Accessible family support in the bilingual Brussels-Capital region for future parents and parents with young children

SUMMARY

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1 Introduction

The bilingual Brussels-Capital region[1] faces challenges in several areas. The demographic situation is marked by, among other developments, an increase in the number of births and a growing diversity in terms of language, culture and socio-economic status (e.g. disadvantage, education and employment rates). Two babies are born in Brussels roughly every hour and 41.5% of Brussels' children are born into a family whose income is below the poverty line (e.g. Guio & Vandenbroucke, 2018). As far as family support is concerned, parents, professionals in the field, policymakers and researchers observe that not all parents are able to find or access family support initiatives easily (e.g. Vandenbroeck & Bauters, 2016). In addition to this initial uptake of support, progression to other family support initiatives is not always optimal.

To identify and understand these obstacles to the uptake of and progression to other Dutch-language family support initiatives in Brussels, including the clinics of the agency Kind en Gezin (Child & Family) and the non-profit organisation Huis van het Kind-Ket in Brussels in particular, and to identify possibilities or conditions for lowering or eliminating these obstacles, the Flemish Community Commission (VGC) funded the research project *'Integrated family support for current and future parents and their young children in Brussels'.*

This research project, which started on 1 June 2018, focuses on future parents, parents with young children and professionals in the field in Brussels. We asked them about their experiences, expectations and challenges with regard to family support initiatives. We also analysed statistical and textual sources to gain a more detailed understanding of the demographic and organisational situation in Brussels and of the developments and challenges facing preventive family support (PFS).

We would like to thank the current and future parents and professionals who took part in our research for sharing their experiences and expectations. We would also like to thank Luc Dekeyser, Sara Mouton, Evelyne Dirix and Daisy Flossy from the VGC, Wouter Boeckmans, advisor to former VGC board member Bianca Debaets, and Pepijn Hanssens, advisor to the chair of the board Elke Van den Brandt, for their contribution and feedback throughout the project. Special thanks also go to the students and volunteers who helped to recruit parents, to translate the research instruments and to transcribe the interviews.

The project culminated in a report, in which the research design and the findings from the survey among parents (the quantitative research element) and from the survey of the professional field (the qualitative research element) are described in detail (Vandewaerde, Fagardo, Nys & Emmery, 2019). In this summary, we briefly outline the research design and context (Chapter 2) and discuss the key findings and recommendations (Chapter 3). The resulting recommendations are presented in the shaded text boxes. In the final chapter of this summary (Chapter 4), we translate the findings and recommendations into a plan of action. This plan of action is one possible strategy to increase the uptake of and progression to other preventive family support initiatives.

[1] To improve readability, throughout this report we use the term 'Brussels' for 'the bilingual Brussels-Capital region'.

2 Research design and context

2.1 Research methods and sources

In this three-part study (see Diagram 1), we carried out a context analysis on the basis of statistical and textual sources. We conducted a quantitative study to learn more about the views of Brussels' future parents and parents with young children (between 0 and 6 years old)[2]. We did this using a questionnaire which we distributed online and also completed with parents face-to-face – in Dutch, French and English. We asked them about their use, needs and wishes or expectations regarding the content and the practical and organisational aspects of family support initiatives.

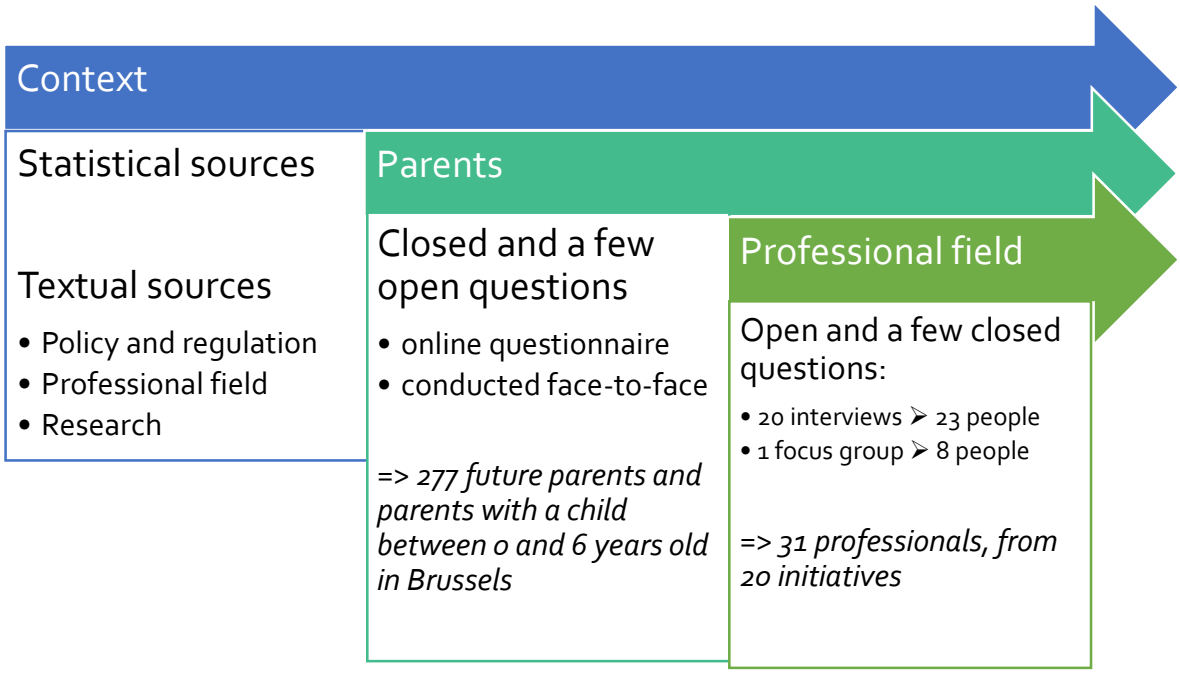


Diagram 1: Research methods and sources

We also interviewed a wide range of professionals who are active in or affiliated with preventive family support in Brussels. This was a qualitative survey in which we inquired, via semi-structured interviews and a focus group, about the experiences and views of professionals on the uptake of (i.e. accessibility of) family support and progression to other initiatives by parents.

2.2 The demographics of Brussels

Current population growth in Brussels is strongly influenced by two factors: (1) natural growth and (2) net international migration. In 2017, 17,709 children were born (Nolf et al., 2019) and net international migration was 12,580. In 2019, there were 51,883 children under the age of three in Brussels. For the period up to 2025, studies offer various forecasts for the number of children under the age of 3 (ranging from 54,630 to 59,227) (Delhaibe et al., 2016; Vandenbroeck & Bauters, 2016; BISA, 2019). However, they all point to an increase in the number of young children. According to the

[2] From now on, we use the terms 'parents' and 'future parents and parents with young children' interchangeably. 'Parents' refers to both 'future parents' and 'parents with young children'.

most recent data, this increase will be less than initially expected (e.g. België in cijfers/Belgium in figures, 2019a).

Families in Brussels are extremely diverse. This diversity is evident in various areas and poses particular challenges for services, organisations and policy.

(1) Family composition: 10.2% of Brussels households are single-parent families with resident children (Nolf et al., 2019). In 2015, 19.4% of Brussels children were born to a single mother (Hercot et al., 2015). The majority of single mothers without work live below the at-risk-of-poverty line (Nolf et al., 2019).

(2) Migration background: 35% of Brussels residents are of foreign nationality and 57% are born with a nationality other than Belgian. In 2016, 71.4% of Brussels residents had a first- or second-generation migration background (Nolf et al., 2019; BISA 2018).

(3) Known and spoken language(s) (including at home): The 2018 language barometer shows that French is still the best-known language (87.1%) and that knowledge of Dutch continues to decline (from 33.3% in 2001 to 16.3% in 2018). Among 18-30 year olds, knowledge of other 'foreign' languages (regardless of whether they also speak French), is common. In terms of the language spoken at home, French is the most common, either in combination with a 'foreign' language (37.6%) or as the only language spoken at home (29.7%). Among 18-30 year olds, Dutch as the only language spoken at home has increased to 20.6% in the last five years, while the combination of Dutch and French decreased to 15.6% (Janssens 2018 in Nolf et al., 2019).

(4) Poverty and child poverty: Brussels residents have the lowest average net taxable income per year in Belgium (€13,980) and 30% to 37% live below the at-risk-of-poverty line (BISA, 2018; Health and Social Observatory, 2018a). In 2017, 41.5% of Brussels children were born into a family whose income was below the at-risk-of-poverty line (Guio & Vandenbroucke, 2018). In 2015, 20.6% of Brussels children were born into a family where the parent(s) had no income from work (Verduyckt, 2019). 23% of 0-17 year olds grow up in a family where there is no income from work (Health and Social Observatory, 2018a). The disadvantage index for the bilingual Brussels-Capital region was 28% in 2018 compared to 14.1% in the Flemish region (Kind & Gezin, 2019)[3]. In other words, in that year more than a quarter of Brussels children were born into a disadvantaged family.

(5) Municipalities and neighbourhoods: the impact of population growth and the above-mentioned challenges play a more pronounced role in some municipalities of Brussels than in others. In addition, there is considerable diversity between neighbourhoods within the municipalities. For example, there is a 'poor crescent' in Brussels. This consists of the poorest neighbourhoods around the north-western side of the city centre (Brussels-Capital Health and Social Observatory, 2018a).

The factors discussed above are not independent of each other and they are connected to several other issues, each with its own challenges (e.g. employment, housing, health, education, etc.). A commitment to increasing the uptake of and progression to other preventive family support initiatives is one way to strengthen families and improve the prospects of parents and children. This brings us to the Brussels Action Plan to Combat Poverty 2014-2019, in which increasing the accessibility of Dutch-language preventive family support provision is mentioned as one of the measures.

The following section outlines the core elements of preventive family support, of the non-profit organisation Huis van het Kind-Ket in Brussels and of clinic activities.

[3] In Flanders, the disadvantage index is calculated as the ratio between the number of disadvantaged children and the total number of children. In Brussels, this index represents the ratio between the number of disadvantaged children and the number of children who received at least one home visit from or a consultation with K&G.

2.3 Preventive family support

The Brussels Action Plan to Combat Poverty 2014-2019 provides a framework for improving the range of preventive family support. This framework aims to promote the well-being of families with children and young people, and of children and young people in terms of well-being and health.

