Regional Centre for Child and Youth Mental Health and Child Welfare - North / Faculty of Health Sciences

Interprofessional collaboration in Family's Houses in Norway

Predicting burnout, engagement and job satisfaction

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Kirsten Buck Rustad

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Supervisor: Monica Martinussen

Forord

Under tiden som jeg har arbeidet med denne masteroppgaven, har jeg blitt overrasket over at så mange rundt meg har erfaringer med utbrenthet. Mange har selv vært utbrente eller hatt noen nære seg som har opplevd utbrenthet. Utbrenthet for meg er ikke lengre noe som få opplever, men noe som mange erfarer i større eller mindre grad i løpet av sin yrkeskarriere. De fleste som jeg har snakket med, forteller om ledere som ikke har forstått hvordan de har det, og om for store arbeidsbelastninger. Både folks fortellinger og forskning forteller at utbrenthet i stor grad påvirkes av organisatoriske faktorer. Her vil kanskje også det største potensialet til å forhindre utvikling av utbrenthet være. Jeg er dermed glad for å kunne være med og bidra i denne forskningen, om en ikke med større formål enn at jeg øker min egen kunnskap om fenomenet.

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Sammendrag

Familien Hus er et tverrfaglig kommunalt tilbud hvor ulike helse- og omsorgstjenester for barn og familier er samlokaliserte. Denne studien omhandler hvordan ansatte i Familiens Hus i Norge vurderer ulike aspekter ved jobben sin. Formålet med studien var å måle grad av samhandling, i tillegg til barnevernsansattes oppfatning av sin jobbsituasjon sammenlignet med ansatte i de andre tjenestene i Familiens Hus. Et annet formål var å undersøke hvordan organisatoriske faktorer, inkludert samhandling, predikerer utbrenthet, engasjement og jobbtilfredshet, med utgangspunkt i Jobbkrav - Ressurs modellen (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001).

Data ble samlet blant ansatte i seks Familiens Hus som var blitt etablerte under ett pilotprosjekt. Antall respondenter var 71, hvorav 20 var barnevernsansatte. Etablerte skalaer ble benyttet for å måle variablene. Utbrenthet ble målt ved hjelp av tre subskalaer: utmattelse, kynisme og effektivitet (Maslach, Schaufeli, & Leiter, 2001).

Resultatene indikerte en generell positiv oppfatning av samhandling i Familiens Hus. Sammenlignet med to tidligere undersøkelser i Norge var samhandling vurdert noe høyere enn i tradisjonelt organiserte helse- og omsorgstjenester. I motsetning til forventet, viste barnevernsansatte en høyere jobbtilfredshet og lavere grad av kynisme enn andre yrkesgrupper i Familiens Hus. Analysen viste at jobbkrav og jobbressurser ble funnet til å predikere signifikante andeler av utmattelse og jobbtilfredshet. Et uventet funn var at tilfredshet med ledelse var positivt assosiert med utmattelse. Samhandling ble imidlertid ikke funnet til predikere utbrenthet, engasjement eller jobbtilfredshet. Lav statistisk styrke i studiet gjør at det var få signifikante funn.

Nøkkelord: Familiens Hus, tverrfaglig samarbeid, samhandling, utbrenthet, engasjement, jobbtilfredshet

Abstract

This study examined several aspects of working conditions in Family's Houses in Norway. The aim of the study was to investigate the level of interprofessional collaboration, and how the child welfare workers perceive their working conditions compared to employees in other services. Another objective of the study was to see how job demands and resources, including interprofessional collaboration, would predict burnout, engagement and job satisfaction in the Family's House, according to the Job Demands - Resources Model (Demerouti et al., 2001).

The data was collected amongst employees in six Family's Houses that were established as a part of a pilot project. The sample size was 71, of which 20 were child welfare workers. Established scales were used to assess the variables. Burnout was assessed by three subscales; exhaustion, cynicism and professional efficacy (Maslach et al., 2001).

The results indicated a general positive perception of collaboration in Family's Houses compared to the results from two earlier studies in Norway. Contrary to hypothesized findings, child welfare workers showed a higher job satisfaction and a lower level of cynicism than professionals from other services in the Family's House. The analysis showed that job demands and job resources predicted significant parts of the variation in exhaustion and job satisfaction. Inconsistent with expected findings, satisfaction with leadership had a positive relation with exhaustion. Collaboration however, did not predict burnout, engagement or job satisfaction. Due to low statistical power, few significant findings were revealed.

