, Martinussen, & Adolfsen, 2012). The pilot demonstrated that this model made more services available to families and that professionals experienced opportunities for greater flexibility and felt more professionally confident (Haugland, Rønning, & Lenschow, 2006). The health authorities recommended that the municipalities further explore the model, and a survey in 2012 found that nationally, 150 centres had been established (Gamst & Martinussen, 2012). The composition of the centres varied, including health care services for children, pregnancy care, child welfare services, pedagogical–psychological services and in a quarter of cases open kindergartens. Despite these differences, they all sought to provide an adequate level of support for families but in a holistic way (Adolfsen, Martinussen, Thyrhaug, & Vedeler, 2012), to promote well-being and good health amongst children, adolescents and their families, and to improve conditions for children and young people (Thyrhaug et al., 2012). In the latest family policy white paper, this model was described as a way to meet the need for coordinated and holistic family services (Meld. St. 24, 2015–2016). The term *Family's house* implies a tangible building but is also a metaphor for how the services are organized, connected, and situated.

Family centres are found in countries throughout the world, including Australia, New Zealand, the United States, Japan, France, Italy, Greece, Belgium, the Netherlands, England, Ireland, Sweden, Finland, and Norway (Bing, 2012; Busch, Van Stel, De Leeuw, Melhuish, & Schrijvers, 2013; Hoshi-Watanabe, Musatti, Rayna, & Vandenbroeck, 2015; Tunstill, Hughes, & Aldgate, 2007; Warren-Adams, 2001). The centres are diverse in the forms of support they offer and their organization. Hoshi-Watanabe et al. (2015) explored family centres in four different countries and found diverse cultural and socio-political contexts and rationales for their creation but shared similar ways of functioning. Family centres are found to provide informal meeting places for parents with young children and professionals (Hoshi-Watanabe et al., 2015; Lindskov, 2010). Both professionals and parents participating in activities in family centres highlight the significance of focusing on families' resources and listening to how they understand their own situation. This approach influences both parents' ability to build trust in professionals and also to position the professionals as able to support families both directly and by connecting them to other services (Bulling, 2016; Leese, 2016). From a professional perspective, the centres lower the threshold for interdisciplinary collaboration (Busch et al., 2013) although the potential for collaboration is not always fulfilled. Research has also shown that establishing a centre does not ensure that professionals will adopt new practices. In her study of a Swedish family centre, Hjortsjö (2006) concluded that the centre was not a unified organization and the professionals working in the centre were more concerned with their individual service rather than collaborating with professionals in other sectors. Leadership and management structures are to too little degree addressed in these studies, which lead us to include the service manager's perspectives in the analysis of the professional's interdisciplinary work for this paper.

2 | METHOD

The fieldwork took place in three Norwegian family centres and was approved by the Norwegian Social Science Data Services. The three sites one in a rural area, one in a small town, and one in a capital city district were chosen to maximize variation in the populations served. To ensure comparability, the centres invited to participate in this study met three inclusion criteria: (a) a minimum of three co-located services targeting children and families, (b) a formal setting for interdisciplinary collaboration, and (c) an open kindergarten. The fieldwork generated rich data including participant observation and interviews with both users and staff. For the purposes of this article however, we present the analysis of how the professionals and managers practice and understand interdisciplinary work across services and sectors and therefore have excluded data from interviews with the parents.

Inspired by grounded theory as a constructivist approach (Charmaz, 2014), analysis and data-generating interchanged throughout the study. The first author had access to the family centres and participated in their various activities, consultations, and meetings together with both professionals and families. The fieldwork was conducted in two stages. The first stage involved visiting each of the centres for eight to 10 working days, generating data through participatory observation and interviews to represent a wide variety of voices including service managers, professionals, caregivers, and children (Fangen, 2011). The second stage was a revisit to the three centres aiming to explicate the categories from the initial analysis, using theoretical sampling to decide whom to interview, which meetings to attend and what activities to observe (Charmaz, 2014). In addition to informal conversations and participatory observations, both service

managers and professionals from the services were interviewed during the first visit to each centre. Twenty individual interviews were conducted, 12 professionals and eight managers; in addition, nine focus group interviews took place, six with professionals and three with managers. This included all the service managers in the three centres. The sampling of professionals for the interviews were based on the participatory observation, aiming to provide a variation in experiences of interdisciplinary work, professions, and the services they worked in. The observations and interviews were documented using digital notes and audio recordings.