The development of PFS provision is partly shaped by the Flemish decree on the organisation of preventive family support (2013). The key elements of the decree and its roll-out are important for the initiatives that have been launched in Brussels by the Flemish government and the VGC.

The aim of this plan is to provide a multidisciplinary, coordinated, complementary, integrated, non-overlapping, targeted and effective range of services, while ensuring that all parents, and in particular vulnerable parents, can access them (according to the principle of proportional universalism) (Brussels-Capital Health and Social Observatory, 2018b). The range of services covers various areas (e.g. health, development and parenting, education) and focuses on the promotion and support of social, informal networks, on the early detection and monitoring of and/or referral for risks or problems concerning health, development, parenting and education and on the strengthening of vulnerable future parents and parents with young children. It is partly because of the importance of 'early' support (pre- and postnatal) for this group of families that this research focuses on the partnership between the non-profit organisation Huis van het Kind-Ket in Brussels and the Kind & Gezin clinics, among other partners.

2.3.1 Huizen van het Kind

A Huis van het Kind (HvhK; House of the Child) is a local partnership that combines, physically or otherwise, services offered by various actors who come together to provide preventive family support. Each HvhK must cooperate with the **local authority**. In Brussels there are 19 municipalities and the VGC assumes the role of local authority as a supra-local organiser.

In Brussels, it was decided to have a single overarching Huis van het Kind: Het Huis van het Kind-Ket in Brussels, a non-profit organisation. Since 2017, this non-profit association has grown out of the Brussels-wide and cross-sector collaboration of Dutch-language organisations in the broad family sector in Brussels. The local activities take place within eight Local Family Support Networks (LFSNs): (1) City of Brussels, (2) Sint-Jans-Molenbeek and Koekelberg, (3) Jette, Ganshoren and Sint-Agatha-Berchem, (4) Anderlecht, (5) Schaerbeek, Evere and Sint-Joost-ten-Node, (6) Saint-Gilles, Ukkel and Vorst, (7) Elsene and Etterbeek, and (8) Oudergem, Watermaal-Bosvoorde, Sint Pieters-Woluwe and Sint-Lambrechts-Woluwe (Health and Social Observatory, 2018a). These LFSNs are supported by network supporters who are employed by the HvhK-Ket in Brussels

Since the start of these collaborations, the number of actors actively involved has expanded and diversified enormously (including childcare initiatives, walk-in teams, community health centres, clinics and many other actors from different fields).

These joint ventures, or LFSNs, are developing at *'different speeds'*. Some are currently still being developed, others' activities are highly coordinated, and some are working closely together or engaged in co-creation projects. Initially, the emphasis was on forming networks. At the instigation of and with financial support from the VGC, three physical locations were created (HvhK Noord, HvhK Nieuwland, HvhK VUB Jette) and a fourth one is in the pipeline (HvhK Anderlecht). Several partners and their services are brought under one roof at these locations.

2.3.2 Clinic activities of Kind en Gezin (Child & Family)

Clinics focus on preventive care in terms of well-being and physical and psychosocial health. They welcome families and provide them with information and advice (Huis van het Kind, 2012; Vandenbroeck & Bauters, 2016).

The new Decree of the Flemish Government on the recognition and subsidisation of clinics and the recognition of clinic physicians came into force on 1 January 2019. This increases the range of services offered by the clinics and broadens their scope. They must provide preventive medical, psychosocial or pedagogical consultations or counselling '*for future parents and children between the ages of 0 and 3 or up to school age and their families*.' (Art. 1). However, a similar decree for Brussels is yet to be drawn up.

Focusing on Brussels, the scope of clinics supported and subsidised by K&G has narrowed in recent years (including in comparison with Flanders). The non-utilisation of clinics is higher in Brussels than in Flanders: 21.7% compared to 8.1% respectively (Humblet et al., 2015 and Kind en Gezin, 2015 in Vandenbroeck & Bauters, 2016). In addition, higher educated people are overrepresented at Dutch-language clinics. Two of K&G's 22 clinics were closed on 1 January 2019. This brings the number of clinics to 20. By way of comparison, the Office de la Naissance et de l'Enfance (ONE) has 80 (Sociaal Brussel, 2018).

To date, there is a lack of information regarding parents' decisions to use clinics or not (in particular K&G and ONE clinics). Various sources point towards accessibility, in particular availability convenience and geographical distribution (Humblet et al., 2015 and Kind en Gezin, 2015, in Vandenbroeck & Bauters, 2016).

3 Research findings

3.1 Characteristics of the respondents

The diagram below gives an overview of the characteristics of the parents and of the professionals in the field who took part in this study.

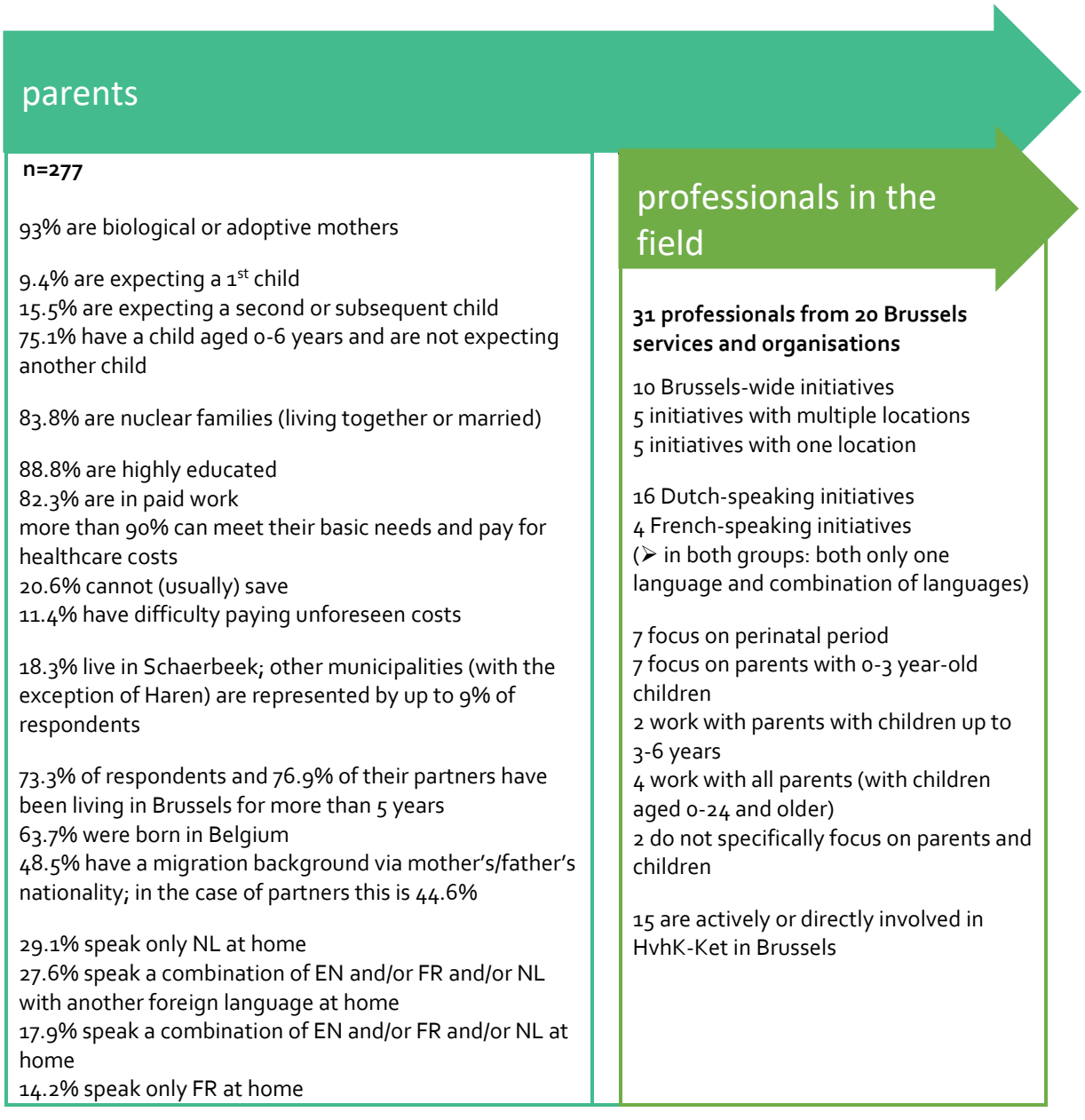


Diagram 2: Characteristics of the groups of respondents

To recruit **parents** to take part in our research, we used a wide variety of channels (flyers, information letters, online, face-to-face in public places, via professionals in the field). We also used various approaches to conduct the survey: online and face-to-face (e.g. at services and organisations, in public places such as markets and shopping centres). Due to the short duration of the study, the survey period was limited. This imposed restrictions on the composition and size of the group of respondents.

If we look at the parents' characteristics, we can see that, despite the use of a wide variety of recruitment strategies (see above), the most vulnerable parents (i.e. those with a low level of education, jobseekers, parents experiencing financial hardship, etc.) are not represented as well as expected if we consider the figures for Brussels. We were able to pinpoint the views of these families to some extent through our questions for professionals in the field. Most of these professionals have frequent direct contact with vulnerable parents in Brussels and are aware of their environment, their experiences, their needs and their requirements for support. When translating our findings into recommendations, we took into account both the information collected directly and indirectly and the insights from other studies into the perceptions and need of vulnerable parents. This meant that we were able to draw up a plan of action that is tailored to the large diversity of future parents in Brussels.

3.2 Accessibility of support initiatives

The seven Bs provide a useful framework for visualising the factors that can promote or hinder parents' uptake of and progression to other support services. The seven Bs (in Dutch) are: bekendheid, begrijpbaarheid, bruikbaarheid, betrouwbaarheid, beschikbaarheid, bereikbaarheid, and betaalbaarheid (in English: awareness, understanding, usefulness, reliability, availability, convenience, and affordability) (e.g. Coussée, Roets, Bouverne-De Bie, & Vettenburg, 2011; Hubeau & Parmentier, 1991; Schouppe, De Visscher, & Van de Walle, 2014). Some of the Bs – especially bekendheid (awareness) and begrijpbaarheid (understanding) – are closely related to each other. Activities to raise awareness of initiatives must be understandable and comprehensible. Bereikbaarheid (convenience) and beschikbaarheid (availability) are also related. As a result, the following discussion of the findings and recommendations includes an element of overlap and internal references to previous and subsequent points.