Keywords: Family Centre, Family's House, interprofessional collaboration, burnout, engagement, job satisfaction.

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1. Introduction

A review of working conditions for employees in Municipal Child Welfare Service in Norway revealed work situations with time pressure and emotional demanding work, in addition to risk of threats, harassments and violence from clients (The Norwegian Labour Inspection Authority, 2013). It has been revealed that Child Welfare Service has a higher turnover compared to other similar municipal human professions services (Johansen, 2014). Burnout is seen as an outcome of chronic emotional and interpersonal stress on the job, and can lead to high turnover, in addition to long term sick leaves and low productivity (Maslach et al., 2001). Research has shown that health care personnel are at risk for developing burnout due to the nature of their work (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Martinussen, Borgen, & Richardsen, 2011). Meanwhile engagement is seen as a positive antipode of burnout, and is found to have outcomes like commitment, health, performance, and lower turnover intention (Halbesleben, 2012). Job satisfaction is defined as the amount of overall positive affect employees have towards their jobs (Hombrados-Mendieta & Cosano-Rivas, 2013), and is seen as an indicator of a functional organization and the wellbeing of the employees (Bhatnagar & Srivastava, 2012).

The Coordination Reform was launched in 2009 by the Ministry of Health and Care Services. Absence of coordinated services to patients with complex needs, had been revealed (Ministry of Health and Care Services, 2009). One of the purposes with the reform was to improve collaboration within the health services to ensure the quality of the given services. An audit found lack of collaboration between services for vulnerable children and adolescents, with the possible consequences that patients were not identified at the right time nor did they receive the services that they needed (Norwegian Board of Health Supervision, 2009).

As a part of the Norwegian Plan for Advancing Mental Healthcare 1999-2008, the Swedish model of Family's House was adopted and a pilot project was launched (Haugland, Rønning, & Lenschow, 2006). The model created an organization that embraced several of the municipal family and child health care services, and the main aim was to make services more coordinated, but also to provide help at an early stage. The pilot project was considered a success and was continued and implemented in other municipalities (Haugland et al., 2006).

The Family's Houses were introduced in Norway by establishing six pilot houses. Both

leaders and coworkers reported increased interdisciplinary collaboration in the evaluation (Haugland et al., 2006). Nonetheless, implementing a new working method can be challenging, and it is not certain that the method works as expected (Ogden, 2012). A study in Sweden, revealed that the collaboration in one Family's House, did not work as intended (Abrahamsson, 2007). A later study of the Family's Houses in Norway, concluded that establishing a full function Family's House, was a demanding process which could take years (Thyrhaug, 2009). There has been more recent studies on Family's Houses both in Norway and Sweden (e.g., Martinussen & Gamst, 2012; Rambøll, 2014). The data in the current study, was collected as a part of a study of collaboration in the pilot houses. Further studies are in process at the Regional Centre for Child and Youth Mental Health and Child Welfare- North (RKBU – North).

With the identified challenges in health and social services, it is interesting to measure the effect of the Family's House Model. This study assesses to which degree collaboration actually takes place in the Family's Houses in Norway. With the challenge of burnout in the Municipal Child Welfare Services, the working conditions of child welfare workers are compared to employees in the other services. Another objective of this study is to investigate if collaboration together with other job resources and job demands, can predict burnout, engagement and job satisfaction within a Family's House context.

2. Theoretical background

This chapter presents research and definitions on Interprofessional Collaboration, Burnout, Engagement, Job satisfaction, and the Family's House Model.

2.1 Interprofessional Collaboration

Collaboration in the Norwegian Child Welfare Services

In Norway, the Child Welfare Service is bound by law (§ 3-2, Child Welfare Act) to cooperate with other public services to ensure children's wellbeing. This includes collaboration with other services to fulfill their responsibilities for the individual child, but also to give statements and give advices for children on a more general basis (Ministry of Children Equality and Social Inclusion, 1992).

The Child Welfare Service most commonly does not have any formal agreements of collaboration with other services. It depends on the matter of the specific case and is initiated and maintained by the individual professionals involved (Willumsen, 2009). There are some research findings confirming collaboration between the Norwegian Child Welfare Service and Child and Adolescent Psychiatric Clinic, but not much research has been conducted on the quality, the extent and the formal aspects of collaboration (Fossum, Lauritzen, & Vis, 2014).