Writing memos and discussions with the co-author, colleagues, and subsequently participants in the study drove the initial analytical process. The emerging ideas and structures were organized using mind maps and became the foundation for the emerging concepts and the initial coding of both field notes and interviews. The first stage of the analysis revealed the tension between the core objectives and interdisciplinary work, and an interest in exploring the differences between the perspectives of managers and professionals. These interests shaped subsequent fieldwork in the centres to elaborate and refine the concepts (Charmaz, 2014). On the revisits, data were gathered through participant observation and interviews in all three centres, both individual (with two service managers and one professional) and in five focus groups (five with professionals and one with a team of service managers) sampling the groups of professionals least represented in the first stage of field work, public health nurses and physiotherapists.

The material was organized using NVivo 11 qualitative data analysis software (Qualitative Solution and Research International, 2015). The program provided a structure that enabled a common analytical framework, searching for commonalities and differences in the material revealing issues prevalent in all three centres. The analysis identified three main issues: (a) how competence was managed in the centres, (b) the challenge of balancing interdisciplinary work and core service objectives, and (c) the spotlight effect, illustrating the impact of leadership on shaping interdisciplinary practice in the centres.

3 | FINDINGS

Here, we present how the managers and the professionals in the family centres understand and practice their work across sectors, aiming to provide insights into their construction of intersectorial collaboration. We focus on three main issues: managing individual and collective competence, core objectives, and the spotlight effect.

3.1 | Managing individual and collective competence

The family centres included different professionals such as public health nurses, physiotherapists, special education teachers, kindergarten teachers, and psychologists. Many of them held specific qualifications such as family therapy, nutrition, trauma, or specialization in parent training programs. Service managers and professionals were concerned with how these resources should be used in a way that not only worked across services and sectors but was also interdisciplinary.

The three centres in this study all included services that belonged to different sectors in the public service system, the health sector, education sector, and the child welfare sector (Table 1). Each sector has specific legislations, regulating their mandate and mandatory assignments. The services included in the centre differed, FC1 was the only one that did not include child welfare services, and FC2 included mental health services. Although all three centres in this study were defined as a part of the public services in the municipality, only one of them (FC3) was defined as a unit within the municipality's organizational map. Thus, this centre had a budget post and a director with the authority to make decisions on behalf of the centre as a whole. The director led a team of managers, each in charge of a service within the centre. The other two centres, FC1 and FC2, did not have a director and were led by teams of service managers. The teams had a flat structure and lead by consensus. These centres did not operate with a common budget. There was a significant difference between the centre with a director and the centres led by the service manager team when it came to the flexibility of the use of the centres resources. The director of FC3 held monthly meetings with the service managers focusing on their assignments in relation to economics and available competence, establishing common accountability and where necessary redistributing resources within the centre.

In the two centres without a director, the resources in the centres were perceived to be the individual responsibility of the relevant service managers. However, this was an area several of the service managers felt that they fell short. One of them explained, "I do not think we have fulfilled

TABLE 1 Management structures in the family centres

				Health sector	Education sector	Child welfare sector
Family centre 1 (FC1)		Team of service managers	Children and family*	X		
			Psychological pedagogical services		X	
			Child welfare services			X
Family centre 2 (FC2)		Team of service managers	Health care services for children	X		
			Psychological pedagogy services		X	
			Child welfare services			X
			Mental health	X		
Family centre 3 (FC3)	Director	Team of service managers	Health care services for children	X		
			Special pedagogical help		X	
			Physiotherapy and occupational therapy	X		
			Family projects**		X	

Note. St.dev = standard deviation.

*The service consists of health care services for children and psychological pedagogy services.

**Focuses on integration and Norwegian language training.

the expectations of leadership held by our employees. I especially think about our inability to utilise the competence and commitment we have around us" (Manager FC2). For these centres, some service managers felt that the capacity to take a holistic perspective about the centre's collective competence was undermined by the way the centres were organized.

Competence was understood in different ways by the service managers. Some talked about competence as a skill held by an individual primarily gained through formal education or training. The managers who talked about competence in this way did not favour interdisciplinary teams as a way of delivering services but rather so referral to other areas as the way to provide services. "Why do we need a [interdisciplinary] team, if we know where the door [to the other services] is?" (Manager FC2). These managers were concerned that collaboration, which was time-consuming, undermined the delivery of services. Instead, they wanted their employees to collaborate across sectors only when it was useful and efficient and typically using referral rather than through interdisciplinary working. The manager team in FC1 described the centres mainly as "a setting to distribute information and develop common routines" (Manager FC1) rather than a setting to engender interdisciplinary working. Other managers talked about competence mainly as something the professionals developed over time through interaction with each other. They saw interdisciplinary work across services as an opportunity to build a collective competence that amounted to more than the aggregate of individual competences. "They need time, working like this [in an interdisciplinary team] is almost an education in interdisciplinary work, they have developed a way to work with families that feeds back to the other services in the centre" (Manager FC1). These two different ways of viewing competence were also apparent in how they planned competence development; some argued to prioritize individual qualifications, whereas others argued to focus on competence development as a collective process.