We would like to point out that we did not ask in detail about all the accessibility factors for all of the PFS initiatives (to limit the amount of time needed to complete and explain the survey). Moreover, given the relatively small user group for these initiatives (see section 3.2.1.2), we would not have been in a position to formulate substantiated conclusions about them. We did, however, ask in detail about the accessibility factors for the clinics and these factors are described in more detail.

3.2.1 Awareness and use of formal and informal sources of support

3.2.1.1 Importance of informal networks

The **informal network** is a valuable source of support for the majority of parents: 84.3% discuss parenthood and child-rearing often or very often with people from their immediate circle. For 77.4%, someone from their immediate circle acts as a source of support when it comes to parenthood and child-rearing. In addition, three-quarters of parents consider the informal network to be an ideal channel for receiving information about aid and support initiatives: 55.5% named this as the most important channel; for 20.2% it was the second most important channel.

3.2.1.2 Awareness and use of formal sources of support

Formal support initiatives can play a role both for parents with a limited informal support network and for parents with a more extensive informal network. They open doors to new informal relationships, they provide parents with more practical support (e.g. information, advice, practical, material or emotional support, etc.) and/or they refer parents to other (more appropriate) support initiatives (i.e. progression). When it comes to referrals, professionals in the field play a key role – provided that the field is aware of relevant initiatives.

Professionals in the field report that there is a lack of awareness both among the user group of parents, especially vulnerable parents, and among other professionals. This has repercussions for the uptake of and progression to other preventive family support initiatives. For example, the Dutch-language PFS initiatives surveyed indicated that they are aware of each other's services, but do not have an overall picture of services provided throughout Brussels. They especially know very little about initiatives in associated areas, small-scale initiatives, temporary initiatives and French-language services and support. The professionals attribute the lack of knowledge about French-language services to the fact that the Dutch-language and the French-language services are two distinct sets of separately operating PFS services, each with their own network. French-speaking professionals surveyed as part of our research confirmed this.

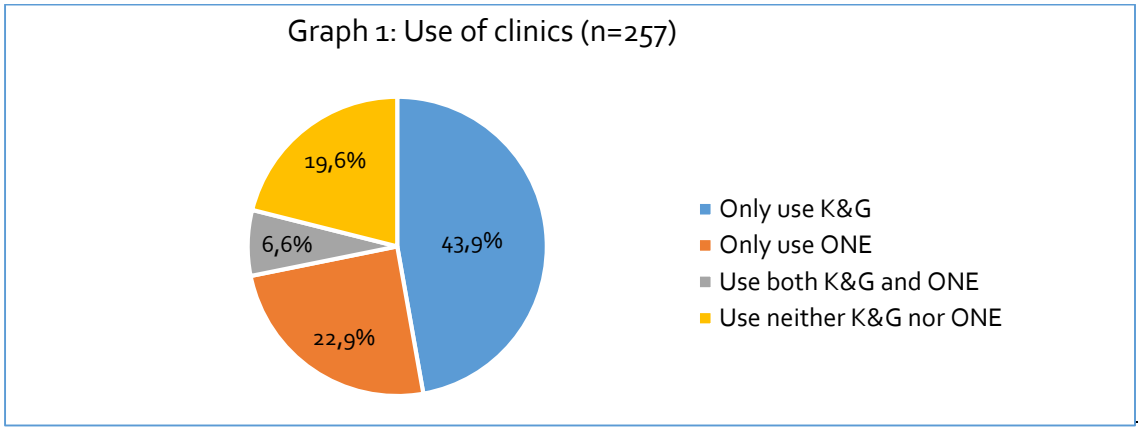
To what extent do **parents** in Brussels know about and use formal sources of support? In each case, around four-fifths or more of the parents were familiar with the following perinatal and other healthcare actors: the GP, gynaecologist, midwife, maternity department, paediatrician, health insurance provider. And they had used their services at least once. Other actors in Brussels who can provide support during the perinatal period (e.g. maternity assistance, Aquarelle and De Volle Maan) were less well known and less used by the parent group surveyed.

The same applies to professionals from the school and child care sector (33.5% and 67.2% respectively were unaware of these actors). 66.5% knew of a childcare professional (e.g. a child-minder or childcare worker) but only 37.8% had actually used his or her services. Social services and assistance professionals are also often unknown (by 73.9% to 94.4%) and are used by a minority (8% or less). Public social welfare centres (OCMW/CPAS) and psychologists are to some extent an exception to this rule. More than half of the parents (67.2% and 77.3%) were aware of these actors. For psychologists, awareness of their services translates to them being used by a respectable number of parents (27.1%). This is not the case for the OCMW/CPAS (4.8%). The high level of representation of parents with a high socio-economic status (SES) in the research group influenced these figures.

Less than half of the parents (3.4% to 41.9%) were aware of Brussels PSF initiatives (Huis van het Kind, Baboes, walk-in teams, HOPON and NASCI). Awareness and use of the services of Baboes, the only actor with four locations, is not confined to the local area: the majority of parents that use Baboes go outside their own municipality to do so.

3.2.1.3 Awareness and reasons for using (or not using) clinics

The majority of parents are familiar with a K&G clinic or a ONE clinic (83.3%) and have used one or both (80.4%). Graph 1 shows that the group of parents who only use K&G clinics is most strongly represented in the research group (43.9%). The number of parents who only use ONE clinics and the number of non-users is around the same (22.9% and 19.6% respectively).



75.2% of respondents who only use K&G clinics are aware of ONE clinics, while 64.9% of respondents who only use ONE clinics are aware of K&G clinics. The majority of respondents who only use K&G clinics have made use of their services on more than one occasion (91.2%). For respondents who only

use ONE clinics, this figure is 76.3%. Most parents who have used K&G clinics at one point or another (both those who only use K&G clinics and those who use both K&G and ONE clinics) have had contact with one single K&G clinic (71.8%). For the group of respondents who only use ONE clinics or who use both types of clinic, 78.2% have so far had contact with one single ONE clinic.

Before we go on to discuss the more specific access criteria, we will first give an overview of:

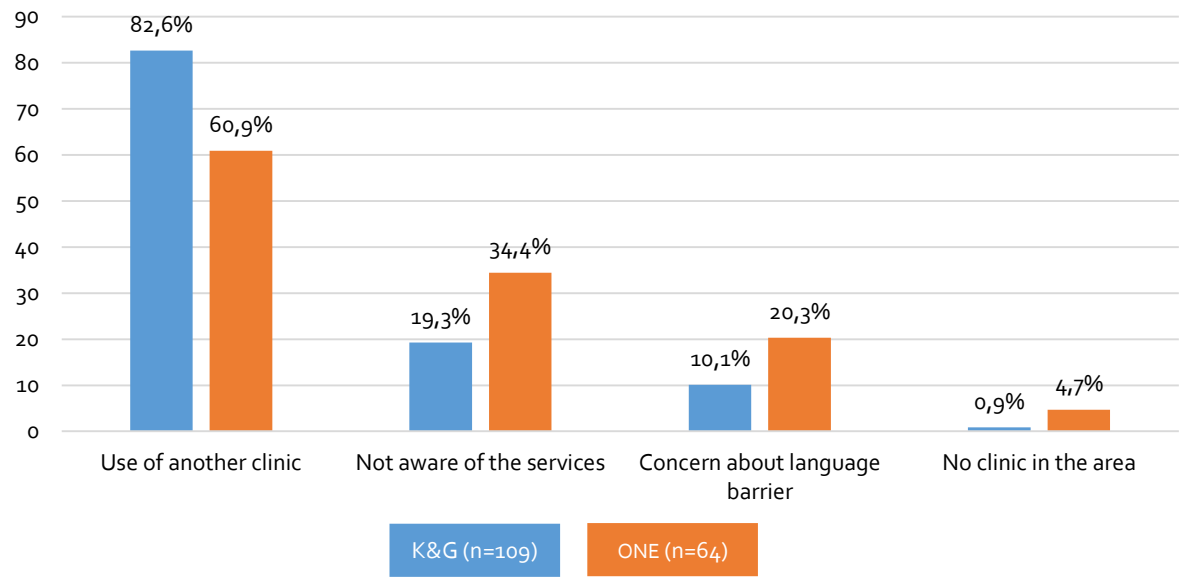
- The reasons for not using a K&G clinic, an ONE clinic or any clinic at all
- The reasons for using a K&G clinic and an ONE clinic
- The reasons for switching from a K&G clinic to an ONE clinic, and vice versa

The recommendations associated with these reasons can be found in sections 3.2.2 to 3.2.7.

Reasons for not using the other type of clinic or for not using a clinic at all

The ***reasons*** given by K&G users and ONE users for ***not using*** the ***other clinics*** (see Graph 2) are (in descending order): (1) already use another clinic, (2) not aware of the services offered by the other clinic (awareness), (3) concern about language barrier (understanding), and (4) do not have a clinic in the neighbourhood (convenience).

Graph 2: Reasons for not using a clinic other than the clinic already used



In the group of 45 parents who have not used a K&G clinic or a ONE clinic, the following reasons for ***not using a clinic*** are the most common: (1) expecting a first child (37.8%), (2) do not need to use a clinic (17.8%), (3) using another professional's services (13.3%) and not aware of the services on offer (13.3%). If, however, we combine the reasons 'using another professional's services', 'getting sufficient help from an informal network' and 'having sufficient access to books, magazines, leaflets, websites, etc.', this adds up to **20%**. In short, one fifth of non-users can **sufficiently** rely on **other sources of support**.

Other reasons (e.g. cannot see the benefit for themselves or the child) are mentioned by fewer than 10% of the parents. Although the number of respondents who 'have a lack of confidence' or 'do not want to be made to feel guilty' is small (three parents and one parent respectively), this is important to know when publicising (increasing the uptake) and implementing the services (retention versus dropping out). We will revisit this under section 3.2.2.3.