In 2008, the Offices of the County Governors and the Norwegian Board of Health Supervision carried out a supervision on the municipal cooperation between health, social and child welfare services for children of school age and young people in the age group of 18-23 years. A total of 114 municipalities were included. The results showed that not all municipalities organized services so that cooperation could take place, and many of them did not follow up planned cooperation. It also showed that the municipalities did not provide adequate training of staff. The report concluded that there was cause for concern about whether children and adolescents were identified at the right time and whether they received the services that they needed. The report advised municipalities to assess their routines to ensure that they plan, follow up and evaluate cooperation between services for vulnerable children and adolescents (Norwegian Board of Health Supervision, 2009).

The Norwegian Government launched the Coordination Reform in 2009. One of the purposes was to improve collaboration within the health care services. The medical services and the social services have historically aimed at two different goals; the hospital toward the patient's

physical healing, while the social services often focuses on the client's mastery of life. Patients and clients had reported poor coordination of services (Ministry of Health and Care Services, 2009). The reform claimed that improved collaboration would increase the quality of the given services, they would be given at an earlier stage, and be more cost-efficient. (Ministry of Health and Care Services, 2009). Working with the reform, the Minister at that time identified several fields that represented obstacles for collaboration; differences in funding, legislation, organization, culture and communication, and finally electronic coordination. Hence, these fields were looked upon as important to improve (Hanssen, 2008). The governmental reports are supported by research findings; successful collaboration has shown to be related to improved quality on Health and Care Services (Rafferty, Ball, & Aiken, 2001).

Definition of collaboration

According to the Cambridge Dictionaries Online, the definition is *"the situation of two or more people working together to create or achieve the same thing"*("Cambridge Dictionaries Online," 2014). In a report on teamwork in healthcare, The Canadian Health Services Foundation defined collaboration as "the process of interactions and relationships between health professionals working in a team environment" (2006, p. 4). Further, they define teamwork as a product of collaborations. Martinussen and Adolfsen (2012) add communication, exchange of information and the sharing of knowledge into the concept of collaboration.

Both the terms interprofessional collaboration and interdisciplinary collaboration are being used when discussing collaboration. *Interprofessional collaboration* is when two or more with different professions work together. Profession refers to a particular field of study, e.g., psychology, social work, maternal care. The term *interdisciplinary collaboration* refers to collaboration between different agencies and service providers (Martinussen & Adolfsen, 2012). When different service providers collaborates, the collaboration often includes interprofessional collaboration; e.g., in the collaboration between the Child Welfare Service and Child and Adolescent Psychiatric Clinic, there can be social workers and psychologist collaborating. The terms are connected, and Thylefors and colleagues did not distinguish between these two terms (2005), which is also the case for this study. The term *collaboration* is used in short, and can implicate both interprofessional and interdisciplinary collaboration. Teams are created to make a synergistic effect, an effect greater than the sum of their

individual effects (Thylefors, 2013). Within the health and social field, there is a great variety in types of team and how they are organized. The structure in the team varies, e.g., various professions or disciplines, size of the team, how they cooperate etc. Sometimes the teams are stable over time and sometimes they are temporary, related to a specific patient or situation. Some have defined members, other teams are more flexible and make liaisons with other individuals/teams related to the specific case (Thylefors, 2013). In interprofessional teamwork, knowledge and competences from the various professions/disciplines are included and new knowledge is being created. This knowledge is in health/social care created through discussions and reflections over the patient/clients situation and needs (Willumsen, 2009). In 2005 a survey was performed to identify the types of team organization in cross-professional Swedish human service organizations (Thylefors et al.). They found three categories of teams; multiprofessional, interprofessional and transprofessional teams. In *multiprofessional* teams the members of different disciplines treat a client /patient independently and only share information with each other. *Interprofessional* teamwork implies a high level of communication, mutual planning, collective decisions and shared responsibilities. In the *transprofessional* team an integrative work process is used and disciplinary boundaries are partly dissolved. Multiprofessional teams and transprofessional teams are at opposite ends of a continuum. Thylefors and colleagues found that the most common type of team in Sweden was interprofessional teams, followed by the transprofessional (Thylefors et al., 2005).