The team of service managers in FC2 spent a lot of time debating how to prioritize the further development of the centre's activity. They often referred to the professionals as "yours" or "mine," signalling which service and sector they belonged to. One example of this was a physiologist that used to be defined as a common resource in the centre, but was now "pulled back" and placed in a regular position within the ordinary service. "I am responsible for her, she is under my jurisdiction, so I had to be sure I could justify how we used her" (Service Manager FC2). The other service managers disagreed with this decision but had no way of stopping it happening. These ongoing discussions were seen as valuable by the service managers as they provided them with insights into the other services in the centre. Even though the discussions were seen as valuable, one service manager stated on several occasions that she thought the centre would have been better off if there had been a director. Because none of the service managers held the authority to make a decision on behalf of the centre as a whole, it was difficult to find resources for interdisciplinary collaboration and development of common holistic practice across services. The tension between the different views on interdisciplinary collaboration resulted in interesting discussions, but because they needed consensus to decide a way forward, they often chose to do more of what they were already doing.

The intersectorial work in the centres was described by many professionals as "a balancing trick" that involved trying to find a way to be both confident in their own competence and open to the perspectives of other professionals. The professionals with experience of working in teams saw teamwork as an opportunity to broaden their experience. Working together over time, the professionals developed a common competence, a foundation for their work with the families. Even though they saw this common foundation as a strength, they were apprehensive about becoming generalists; there was a fear of this constraining innovation. This was also a concern expressed by some of the service managers. Diversity was seen as key resource; if everyone brought the same perspectives to discussions, then the collaboration lost momentum. Some of the professionals who had been working in the system for many years held a broad competence that reflected far more than their formal education. However, they were very attentive to being overconfident and working beyond their area. "I have to remember I am here with my special education hat on; that is the area I am supposed to take care of" (Professional FC3).

3.2 | The core objectives

The professionals and the service managers seemed to divide the work in the centres into two types of tasks, intersectorial collaboration and what they described as *the core objectives*. They saw intersectorial collaboration as crucial for developing a high-quality family support service. At the same time, this part of their work was under constant pressure of being squeezed out. One of the professionals working in the children's health care service said, "We have no choice; we have to do our real tasks first. They are statutory, not optional" (Professional FC1).

The service managers in all three centres found balancing the core objectives and the intersectorial collaboration challenging. Both service managers and professionals described prioritizing core objectives, the part of their work that was defined by legislation and guidelines with specific reporting requirements and deadlines. If they did not fulfil these requirements, they were considered to be in breach of their duty. Health promotion work across sectors were also a part of their mandates defined by national policy. Still, there were no regulations or guidelines that defined how these policies should be implemented in practice, and there was no system to evaluate if the municipalities met these requirements. Exploring the intersectorial collaboration, we found four main types of collaboration (Figure 1): family support interventions, system-oriented teams, family-oriented teams, and informal collaboration. The four types were present but differently stressed and developed in all three family centres.

FC1 had an intersectorial team that worked with families with preschool children to help them find ways to tackle their challenges before their issues grew too large. The team, which had been functioning for a decade, had stable resources and was well known in the municipality. In addition to this, the service managers now wanted to establish family support interventions that were not related to a specific target group but could be used by the different services in the centre. Even though the service managers agreed that this was a good idea and had undertaken extensive discussions it had not yet been implemented. The imbalance in the level of regulation between the core objectives and the intersectorial work seemed to make it difficult for the services managers to make decisions favouring the latter

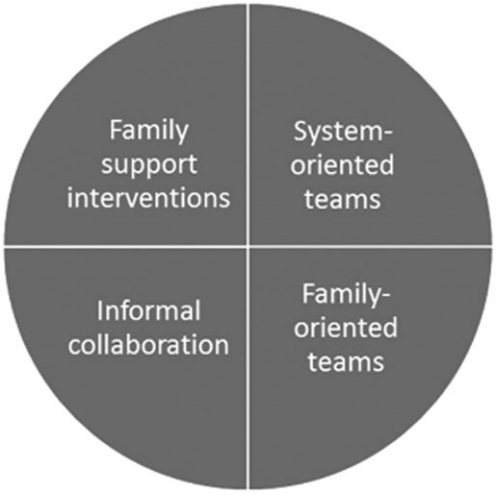

FIGURE 1 Four types of intersectorial collaboration practiced in the family centres

approach. In addition, several of the professionals lacked motivation to alter their own practice.