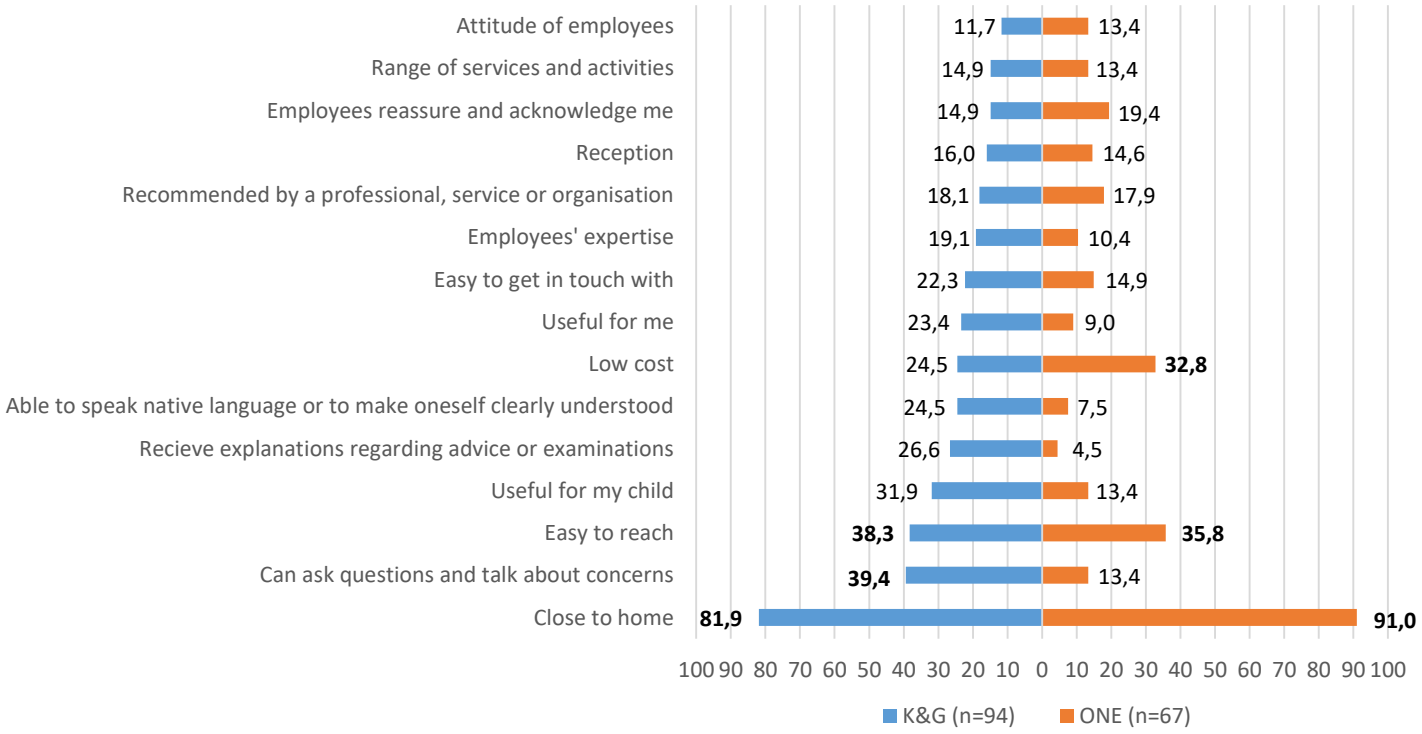
If we take the three groups of 'non-users' together (exclusive K&G and ONE users and non-clinic users), it appears that just over a fifth of the respondents (49/218 or **22.5%**) state that the reason why they do not use a clinic (or do not use the other type of clinic) is (partly) because they are **'unaware'** of their services. **11.9%** (26/218) of parents across all three groups gave **concern about a language barrier** as a reason.

Reasons for using a clinic

Parents who use a clinic mainly stated reasons relating to the physical accessibility of the clinic (see Graph 3), i.e. proximity (81.9% for K&G, 91% for ONE) and convenience (38.3% for K&G, 35.8% for ONE). For K&G users, however, 'being able to ask questions and talk about concerns' was also in the top 3 (39.4%). For parents who use a ONE clinic, only 13.4% gave this as a reason. However, 19.4% of this group indicated that 'getting reassurance and affirmation from an employee' was a reason for them using a clinic. Of the K&G users, 14.9% cited this as a reason. 24.5% of K&G users and 32.8% of ONE users gave the low cost as a reason for using a clinic.

The decision to go to a particular PFS service and more specifically to a clinic is also influenced by **formal or informal referrals by third parties** (either as a recommendation or as an obligation). A little less than 20% of clinic users in each case (18.1% of K&G users, 17.9% of ONE users) indicated that their clinic was recommended to them by a professional, service or organisation. More specifically, they were contacted by the clinic itself, by the maternity department, the midwife, the gynaecologist, the GP or the paediatrician. Only rarely did parents (two ONE users) report that they were obliged to use that clinic.

Graph 3: Most frequently reported reasons for using a clinic (%)



Reasons for switching from a K&G clinic to a ONE clinic, and vice versa

For 32% of K&G users (33/103), one or more factors could influence their decision to switch to a ONE clinic in the future. The most frequently reported reasons were (up to 8 times): offering services in

more languages (e.g. NL, EN), if there was no other option (if their K&G clinic closed) or if the ONE clinic was nearer by.

Among ONE users, 38.6% (22/57) would use a K&G clinic if one or more factors in relation to those clinics were to change. The most frequently reported were (up to 11 times): increased awareness of their services (e.g. more publicity and/or information, either in hospitals, from the paediatrician, etc.) and if they were located nearer by.

3.2.1.4 Desired publicity channels

Slightly more than half of the respondents (**53.8%**) reported that they have **not yet received any information** about **help or support initiatives**.

Looking at which channels of communication are most suitable for parents, the **informal network** in particular stands out: for 75.7% this is in first or second place (we asked respondents to list the channels of communication in order). **Written or electronic channels** also score highly (63.9%), although respondents ranked them in second place most frequently. Slightly more than half of the parents (52.1%) awarded first or second place to '**services or professionals**.'

3.2.1.5 Towards improved publicity and increased awareness

With the exception of the clinics and the healthcare professionals, (future) parents are rarely aware of the Brussels initiatives that support (future) families with young children.

It is essential that the existing services are publicised in an accessible, simple way and through various channels (e.g. flyers, posters, online, face-to-face) in order to inform parents about those services and increase the rate of uptake. Improved cooperation with institutions that are well known and used by parents, such as first-line healthcare professionals, can help achieve this.

Bearing in mind the developments in the professional field at staff and services level, commitment to publicising and getting to know other PFS initiatives is a point requiring ongoing attention for the partnership between the Huis van het Kind-Ket in Brussels and the LFSNs in particular. This could be addressed, for example, by establishing these topics as regular agenda items (e.g. in a speed-dating format, explorations of neighbourhoods, development of a neighbourhood social map).

More specifically for Dutch-language clinics, a greater commitment to increase publicity via both first-line and second-line healthcare professionals (doctors, midwives, hospitals) could also increase uptake. This requires both the space and the openness from these actors to take on and support these publicity measures. Since the informal network is an extremely suitable publicity channel for (future) parents, it may be worthwhile exploring the possibilities of appointing 'ambassadors'. In both cases (formal and informal) it is recommended that attention is drawn even more strongly to the 'substantive' benefits of the K&G clinics (e.g. being able to ask questions, being useful for children, receiving explanations for given advice and examinations, medical and other support).

Additional efforts are needed to reach a larger group of children and their parents, in particular vulnerable groups, and to open up access to the universal (basic) services and the variety of areas of life. In addition to the walk-in teams, which are already key partners at the HvhK, this also emphasises on neighbourhood health centres and public services such as the OCMW/CPAS.

In the longer term, and starting from an institutional logic and thinking in terms of a systemic approach, the creation of a physically and virtually integrated and complementary range of services for families would be easier to understand and less confusing. A Huis van het Kind where lesser-known initiatives take place and where cooperation with non-Dutch-language initiatives is developed or strengthened can contribute to this. In order to set priorities for this closer cooperation and improved coordination of services, moments of transition experienced by children and their parents can serve as a starting point. These include the transition from a partner relationship to parenthood, from home to informal or formal childcare or from pre-school care to school.

3.2.2 Usefulness

Usefulness is the extent to which the support provided meets the requests or needs of parents. In this study, we asked parents about the topics and areas about which they wanted to receive information, support or guidance. We also asked them about the way in which they would ideally like to be provided with this information, support or guidance.

3.2.2.1 Topics and areas about which parents need information, support or guidance

Of the parents surveyed, 58.2% reported that they felt a need for information, support or guidance. Among the parents who reported such needs (see Table 1), the most frequently reported topics are: behaviour and social and emotional development of children (91%), approach to parenting (85.4%), and health and physical development of the children (77.5%). Just over half of the parents mentioned the topic 'my physical and mental health' (56.2%).

More than one quarter up to just under one third of the parents reported that they needed information, support or guidance on the following topics: financial situation of the family (30.3%), material living situation of the family (29.2%), work situation (25.8%) and the relationship with their partner (25.8%). 11.2% of the parents mentioned that they needed information, support or guidance on the topic 'relationship with the ex-partner'.

Table 1: Topics about which parents need information, support or guidance (n=89)

	Information a		Support or guidance b		a + b		Total	
	n	%	n	%	n	%	n	%
Health and physical development of my child(ren) (e.g. weight, growth, nutrition)	52	58.4	10	11.2	7	7.9	69	**77.5**
Behaviour and social and emotional development of my child(ren) (e.g. dealing with others, negative behaviour)	42	47.2	20	22.5	19	21.3	81	**91.0**
Approach to parenting (e.g. dealing with child's behaviour)	37	41.6	21	23.6	19	21.3	77	**85.4**
My physical and mental health	19	21.3	22	24.7	9	10.1	50	56.2
Financial situation of our family	11	12.4	12	13.5	4	4.5	27	30.3
Material living situation of our family	14	15.7	10	11.2	2	2.2	26	29.2
Work situation	7	7.9	11	12.4	5	5.6	23	25.8
Relationship with partner	4	4.5	17	19.1	2	2.2	23	25.8
Relationship with ex-partner	1	1.1	7	7.9	2	2.2	10	11.2
Other	3	-	4	-0	3	-	10	-

There are a number of topics for which parents expressed a need for information more frequently than a need for support or guidance, and vice versa. For the topics 'health and physical development of the child(ren)', 'behaviour and social and emotional development of the child(ren)' and 'approach to parenting', a need for information is mentioned twice to five times more than a need for support or guidance. A topic for which a need for support/guidance is mentioned more frequently (four times more often) is 'relationship with the partner'.