In an interprofessional collaboration in the health care system, the engagement and participation of users/clients is seen as very important (Willumsen, 2009). Although user participation is central, the engagement and participation of the client will not be further discussed due to the limitations of the current study.

Aspects of collaboration

San Martin and colleagues defined three categories of elements to successful collaboration in health care; processes in interpersonal relationships within the team (the interactional determinants), conditions within the organization (the organizational determinants) and the organization's environment (the systemic determinants) (San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Several researchers has studied what successful collaboration requires, and in the following the most common challenges are presented, sorted under the three categories created by San Martin-Rodriguez and colleagues (2005).
The most essential element San Martin- Rodriguez et al. found to be the *interpersonal*

relationships. Interactional determinants are the individual members' willingness to collaborate, to trust, their communication skills and mutual respect. This is supported by Thylefors (2013) who also add the strong feeling of belonging (to the team), a common identity, moral engagement, and a feeling of an interchangeably dependence. San Martin-Rodriguez and colleagues referred to studies showing that power differences based in gender stereotypes and disparate social status among the professionals in a team, works as barriers for collaboration. They also found that equality is one of the basic characteristics of collaboration. Differences in professional cultures will also affect collaboration. Limited knowledge of other professionals in the team were considered to be one of the main obstacles for collaboration (San Martin-Rodriguez et al., 2005). Individual personality traits are also found to have an important impact on collaboration (Martinussen & Adolfsen, 2012).

The organizational determinants facilitates, motivates teamwork and defines how the team should work. This is affected by organizational structures and philosophy, and administrative support. Sufficient team resources, procedures describing coordination and communication mechanism is also required (San Martin-Rodriguez et al., 2005). Thylefors (2013) sees the necessity of the team working closely together, that they have a well-functioning communication, and shared responsibility. The need for described procedures for communication were also identified by Martinussen and Adolfsen (2012). This includes what kind of communication should be given in which form (face to face, email, etc). Cameron, Lart and Bostock identified the lack of common software as a challenge for communication and information within the team (2014). It is also seen as important that employees are given autonomy in their work to make collaboration more successful (Thylefors, 2013). This is also supported by Rafferty and colleagues (2001) who found a strong positive association between teamwork and autonomy. According to some authors, successful collaboration requires a shift from traditional hierarchical structures toward more horizontal structures; a successful collaboration requires a more horizontal structure within the team to make all the team members contribute their best (e.g., avoid obedience to authority and minimize conformity) (West, 2012). Interprofessional teamwork can give flexibility, making it easier to respond to the different users' needs. But is can also be a challenge, making areas of responsibility more blurred (Cameron et al., 2014). Within the team it is important that the individuals do not share all the tasks; the specific competences from every profession/person must come to use, and the team members know their responsibility (Thylefors, 2013). Since boundary for tasks and responsibilities are not always evident, it is important within a collaboration that the

involved partners have a clear knowledge and agreement of the different areas of responsibilities and competences. Clarification of boundaries are important to make the most out of the collaboration; that each member know what to expect of the other partners and what is expected of themselves (Willumsen, 2009). Martinussen and Adolfsen also emphasized the importance of agreeing on expectations and roles to have a solid team (2012). The separation between primary and shared tasks, and to agree on expectations and roles, is an important part of the organizational determinant. Another important part are meetings where team members exchange information, solves problems and make decisions. A lot of this communication can happen informally when the team members are co-located. But even if they are at the same location, formal meetings are also required to coordinate services for specific users, develop and ameliorate the teams' competence and work routines, and other organizational matters. Regular meetings are seen as important, but meetings can be time consuming. If lack of time makes team members skip a meeting, the benefit of team work withers, as most of the members carried a unique competence. It is important that structures for meetings are set, to make them efficient and less time consuming (Thylefors, 2013). The authors Glavin and Erdal discusses the importance of a common culture and values within an organization to make collaboration work (2007). It is seen as essential that everyone in the team understands and agree on the purpose and the goals for the collaboration (Cameron et al., 2014; Martinussen & Adolfsen, 2012).