Another example of this challenge was apparent in a discussion between two service managers in FC2 who wanted to initiate a universal intervention in the public schools to promote children's mental health. The intervention would require efforts from professionals in the two sectors and schoolteachers throughout the municipality. The two service managers both saw this intervention as relevant to their mandates, but it would require moving resources. One of them was very enthusiastic about the idea, whereas the other one was more reserved. It was mainly the timeline that they did not agree upon, as one wanted to start right away but the other did not see how that would be possible.

Collaboration across sectors was understood, by many of the professionals, as something that came on top of their existing workload. The professionals were torn between fulfilling the legally required tasks described in strict guidelines and the less distinct areas described in their mandates. A public health nurse described how they were striving to meet conflicting expectations:

> *We go a bit outside of our mandate—well, not our mandate, but the guidelines. We are starting these guidance groups, and we believe that to be a strength for the parents. However, they are constantly adding more tasks to our "not optional" list. It does not add up. (Professional FC2)*

Several of the professionals perceived the guidelines as a job description rather than viewing their work to a broader mandate. Several of the service managers talked about the need for a different perspective. Inspiring the title of this article, one service manager said her dream was that all the services working with children and their families would join forces and take shared responsibility for all children, rather than focusing on individual cases. "We need to think about all the children in our municipality. It's our children. We need to see everything in relation to them" (Service Manager FC1). A service manager in FC3 argued that now was the time to reinterpret the mandates.

> *We need to use our position to look at our assignments, redefine them, how we think about them, and how we distribute them. What we should do in a centre like this is to look at how we can solve the tasks together. (Service Manager FC3)*

Some of the professionals defined intersectorial collaboration as a vital part of their job and a primary motivation for working in the centre. They saw the short communication lines between the different services as an opportunity to provide support for the families at an early stage, thereby preventing escalation. "I think we can replace some of the individual work, where we often meet one child and a parent, with group sessions. I even think it might be better in some cases" (Professional FC2). Even though they saw this as an important part of their work, they often felt that their efforts in this area were not valued as much as the core tasks.

> *If someone, for example, takes a leave of absence, we become short-staffed. Then the cut is always taken from the resources assigned to the interdisciplinary prevention work. It could have been the other way around. (Professional FC1)*

3.3 | The spotlight effect

Both managers and professionals were concerned with the challenge of keeping momentum for their intersectorial collaboration. Simply establishing routines, teams, and interventions was insufficient, as such structures could easily erode over time. Exploring the collaboration across sectors within the centres, we found a spotlight effect (Figure 2). This effect was created by service managers focusing on one specific type of collaboration by initiating projects, arranging seminars or allocating new resources. The spotlight focuses attention on a particular issue or area thereby encouraging intersectorial working, where the professionals work together to solve an issue or develop a service. At the centre of the collaboration was the families' perspectives. The professionals were constantly considering how their own

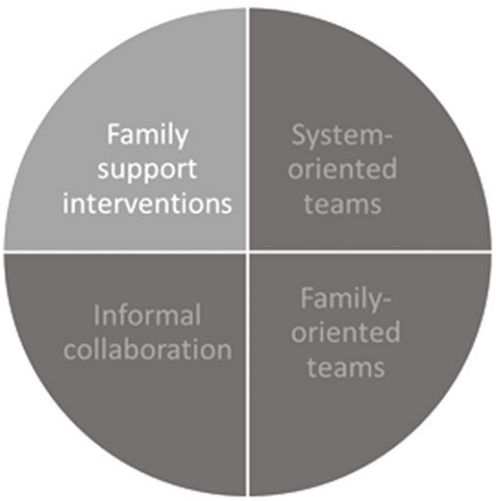

FIGURE 2 The spotlight effect [Colour figure can be viewed at wileyonlinelibrary.com]

competence could be a resource as part of holistic approach rather than asserting single competing sectoral perspectives. "This is what makes my job interesting, to be allowed to contribute with my ideas, and to see them develop" (Professional FC1). The structure of the centres, where services from different sectors were brought together to support families, provided the professionals with a frame that made sense to them.