Several of the topics mentioned above also emerged when we asked parents about the areas in which they would like to receive support (see Table 2), for example, relationship support and financial and material assistance. Childcare and leisure were most frequently selected (61.6% to 76.1%) as areas in which parents would like to receive support. Household help also scores highly (63.8%). These

percentages increase even further (e.g. up to 92% for childcare) if we also include the answer option 'sometimes'.

Table 2: Desired support areas

	Yes		Sometimes		No		Don't know		Total
	n	%	n	%	n	%	n	%	n
Household help (e.g. cleaning, shopping, cooking)	95	63.8	26	17.4	26	17.4	2	1.3	149
Help maintaining your garden	17	11.6	17	11.6	102	69.4	11	7.5	147
Material aid (e.g. clothing, food, toys, books, furniture)	21	14.2	28	18.9	99	66.9	-	-	148
Financial help	33	22.0	19	12.7	95	63.3	3	2.0	150
Childcare (e.g. because you work, are doing a training course, etc.)	115	**76.1**	24	15.9	11	7.3	1	0.7	151
Babysitting for your child(ren) if you need to go out for a while	112	**73.7**	24	15.8	16	10.5	-	-	152
Leisure activities for your child(ren)	102	**68.4**	32	21.5	14	9.4	1	0.7	149
Leisure activities for me and my partner	93	61.6	20	13.2	36	23.8	2	1.3	151
Relationship support or mediation	34	24.3	30	21.4	71	50.7	5	3.6	140

The importance of using preventive family support in different areas of life and for different topics was confirmed by the professionals in the field. When asked what they understand by 'integrated family support', they identified a wide range of areas and topics:

- Health: physical and mental (e.g. preventive healthcare, psycho-emotional support tips, etc.)
- Education (e.g. information on how to register for Dutch-language education)
- Parenting
- Social
- Relationships with partner and others (e.g. violence in the family)
- After-school care and leisure (e.g. youth work, sport)
- Language (e.g. multilingualism)
- Culture (library, ABC House)
- etc.

Professionals in the field believe that there is a lack of provision in various areas, some of which correspond to the support needs most frequently identified by parents: social services (material and financial support), psychosocial support (mental health, partner relationship) and childcare. In addition, professionals have also noted gaps in perinatal and home support (e.g. vulnerable families, families with newborns).

According to various professional actors, an integrated approach requires not only a strengthening and expansion of the range of services on offer, but also consistency in terms of the content of the information and advice provided, which in turn presupposes a common basic and action framework.

The way in which PFS initiatives are implemented (per topic) and designed must be in line with the needs of Brussels' parents. Among other things, this means taking into account the difference between the need for information (e.g. on the health and development of their young child and the material living conditions of the family) and the need for guidance or support (e.g. on the relationship with the (ex) partner and children, work and financial situation). As far as these guidance and support needs are concerned, a number of services are already available (CAW and OCMW/CPAS). These services are not widely known and/or used by the parents surveyed, which brings us back to our earlier recommendation concerning raising awareness of the services on offer.

In two areas, namely childcare and leisure, and despite (recent) expansions, demand from parents (and to some extent also from professionals) remains particularly high. Further expansion is therefore necessary.

3.2.2.2 Support types and services

We know that the majority of parents (77.4%) see the informal network as a source of support for parenthood and the development and parenting of their children (see above). Websites and an individual (consultation) session with a professional are also a source of support for many parents (70.4% and 68.1% respectively). More than half of the parents (57.7%) see meetings at which a group of parents can exchange their experiences as a source of support. Reading information online and a telephone support or helpline are least frequently selected as sources of support. However, more than a third of the parents (38.5% and 37.6% respectively) still reported that they found these methods supportive in all cases.

If we focus on the types of support that most parents want, information (72.7%) and tips and advice (70.2%) are the most popular. Almost two-thirds of the parents (65.8%) wanted 'a listening ear' and just under half (47.3%) wanted a referral.

Table 3: Desired support services

	Yes		Sometimes		No		Don't know		Total
	n	%	n	%	n	%	n	%	n
Information	109	**72.7**	36	24.0	5	3.3	-	-	150
Tips, recommendations, advice about approach	106	**70.2**	40	26.5	5	3.3	-	-	151
Referral	70	47.3	57	38.5	17	11.5	4	2.7	148
Listening	98	**65.7**	35	23.5	15	10.1	1	0.7	149

Professionals in the field are also aware of the importance of providing information. In addition, they referred to a number of other more specific forms of support, such as mediation work, adult education, neighbourhood work and workshops.

The informal network is an important and appropriate source of support. Many PFS initiatives can usually only have an indirect effect on the closest informal network (such as family and friends) (e.g. by urging parents to use these sources for support). The strengthening or expansion of other informal support sources (e.g. other parents) can be promoted more directly and in different ways.

Continuing to provide and increasing the number of meeting rooms for this purpose is a first step. In addition to these meetings being useful moments in and of themselves, they can also be combined with other group meetings or workshops that focus on exchanging experiences or providing information and advice. Ideally, these should be offered at neighbourhood level or at least within a manageable proximity (see also below), as this can help parents stay in touch with each other or support each other in one or more areas (e.g. swapping baby or other items, registering for new or different support initiatives together).

Since many parents benefit from online channels, exchanges of experience and the provision of information and advice via these channels also need to be stepped up. This will involve publicising the current range of services in Brussels and the supra-local range of services (e.g. Groeimee.be, The Parenting Line, etc.) among parents online in a more integrated way. Consideration should also be given as to whether and how the topics about which parents need information or support can be presented (more explicitly) online (see above) or should be developed.

The fact that not all parents have access to online channels and that parents also prefer to have personal contact with a professional (either through oral explanation or a consultation), supports the need for a diversified range of services that are widely available. When it comes to individual consultations and group activities in particular, it is a matter of keeping or making them free or affordable (see section 3.2.7).

3.2.2.3 Attitude and expertise of employees

Future parents, parents with young children and professionals in the field often mentioned the importance of the attitude and expertise of PFS employees. These factors partly determine parents' decision as to whether or not to use a PFS initiative in general and a clinic in particular. For K&G clinic users, for example, the second most frequently reported reason for using these clinics is that they are 'able to ask questions and talk about concerns' (39.4%). 'Receiving explanations for given advice is in fifth place (26.6%) and 'employees' expertise' is in tenth place (19.1%) (see Graph 3 in section 3.2.1.3).

More generally, parents consider the attitude and expertise of the employee(s) to be a hallmark of good support (see Figure 1): 'listening to parents' (93.3%), 'treating obtained information confidentially' (91.5%), 'devoting sufficient time' (89.4%), 'respecting private life' (82.2%), 'taking family situation into account' (81.9%) and 'reassuring parents when they are concerned' (79.7%). The vast majority of parents also consider 'providing clear, understandable information', which is discussed in the section on understanding (3.2.5), and 'being able to ask questions and talk about concerns' to be key features of good support (91.1% and 86.2% respectively).

1. employees listen to you (93.3%)
2. employees treat information about parent, child(ren), and family as confidential (91.5%)
3. employees provide clear, understandable information (91.1%)
4. employees devote sufficient time to you and/or your child(ren) (89.4%)
5. easy to reach (87.1%)
6. services/activities offered are good (87%)
7. can ask questions and talk about concerns (86.2%)
8. employees respect your privacy (82.2%)
9. employees take your family situation into account (81.9%)
10. employees reassure you if you are concerned (79.7%)

Figure 1: Features of good help and support: Top 10

Brussels-based professionals also mentioned additional work attitudes that are necessary in order to be able to offer good, integrated support tailored to meet parents' needs. When combined, taking into account all the input received from professionals, this results in the following PFS employee 'profile': an engaged, motivated and enthusiastic team player, who is able to cooperate with others and can surround themselves with a team of volunteers to set up projects based on the needs of the families. However, this also requires a degree of affinity with the situation in Brussels, appropriate training, knowledge of the current social landscape and preferably a long-term commitment.

Providing support tailored to parents calls for competent employees who fit the profile of a family support worker in terms of attitude and expertise and who are mindful of the presence/absence of an informal support network around the Brussels parents (see the importance of the informal network as a source of support and awareness).

Working with experts with relevant life experience, with people from the same cultural background and using a direct, proactive approach is recommended in order to reach vulnerable parents and to offer them the best possible support. However, the efforts of employees and others with relevant life experience will not be enough on their own. They also need to be supported (peer support and supervision) and be able to rely on training that is evidence-based and tailored to the situation in Brussels, which can be offered to them either within their own organisation or across various organisations. Both LFSN supporters and VGC educational supporters can play a key role in identifying local and supra-local support needs and in bridging the gap with existing support, education or training provisions or in initiating new services in the field.

3.2.3 Reliability

As also mentioned in the 'usefulness' section (section 3.2.2), parents ranked 'treating obtained information confidentially' (91.5%) and 'respecting privacy' (82.2%) in the top 10 features of good support. Professionals agree that these two factors are important when it comes to reliability. While some reported that they were able to establish a common ethical framework with different services and organisations (strength), others observed shortcomings in this area.

In order to ensure that enough parents start using and progress to other initiatives, it is essential that there is a clear ethical framework in place when different services and organisations work together. The development and roll-out of that framework requires a supra-local approach (e.g. LFSN level). Information about professional secrecy and the duty of discretion, supporting material and/or coaching and training opportunities can be found at various supra-local services, including the non-profit organisation SAM and EXPOO, among others (https://www.samvzw.be/thema/beroepsethiek and https://www.expoo.be/beroepsgeheim-en-deontologie-binnen-een-huis-van-het-kind).

3.2.4 Convenience

Convenience covers various aspects and refers to the extent to which the range of services is accessible physically, and in terms of time (schedules) and space (locations).

For the majority of parents (87.1%), **physical accessibility** in terms of the services being 'easy to reach' is a key feature of good support (fifth place in the top 10, see Figure 1). More than two-thirds of the parents (69.9%) said that it is important that the support is close to other locations or services that they or their children use.

When specifically asked about their use of clinics, being 'easy to reach' was one of the top 10 reasons for using those services (see Graph 3): this reason came in second place among ONE users (35.8%) and in third place among K&G users (38.3%). In addition, the majority of K&G users (81.9%) and ONE users (91%) emphasised the importance of a clinic being located 'close to home'.

The analysis of the mobility assessment of the visited clinics shows that a much larger proportion of ONE users exclusively travel to the clinic on foot than K&G users (87.1% and 47.8% respectively). Additionally, 80.7% of ONE users who walk to the clinic have to walk less than 15 minutes to reach it. For K&G users, the corresponding figure is 61%. Moreover, 11.4% (10/88) of K&G users said that their journey is 'too long', compared to only one of the 58 ONE users.

One of the strengths of cooperation identified by professionals in the field is that some actors share an easily accessible location which also has a good infrastructure. Other professionals pointed more specifically to the well-developed public transport network, which improves convenience. Partly because of this, parents are able to visit clinics and use services across district or municipality boundaries. Nevertheless, various professionals have observed that this is not an option for all parents. They recommend introducing more local and district-oriented services. At the same time, however, there is some overlap between the services offered in certain districts and neighbourhoods (similar services offered by different initiatives).

Further development of initiatives at neighbourhood or district level could help to improve physical accessibility. Given the fact that there is some overlap between services offered in some neighbourhoods and districts, the challenge is to make sure that those services are spread out across those areas as effectively as possible. When developing and implementing the range of services, it is also advisable to establish as many connections as possible with initiatives that parents and/or children already use (e.g. childcare, leisure initiatives). We will return to this point in our discussion of the recommendations concerning availability.

The physical proximity and convenience of K&G and ONE clinics is also a point to consider. Experimenting with mobile clinics within the established LFSNs may provide an answer. For example, teams could rotate between physical locations that are also home to other PFS initiatives.

For the clinics we were able to get an overview of **convenience in terms of time**. Compared to 'easy to reach' (which refers to physical convenience), 'easy to get to during opening hours' was mentioned less frequently as a reason to use a clinic: by 22.3% of K&G users and 14.9% of ONE users.

Slightly more than half of K&G users (52.3%) and slightly less than half of ONE users (45%) reported that their appointments at the clinics are 'sometimes easy to get to, but often require adjustments'. Of the ONE users, 30% think that consultations are held at 'often difficult to almost impossible' times for them. Only 11.4% of K&G users said that the times of their consultation appointments are 'often difficult to almost impossible'.

There is also a difference between K&G users and ONE users in terms of the actual and desired contact moments; in descending order, K&G users have consultations in the evening (36.8%), morning (29.9%) and afternoon (25.3%). ONE users hardly ever have consultations in the evening (5.3%); they mainly take place in the morning (42.1%) and in the afternoon (38.6%).

For K&G users, their actual contact moments (in the evening and in the morning) largely reflect their wishes in terms of times of the day at which they would like to have their consultations. For ONE users, this is generally true for morning consultations but there is considerable demand for consultations to be held in the evenings and on Saturdays.

One of the advantages of the K&G clinics is that the times of their consultations are largely attuned to the parents' needs and wishes. These consultation times should be continued, in particular the evening consultations. We recommend stepping up efforts to publicise this strength among parents and supervisors in order to increase the uptake of services (see section 3.2.1.5).

The (future) parents surveyed think that various factors relating to the third and final aspect of convenience, **convenience in terms of space**, are essential for good support. This concerns a number of distinctly practical factors such as 'interior and equipment adapted to children' (79.4%), 'possibility to care for children' (77.1%), 'comfortably furnished for parents' (58.5%) and 'presence of an outdoor (play) area' (46.5%). Just under three-quarters of the parents (74.8%) said that the factor 'it is a pleasant space' was important.

For the K&G clinics in particular, each of the previously mentioned factors concerning convenience in terms of space was cited by 18.8% or fewer of the parents as a reason for them to use K&G clinics. For ONE, these convenience-related factors were mentioned by 9% or fewer of the parents.

In practice, there are major differences when it comes to infrastructure. While some professionals in the field are satisfied with the infrastructure, others identified areas for improvement. We also noted significant differences between the various locations when conducting the interviews.

A comfortable and pleasant location encourages you to keep coming back (uptake and retention). In the short term, there are usually few options available to improve cramped spaces. Expanding the available space and/or improving the infrastructure often requires a substantial financial contribution from the organisation itself and from supra-local financial backers. This brings us back to the previously mentioned recommendation on physical convenience – to make optimal use of resources, according to the needs of and the ease with which families can access the services.

3.2.5 Understanding

'Understanding' refers to the extent to which users are able to understand the purpose of the services and on that basis are able to determine themselves (autonomy) which services they need.

Following the discussion of the large variation in languages spoken (at home) by Brussels residents (see above, section 2.2), we would like to focus on the language and communication skills of PFS employees.

After all, a language barrier and/or unclear information about an initiative are likely to result in less knowledge about a particular activity. This, in turn, may translate into the non-use of a support initiative.

In general, **parents** agree on the importance of understandable information: 91.1% of parents expect PFS employees to be able to provide clear and understandable information. **Professionals in the field** were more explicit about the need to move away from monolingualism and advocated that professionals working in Brussels should be able to speak at least two languages. They reported that language was a barrier (from an organisational and policy perspective). They try to overcome these barriers by using interpreters or looking for a common language, for example.

If we turn to the clinics for a moment, we would like to remind readers here that the K&G clinics are relatively less known among parents who only use ONE clinics than vice versa: 35.1% of respondents who only use ONE clinics are not aware of K&G's clinics (so 64.9% are aware of them); 24.8% of respondents who only use K&G clinics are not aware of ONE's services (so 75.2% are aware). This can be explained not only by the limited geographical spread of the K&G clinics (20 as opposed to the 80 ONE clinics), but also by language barriers and the associated migration background.

This is evident when we look at the extent to which parents consider 'being able to speak your mother tongue or being able to make yourself clearly understood' to be an important factor when deciding to use a clinic. There is a discrepancy between the (predominantly Dutch-speaking) K&G users, of which a quarter consider this factor to be important (24.5%), and the (predominantly French-speaking) ONE users, of which less than 10% consider it important (7.5%).

A possible explanation for this is the greater prevalence of a migration background among ONE users. Relatively speaking, parents who only use ONE clinics are more likely to have been born outside Belgium (51.5%) than K&G-only users (23.1%). In addition, ONE-only users are more likely to have a father or a mother who has a nationality other than Belgian: 69.7% and 32.3% respectively. This often has an impact on the native language of these respondents, which will more often than not be a

language other than Dutch or French. In turn, this may lower expectations regarding the use of one's own language.

Another possible explanation is that ONE users who are native-French speakers and ONE users who understand French take it for granted that they will automatically be addressed in French at a clinic in Brussels. With this in mind, it seems reasonable to assume that they do not spare much thought for the 'native language and communication' factor and that they did not select that factor when completing the survey. This is less clear-cut for Dutch-speaking Brussels residents who use K&G clinics.

This will need to be analysed further. Previously, in section 3.2.1.3, we mentioned that fewer K&G users reported that concerns about a language barrier influenced their decision about whether or not to use a ONE clinic (10.1%) compared to ONE users deciding whether or not to use a K&G clinic (20.3%).

The 'understanding' factor is a key issue to take into account when improving the accessibility of Brussels PFS initiatives and Dutch-speaking clinics. For these clinics in particular, there is a language barrier due to the incompatibility of the mother tongue and/or the known language versus the perception (presumption) that people have about the language used in the clinic. As such, it is important to look for strategies to change this perception when publicising the clinics and initiatives (linguistic openness is appreciated by non-Dutch-speaking parents). Intercultural mediators could play a role here.

More generally, we can state that a broader linguistic approach is necessary in order to be able to offer clear and comprehensive support or to respond optimally to the needs of parents. Alternative approaches include: using practical language, searching for a common language, using (more) visual language or social interpreters. The latter, however, is currently under threat due to financial constraints and requires creative solutions. In addition, various language support options are already available for professionals and/or parents. Examples include: 'Dutch for parents' provided by the Huis van het Nederlands (encourages parents to learn Dutch), opportunities to review the accessibility of publicity and support material (VGC language advisor for accessible Dutch) and there is the PIM Language Advice Centre (language support for parents, offered at Foyer).

A step further in terms of understanding is the extent to which **parents are able to determine themselves (autonomy)** which services they need. In addition to using an integrated approach, professionals in the field also explicitly referred to the role of the parents. When parents are well informed, it is easier to decide for themselves what kind of support they need and to make an informed choice. That, however, means that they have to be given the opportunity to do so (freedom to decide, availability and convenience of the services). Professionals also envisage a more pronounced role for parents: they want parents to participate actively in the development of services.

Ideally, 'empowering parents' should not only be seen at 'outcome level' (after participation or use of a support initiative), but also at 'process level'. Parent participation in the sense of co-actorship or co-creation means that they are actively involved in the development of services. It goes without saying that this will improve alignment between the services offered and the needs of families. This requires local and supra-local initiatives and partnerships to proactively look for ways to give parents this privileged place in their operations. More inspiration can be found at https://www.expoo.be/participatie-o and https://vbjk.be/nl/themas/ouderbeleid. In Chapter 4, we present our recommendations as to how this can be translated into a parental programme.

3.2.6 **Availability**

Here, the term availability does not refer to whether there are sufficient services available, but to the fact that there are no (prior) admission requirements and that users have the opportunity to develop a stable relationship with the supervisors (Lenaers & Zanoni, 2013). In the context of preventive family support, and in particular of an integrated approach, we are compelled to interpret this in a broader way.

The fact that parents can go to a single location for a variety of issues, help or support can be understood as one aspect of convenience (see section 3.2.4), but it also indicates the stability (continuity) of the service. More than two-thirds of the parents (68.6%) considered this to be a key feature of good help or support. In addition, slightly less than two-thirds (62.1%) said that they think it is important that they can contact the same employee for various questions, help or support. The factor 'being able to contact the same employee' was equally important (60.2%). Only 6.4% of K&G clinic users stated this as a reason to use a K&G clinic. Of the ONE users, 9% cited this as a reason.

Professionals stressed the importance of the foregoing aspects of availability, especially from the perspective of (the most) vulnerable parents. This has also been confirmed in many other research projects and interviews in the field.

Other aspects of availability are important for more than a third to more than half of the parents in terms of help or support: 36% said that the item 'you can come and go freely, you don't have to make an appointment or have to register' was important and 55.6% said that the fact that 'employees can easily be contacted if you need them' was important. For the last aspect, several parents said that digital channels of communication could help in this regard (e-mail, WhatsApp, online, chat), and they also recommended that employees be contactable by telephone.