The service managers seemed to be able to create change by agreeing an area to light up. In one of the centres, the team of service managers devoted significant resources to develop parent training programs. Teams consisting of professionals from different sectors in the centre were brought together in pairs to lead the programs making it possible for the centre to offer a wide range of interventions supporting parents in the municipality. The service manager of the child welfare services in the centre explained,

> *I am proud of the development of the different family support actions we have managed to establish together. I am convinced that we could not have done this alone, especially when it comes to the efforts directed towards parents. This has been made possible by collectively prioritising competence development, both by selecting the same programs and implementing them together. (Manager FC2)*

The challenge lay in what happened outside spotlight. When the service managers steered the light to one type of intersectorial collaboration others were left in the dark. The opportunity cost of prioritizing family support interventions meant less focus on the overall system in the centre. This pattern was apparent in all three centres. When one type of intersectorial collaboration was highlighted, the other three types of collaboration became less functional, and established routines and practices eroded. One example was a family-oriented team that had not held a single meeting for 6 months; meetings were cancelled due to low participation and a lack of referred cases. When asked about the meetings, the professionals explained that although they were useful, they could not find the time or that they tended to conflict with other obligatory meetings. The service managers confirmed that they had not discussed the importance of these meetings for a long time.

It seemed to be easier to set the spotlight on formal settings for collaboration rather than informal collaborative efforts. Informal collaboration was considered an important part of interdisciplinary work, but the professionals varied in recognizing that co-location provided greater opportunities for this form of collaboration. The teams of service managers in all three centres emphasized that informal collaboration was vital for ensuring high-quality services. They attempted to bring the sectors closer together through arranging coffee meetings and organizing development programs although this had little impact on practice. Instead, informal collaboration was far more dependent on individual initiative.

Observing the professionals at work revealed significant individual differences in commitment to collaboration across sectors. Having interdisciplinary collaboration when defined as a part of one's job, such as belonging to an interdisciplinary team, seemed to promote broader informal interdisciplinary collaboration. Formal collaboration provided professionals with a network of colleagues from other sectors and a common language across sectors. This enabled professionals to draw on informal contacts with other services and to communicate more precisely about families' challenges and possible solutions.

4 | DISCUSSION

The findings show the importance of both leadership and management structures in facilitating collaborative interdisciplinary practice when different services are co-located. Lacking a centre director and a common budget, it was challenging to achieve the potential of interdisciplinary working promised by co-locating family support services. The flat structured service manager teams became discussion groups rather than enacting a collective strategy. This managerial form relied on consensus to make changes, which was challenged by substantial differences in commitment to collaboration between the different services. The service managers were primarily accountable for the tasks defined for their sector, thus prioritizing these core objectives above interdisciplinary activity. If new proposals for interdisciplinary collaboration were not compatible with their interpretation of their sectoral mandate, they were inclined to refuse to participate. Without clear leadership professional's ability to take initiative in collaboration across sectors, both formal and informal was limited. This was contrasted with the approach in the team of sector managers led by a director, who held the authority to make decisions. In this team, all the participants were expected to contribute to the development of the centre, whether such activities fell within or beyond their sector. The result was that the sector managers felt accountable for the collective service delivery from the centre rather than clinging to their own sectoral responsibilities.

These conflicting perspectives in the flat structured team can be seen as an expression of the absence of an agreed conception of the centre's aim and the relevance of service integration. The importance of addressing such concerns is highlighted by Boston and Gill (2011) in considering accountability in working across organizational boundaries. They illustrate the different degrees of integration using a model defining a continuum from co-existence to full collaboration. The highest level of collaboration is defined by characteristics such as shared responsibility, shared practice, and having a common goal. They argue that a key design issue for work across organizational boundaries is intensity and that this has to be related to consideration of scope. They define scope as having seven dimensions: duration, focus, societal reach, vertical reach, horizontal reach, breadth, and orientation and purpose. Discussions about these factors in the centres were rare according to the professionals' accounts. In the *Family's House Model* (Adolfsen et al., 2012), such discussions are considered essential to constructing the house's foundations, a necessary prerequisite for a sturdy house. If the purpose of the collaboration is to align activities to ensure that they do not conflict, this requires a lower level of intensity than simply developing new shared practices. The service included in the centres are from different sectors each of which is strictly regulated by legislation. There is a risk that such requirement

undermine the reflexivity about professional practice that creates opportunities for change.