We would also like to point out that both parents and professionals have reservations about the central registration system (via telephone) for making an appointment for a consultation at a K&G clinic. K&G has partly addressed this issue: for example, there is now also an online system for making or changing appointments. Professionals, however, question how accessible such anonymous channels are for vulnerable parents.

Finally, we observed that if we also take the answers 'reasonably important' into account for the availability aspects, the vast majority of those aspects are in fact '(reasonably) important'. 'You can come and go freely' is an exception; opinions are more divided about this (33.6% do not think it is important).

From a parent's point of view, there is a clear preference for physically bundling or offering services close to each other. In addition, there is a clear need for parents to be able to contact one (regular) employee. This brings us back to the earlier recommendation concerning convenience on the further development of initiatives at neighbourhood or district level. This could particularly improve the uptake of and progression to other preventive family support initiatives of vulnerable parents.

3.2.7 **Affordability**

Ideally, an accessible service should be affordable for users. The vast majority of parents indicated that 'low cost' was an important or a reasonably important factor (65.9% and 27.1% respectively).

For the clinics in particular, 32.8% of ONE users reported this as a reason for using the ONE clinic, putting it in third place. This factor was cited as a reason by 24.5% of K&G users (shared sixth place).

The majority of Brussels PFS initiatives effectively have a low cost (or are free) for the users. Initiatives whose services are not free do what they can to make sure they are affordable for parents. For example, they use a flexible pricing policy in which they adapt the amount, the method of payment

and the term of payment to the financial situation of the family. However, it is not always possible to use such a pricing policy or to apply it consistently. This applies in particular to non-conventional healthcare professionals, private physicians and therapists. It also significantly limits accessibility (affordability) for vulnerable parents.

A strength of the PFS services is the fact that the majority are free for parents and their children and the efforts made by initiatives, where necessary, to make sure that parents can participate in the services. It goes without saying that this should be continued and, if necessary, also supported at supra-local level. The question is whether more systematic alternatives can be found for paid services in perinatal and general healthcare. This could help to make these services more accessible to even the most vulnerable parents.

3.3 Progression within and between initiatives

Elements that improve or hinder uptake also have an impact on the progression within and between initiatives. In our discussion of the seven accessibility aspects we focused in particular on uptake (e.g. reasons for using or not using PFS initiatives, factors that are important for good help or support); in this section, in our examination of the findings we will focus more specifically on progression. We will start by examining progression within the clinics. We will then zoom in on the progression (referrals) between different services and organisations.

3.3.1 Progression within clinics

Most K&G clinic users (71.8%) have only had contact with one K&G clinic. The other K&G users have moved between K&G clinics (22.3%) or from a ONE clinic to a K&G clinic (5.9%). This pattern can also partly be found among ONE users: 78.2% of them have only used one ONE clinic. However, the percentage of ONE users that have switched from a K&G clinic to a ONE clinic is three times higher (16.4%) than the percentage that have switched from ONE to K&G.

It is striking that in the mixed user group, i.e. the group of parents who switched from K&G to ONE and vice versa, the parents do not have any children who are 6 years of age or older, and that the youngest children (under the age of 3) are proportionately the most represented in this group. This means that the switch to a clinic takes place within a relatively short period of time.

Progression within K&G clinics can be seen as a strength: i.e., K&G is able to bind parents to the clinic activities for a longer period of time and across locations. At the same time, progression from a K&G clinic to a ONE clinic is proportionately greater than the other way round. This sheds a different light on the aforementioned bond to K&G clinics. The questions in this survey did not allow us to investigate this further. Partly for this reason, clinic employees should pay attention to signals that may indicate a switch to a different clinic and try to respond to them. They should also relay such signals to their supra-local organisational structure.

3.3.2 Progression between different services

Earlier, when discussing the types of support desired (section 3.2.2.2, Table 3), it appeared that slightly less than half of the parents (47.3%) 'do want to be referred' and more than a third (38.5%) 'sometimes' want to be referred. Put together, 85.8% of parents 'sometimes do' want to be referred.

We also asked the clinic users more specifically whether they wanted or found it useful to be referred by the clinic. Regardless of whether or not they had previously been referred by a clinic, for 50% of clinic users a referral is a desired type of support. Only a minority (2.8%) indicated that they were referred by the K&G clinic and that they did not want this referral. In addition, it appears that a small percentage of K&G and ONE users were not referred, even though they would have preferred to have been referred (5.7% and 8.9% respectively).

For the sake of completeness, we note that the percentage of K&G users referred by their clinic to another service or professional is about the same as that of ONE users (28.7% and 23.2% respectively). Whereas ONE users (with the exception of one) indicated that they were only referred to physicians, K&G users reported that they were referred to medically trained professionals as well as to parenting support and information provision services. This suggests that K&G is more explicitly establishing connections with other domains and other professionals.

Professionals underlined the importance of family-specific referrals and believe this is vital for an integrated approach and for the continuity of care and support services. One professional referred to there being a common thread that runs through the family's support process. The professionals also set out in detail the conditions under which such referrals can be made.

The first step towards a good, warm referral is a warm welcome, during which sound information is provided (e.g. *'a warm welcome, a good explanation, a friendly phone conversation').* The employee prepares the person(s) concerned for the switch to another service or organisation, based on the relationship of trust that has already been established. This means that the professional needs to be aware of the limits of their own activities as well as the support services provided and the approach used by other PFS actors. In addition, the employee must recognise the quality and added value of the other actor (*'know that that person/organisation is very good at something', 'have respect for each other as well as for each other's distinctive place in the range of services'*) and that added value must also be recognised by the others involved.

The majority of parents recognise or have experienced the added value of a referral. We recommend continuing to develop a well-founded, suitable and sensitive referral process. Since it is important to provide integrated services and, in particular, to ensure continuity in the care and support of parents and children, it is also very important to follow up on a referral.

It is not only K&G clinics that are able to identify connections between their own services and the support offered by other initiatives and that know how to take advantage of them, depending on the needs of the parents and their children. This also applies to many other surveyed Brussels initiatives which are trying to avoid breakdowns and bottlenecks in their support by ensuring a warm transfer. A prerequisite for this is that there is a good relationship and cooperation between other professionals, services and organisations in Brussels (principle of reciprocity). The LFSNs can play an important role here.

In addition, offering a range of services under one roof (the physical bundling of services, see also section 3.2.4) will have significant benefits for the continuity of support. Besides the fact that it will facilitate referrals, it will also lead to dynamism and creativity which in turn will result in new collaborative initiatives. One example is combining care with, for example, leisure activities and playtime activities with children. These informal moments help to establish a relationship of trust and make it easier to pass on information, for example. As mentioned earlier, such initiatives are ideally organised at district level because this improves accessibility for vulnerable families.

3.4 Cooperation

In the previous sections we have already discussed various factors that underline the importance of good cooperation and set out the conditions for being able to achieve that. In this section, we present an integrated overview of the goals of and conditions for good cooperation from the perspective of professionals in the field.

Knowing each other improves uptake and progression or referral possibilities for parents and children. This encompasses various goals of cooperation, for example, being able to reach families optimally and building bridges to other domains and services. The professionals questioned identified eight goals of cooperation. Each goal has its own particular emphasis, but they are also connected to other goals. The following is an overview of these goals, listed according to the number of times they were mentioned by the professionals:

1. Reach out to families, with the emphasis on '*all families'*
2. Take action and set things in motion together (e.g. through activities)
3. Coordinate activities
4. Build bridges to other domains and services: warm transfer, seamless transition, inform parents about the wide range of services on offer
5. Make optimum use of and share expertise
6. Develop an integrated approach
7. Be aware of and familiar with each other's activities
8. Detect signals

Professionals agree on the need for close and smooth cooperation in order to provide comprehensive preventive family support in Brussels. However, a number of important issues remain. For example, professionals indicated that it is best for collaborative ventures and a common vision and mission to grow organically, at their own pace and from the bottom-up. A coordinator who has the necessary expertise can help to manage this. To do this, there must be respect for each other's contribution to the range of services and the common vision and mission must be based on evidence-based frameworks (children's rights, pedagogical frameworks, family strength, mental health, multiculturalism, etc.).

Good cooperation involves adjusting the range of services on offer to the specific needs and characteristics of Brussels families and to similar activities already offered by services and organisations. It is the responsibility of all the initiatives and network supporters involved (LFSNs) to facilitate the provision and exchange of information and experiences in such a way as to enable them to join forces and create synergies. As a result, initiatives and activities will be more complementary and overlap will be avoided or reduced. There is currently an element of overlap in certain neighbourhoods (see above), in particular in the provision of pedagogical advice and in peri- and post-natal care, support or guidance. Improving the complementary nature of services and reducing overlap will lead, among other things, to a more efficient distribution and use of resources. This can contribute to increasing the return on investment for the entire system (Huis van het Kind-Ket in Brussels) and to ensuring that it is appreciated by each individual PFS actor.

Some examples of good cooperation cited by professionals are the AMIF project, Aquarelle, Huis der gezinnen, Babyboost and Koala. A noteworthy initiative that is still being developed is 'Born in Brussels', in which all professionals can work together on 'a dossier' of vulnerable pregnant women.

The professionals also commented on the role and impact of local and supra-local authorities on cooperation. These are discussed in the following section.

3.5 Role of local and supra-local authorities

In Brussels there are several regulatory frameworks that relate to the wide range of PFS services on offer. These frameworks are rarely implemented in parallel. Professionals in the field point to the fact that the authorities involved do not make the same policy choices, do not implement the same measures and do not have a shared (management) database (broad PFS services, preventive healthcare, perinatal care, childcare and education) is a hindrance. The professionals have identified a number of challenges that need to be explored at different speeds and in the short or medium term. These can be divided into five points:

1. A need for policy-makers and facilitators.
2. A need for sufficient consultation and coordination with the field with a view to, among other things, closer cooperation at municipal level.
3. A need for sufficient consultation and coordination between the regions and language communities: professionals see this reflected in a number of specific challenges such as cooperation at policy level, exchange of information and coordination between Dutch-speaking and French-speaking actors. This requires, among other things, an adjustment of the legal frameworks (e.g., attuning the child-supervisor ratio in Brussels).
4. A need for sufficient consultation and coordination between the various policy areas such as welfare, education and health. Professionals see potential in establishing connections between existing collaborations (e.g. 'brede school' and 'HvhK').
5. A need for a long-term vision for and alignment with the situation in Brussels in order to create an effective preventive family support network in Brussels.

Professionals regard the presence of supportive (local and supra-local) authorities as a strength. They also indicated, however, that the funding authority could assume a clearer role in steering the content, for example in cases where there is a lack of clarity about the link between an initiative and the partnership Huis van het Kind-Ket in Brussels.

4 A basic range of services at district level

As mentioned in the introduction, in this chapter we will translate the findings and recommendations into a potential plan of action. This plan of action (1) is the culmination of the three-part research project into accessible family support for future parents and parents with young children in the bilingual Brussels-Capital region and (2) is one possible strategy to increase the uptake of and progression to other preventive family support initiatives.

4.1 Outline of the potential basic range of services

A key challenge is to reduce the fragmentation of services, especially in disadvantaged areas. This requires an integrated and holistic approach based on proportional universalism (PFS regulations and HvhK roadmap). A second focus or source of inspiration is the VGC policy document in which the fight against child poverty is mentioned as a priority. Finally, we would like to stress that the aim is not to develop a completely new range of services in addition to existing practices. Instead, we want to enhance the existing strengths of PFS partnerships in Brussels and develop the basic range of services at existing locations where there are already initiatives in place.

4.2 Further development and implementation

These recommendations **focus** on the **accessibility** (uptake and progression) of Dutch-speaking PFS initiatives for Brussels families with young children. The recommendations are geared towards the **short and medium term** and focus on partnerships for preventive family support (both the local family support networks of the Huis van het Kind-Ket in Brussels and other Brussels-based networks). The aim of creating an integrated and accessible range of support services for all parents expecting a child and parents with a child between the ages of 0 and 3 is to give all these children the best possible developmental opportunities and to empower their parents as they tackle parenthood challenges and assume other roles.

An overview of the proposed plan of action to address the basic range of services can be found in Diagram 3. In the short term, we propose implementing the basic range in municipalities with a high birth rate and a high deprivation index score. This study allowed us to identify and propose 21 priority districts in: City of Brussels (6), Anderlecht (4), Sint-Jans-Molenbeek (3), Schaarbeek (2), Sint-Gillis (2), Jette (1), Vorst (1), Koekelberg (1) and Sint-Joost-ten-Node (1). Where possible, this basic range builds upon existing HvhK locations and PFS initiatives such as clinics, childcare facilities, the maternity care expert centre, initiatives set up by local health centres for prospective parents (e.g. BabyBru), workshops organised by midwives in practices or a hospital, etc. Ideally, this basic range should be developed and/or coordinated by LFSN supporters of the partnership Huis van het Kind-Ket in Brussels.

In the longer term, we propose making the basic range of services available in all districts of all the municipalities of Brussels, coordinated by the eight local LFSNs. In order to guarantee continuity of care (progression), we also propose providing a basic range of PFS activities for parents with children in older age groups. Ideally, parents who are already actively involved should be offered a basic range of PFS services at each transition moment (from childcare to nursery school, from nursery school to primary school, from primary school to secondary school, to higher education and 'leaving the nest').

Within this basic range, efforts can be made to increase the diversity of methods in order to fulfil the various roles of the Huis van het Kind. In the short-term recommendations we refer to the

development and launch of the VGC/HCHK website[4] (Facebook page). In view of the linguistic diversity of Brussels parents, the use of visual language on this online information channel could provide added value. Online videos can also be used to inform parents and support them in their preparation for parenthood (a good practical example here is the 'Kraamzorg in Brussel' (Maternity care in Brussels) video).

In the long term, we recommend further developing intensive and general home support for vulnerable families (see, for example, the 'Thuiscompagnie' project, Engelen & Nys, 2014). The buddy programmes (e.g. 'Buddy bij de wieg') also offer intensive support and guidance to prospective parents. There is potential for collaboration with the Erasmus University of Applied Sciences here. Finally, there are also volunteer organisations that focus more specifically on vulnerable families and in which volunteers provide parents with 'tailored' parenting support (e.g., DOMO, Stapsteen). In the long term, we recommend expanding such services to every Huis van het Kind network.

4.3 Features of the potential basic range of services

1. **Approachable** services at district level: family support services offered at the same place and in line with existing good practices (e.g. Baboes, Babyboost, KO, KOALA, walk-in teams, clinics, etc.).
2. **Integrated services**: contacts via healthcare and parenting support activities can result in social services and vice versa.
3. **Parenthood programme** with the aim of supporting parents in the transition to parenthood and in building a qualitative relationship with their child (0 to 3 years). The goal is to improve development opportunities for the children and to empower parents.
    - services offered through a HvhK partnership as a recognisable place to meet and receive support, for all families
    - for all future parents and parents with children up to 3 years of age, focusing in particular on the needs of vulnerable parents
    - empowering: interactive and offering encouragement to address issues such as mental and physical health
    - individual (consultations) and group activities
    - pre- and postnatal services
    - services covering the various aspects of preventive family support, such as:
      a) **Information** on issues related to children's behaviour and emotional development, approaches to the parenting, health and physical development of children.
      b) **Support** through freely accessible consultations (individual) and support through groups (interactive information provision and support).
      c) **Meeting** through games/playtime and meeting opportunities for parents with children to promote social encounters and cohesion (as well as providing information and support).

For the practical implementation, we can also draw on existing parental programmes such as the PREP method (Mary Nolan) and Centering Pregnancy (Born in Brussels).

[4] Following this study, two new websites were launched: the VGC web page on well-being and family (https://www.vgc.be/wat-biedt-n-brussel/gezin/opvoeden) and the HvhK-Ket in Brussels website (https://www.ketinbrussel.be/).

<table>
<tr><th colspan="2"></th><th>Short term</th><th>Long term</th></tr>
<tr><td rowspan="3">Information and support</td><td rowspan="3">Services
• digital
• individual
• in groups</td><td>HvhK website (Facebook): basic format:
• For parents[5]
• For professionals</td><td>HvhK website (Facebook): further development:
• Image and audio-visual material tailored to Brussels</td></tr>
<tr><td>Basic services for young families in each priority district</td><td>Basic services for young families in every district in Brussels</td></tr>
<tr><td colspan="2">• group-based initiatives for future parents and parents with children from 0 to 3 years old
• prenatal contact point with 'vulnerable pregnant women' consultation
• 'baby and toddler' consultation
➔➔➔By Local Family Support Networks</td></tr>
<tr><td>Games/playtime and meeting opportunities</td><td>Build on existing good local practices + organise new spaces</td><td>Space to meet and organise games/playtime in each priority district</td><td>Space to meet and organise games/playtime in every district in Brussels</td></tr>
<tr><td colspan="2">➔➔➔By Local Family Support Networks and actors from other domains who (already) focus on increasing social encounters and cohesion</td></tr>
</table>

Diagram 3: Proposed action plan to develop and implement a basic range of services

[5] See footnote 4

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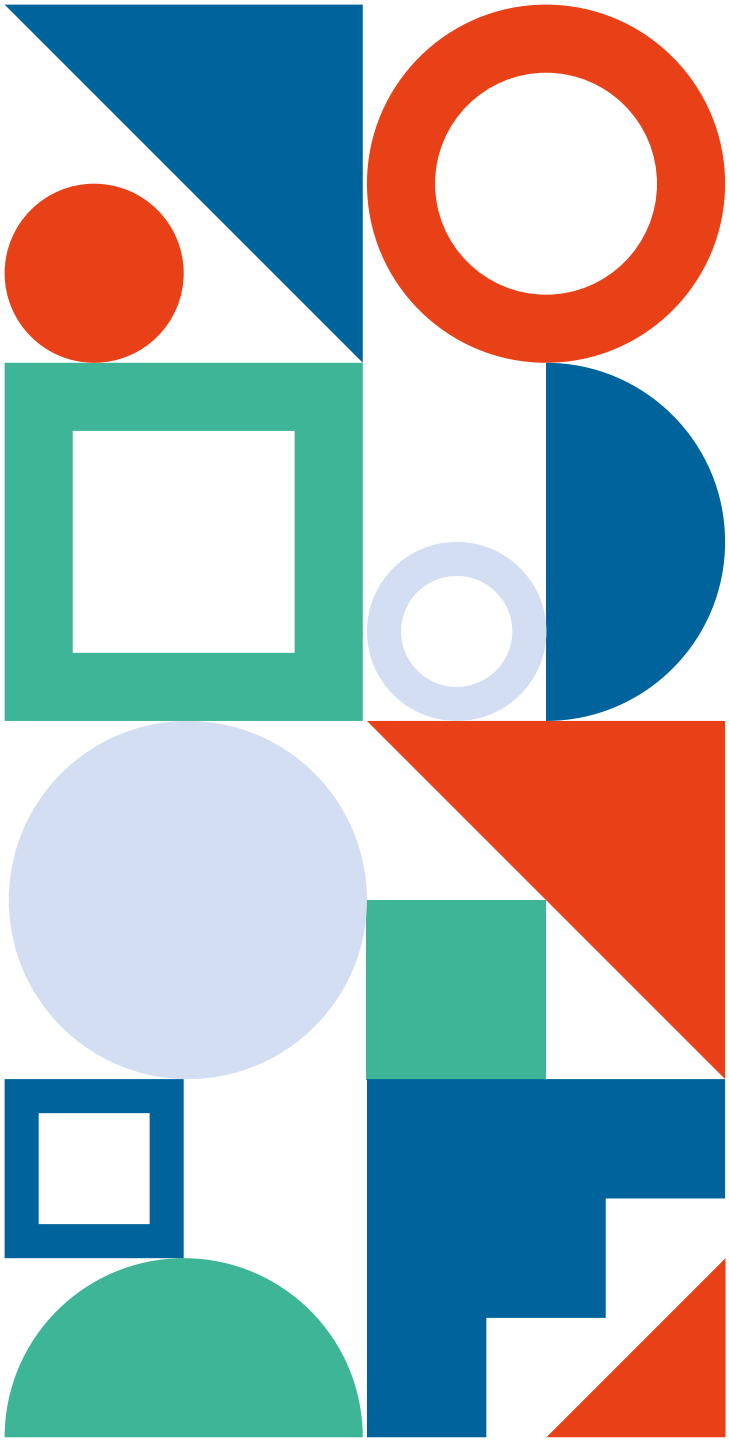

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