Professionals working in interdisciplinary settings valued the multivoicedness of discussions. In line with the findings of a study of multidisciplinary teams working with children and families in the UK, professionals in our study seem to experience a culture that contained difference (Frost et al., 2005). Engeström (2001) highlights the need to negotiate a shared objective for a group's common activity while at the same time acknowledging particular activity systems related to the individual sectors. Through keeping the connection to their sector but transforming their objectives, an opportunity to develop new practices is created. Engeström frames development of new interdisciplinary practices as a collective learning process, using the term *expansive learning*.

> *In expansive learning, learners learn something that is not yet there. In other words, the learners construct a new object and concept for their collective activity, and implement this new object and concept in practice. (Engeström, 2010)*

Establishing family centres represents a policy shift promoting more collaborative and shared practice and less emphasis on core objectives and require that the professionals take part in constructing a new object for their collective activity. Dedicated time together is essential for expansive learning and thus dependent on both service managers and professionals believing in the creative potential that lies in collaboration across sectors. In these processes, it is important that everyone is equally involved in the discussion (Frost et al., 2005), to define the object of the common activity and potential solutions (Engeström, 2001). Framing intersectorial collaboration as a learning process may establish an interdependency (D'Amour et al., 2005) that motivates participants to prioritize this aspect of their work.

In the spotlight, the collaboration across services being highlighted by the service managers, there seemed to be a consensus on both the scope and intensity of the activity. Highlighting the collaboration formalizes this type of work and defines who should contribute and to what extent. This seemed to redefine the responsibility for engaging in intersectorial collaboration from an individual to shared responsibility, thus moving the activity towards collaboration on the continuum of integration. The consensus in the spotlight contrasts with the dissent in the "shadows." If the service managers did not follow up the interdisciplinary collaboration across services, it became devalued as part of professionals practice, less important than the clearly defined core objectives. When service managers prioritize some sectors and activities, there are opportunity costs (Drummond, Schulpter, Claxton, Stoddart, & Torrance, 2015), resulting in some aspects of the centres having less functional strategies for intersectorial collaboration. It is not plausible for all of a centre's activities to be spotlighted all the time. Still, it is important that the service managers know the consequences of focusing on one area and consider the implications of not only where but also when to move the spotlight.

The professionals that had collaborated in interdisciplinary teams for a long time described moving beyond coordinating their efforts with colleagues to developing new shared practices. Although being confident that the new practice was valuable, professionals were apprehensive about balancing the development of a common competence and still preserving their distinct approaches. Keeping their professional affiliation to their services was important for retaining competence in their fields. Engeström's (2001) theory of inter-organizational learning, the third-generation activity theory, might contribute to the understanding such processes. He suggests that different activity systems, here understood as the sectors within the centres, can work together to develop a new practice without denying or changing the activity system or sector. In this theory, the contradictions in a group, here represented by the different perspectives on family support, are seen as the driving force behind the development of new practices.

5 | IMPLICATIONS FOR PRACTICE

This study provides insights into the construction of intersectorial collaboration in family centres and is relevant for municipalities considering establishing such organizations, actors working in family centres, and other practitioners and service managers involved in joint work across organizational and sectoral boundaries. The results of this study emphasize the necessity of articulating the aim of intersectorial collaboration and exploring its implications. In this paper, we suggest reframing intersectorial collaboration from a problem solving approach to a form of collective learning. In framing collaboration as a learning process where none of the participants has a monopoly on the answers redressing existing professional hierarchies. The process of negotiating shared objectives may construct a setting in which the participants are interdependent and diversity in competence is valued, thus making the setting equally useful for all participants and strengthening its resilience and durability.

There is also a need to address the leadership and management structures in family centres. The absence of a centre director may undermine the opportunity to develop innovative and holistic interdisciplinary practice.

This study shows that both service managers and professionals struggle with the dilemma of prioritizing intersectorial work above traditional activities, a pattern that compromises the potential of both preventative and health promotion activities. We suggest three questions that might be useful for structuring such activities in a new way: Which parts of a sector's mandate are best delivered solely with resources from that sector? Which mandates can benefit from developing shared practice and pooled competencies and resources? Which challenges are not addressed through attention to core tasks? Answering these questions requires viewing services in a holistic context in which the centre is situated, involving other public services as well as the voluntary sector in taking part in a shared responsibility for all children (Daro, 2016). Thus, building integrated services within the centre walls is not the goal. It is the first step towards building interconnected support systems for all the children in the community, where the adults from a range of sectors and disciplines hold shared responsibility for creating a supportive environment for all children.

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