Systemic determinants are legislation, size of budget, type of funding (e.g., capitation- funding related to numbers of patients) (San Martin-Rodriguez et al., 2005). Contextual circumstances are found to be crucial to make the collaboration succeed (Cameron et al., 2014). Cameron and her colleagues found that changes in political priorities and the complexity in new services, made the collaboration become more difficult to operationalize. Different legislations in the various professions and services can hinder or make collaboration challenging in health and social services (The Norwegian Associaton of Local and Regional Authorities, 2013). Sharing information is basic to ensure efficiency and quality of the teams' services, but protection of the individual's right on the other hand can hold some of the information back (Brekk, 2014). Both in the Health Personnel Act and the Child Welfare Act the professional secrecy is important. However, acts also opens for the sharing of important information; the sharing has to be based on the clients' need of services (Ministry of Children Equality and Social Inclusion, 1992; Ministry of Health and Care Services, 1999). Finding the right balance can be challenging (Brekk, 2014).

Conflicts

Conflicts are common, and can even be a sign of a well-functioning team; the differences between the individuals present the various competence, knowledge and experience that is needed in the team. The process where the different backgrounds meet and creates a joint understanding, can therefore consist of conflicts of various degrees (Thylefors, 2013). The need of some differences between team members were also accentuated by Willumsen, stating that too similar partners can cause a less dynamic movement in the collaboration (2009). Nonetheless, conflicts can also be destructive; conflicts that start as disagreements concerning a task, can escalate into a personal conflict between colleagues. To have a 100% conflict- free collaboration is rare, but there need to be strategies in the organization to resolve disagreements and avoid high level of conflicts (Martinussen & Adolfsen, 2012).

Collaborative competence

Several challenges in collaboration have been identified. Researchers draw attention to the need of collaborative competence to meet these challenges. Knowledge of how to handle the difficulty of cultural (both profession and cultural) and linguistic barriers in a collaboration may reduce the chances of misunderstanding (Martinussen & Adolfsen, 2012). Glavin and Erdal saw the importance of having routines for training new colleagues and further development of the collaboration in the organization (2007). Cameron also identified training and supervision as important to make the collaboration work (2014).

In their review, San Martin-Rodriguez and colleagues identified the need for further development of the educational programs to make students value professional pluralism and give them knowledge of interprofessional collaboration (2005). A report to the Norwegian Parliament emphasized the need for knowledge and competence amongst the various health- and social professions, and recommended that is was to be embedded in the educations (Ministry of Education and Research, 2012). The education has to create positive attitudes towards other disciplines and a positive attitude towards collaboration.

Leadership in teamwork

Thylefors described different aspects of leadership in relation to teamwork (2013), and this section is based on her work. Leadership is one of the most important factors when it comes to the teams' structure. Within the team there can be two forms of leadership; formal leadership and leader behavior. Leadership is a position or role, connected to specified

responsibilities. The leader behavior on the other side, can be performed of any employee. This is any behavior with the purpose of supporting collective or individual efforts to achieve the common goal. Thus, team leadership has two dimensions; one that is vertical and consists of formal leaders, and another which is a horizontal dimension with shared leadership and changing leader-roles.

Leading a team consisting of different professions, can be a challenge. The leader will not have the natural given authority as an expert in relation to all the employees. Sometimes the employees will not be so susceptible to the leader, feeling that the leader does not have the competence in their discipline. It also occurs that employees with the same profession as the leader, feels closer to the leader and better understood. At the same time there are leaders who have competences in many fields, and others who take advantage of their own coworkers and external experts to make good decisions.

Several researchers argue for both horizontal and vertical leadership within a team. Without a formal leader, the teamwork may fail. This can be caused by internal power struggle, and an unproportioned amount of time spent on discussing process and handling conflicts. The autonomy and engagement needs a leader that can assist when it is needed. This by reminding of the common goal, encourages, distributes tasks, and is the objective part in a conflict.

Thylefors also adds important features of the leader; he/she needs to be more like a "coach" and a team leader than a traditional leader, engaging the whole team to achieve the common goals (Thylefors, 2013).

Using collaboration to create healthy workplaces.

Interprofessional collaboration in healthcare is not only seen as a mean to achieve better and more cost-efficient services for clients. Collaboration is also seen as a potential mechanism to create healthy workplaces (Suter et al., 2012). In their knowledge synthesis the authors shows how interventions implemented to improve interprofessional collaboration impact health human resource outcomes, in addition to cost-effectiveness. Health human resources are work related conditions like quality workplace, staff satisfaction, recruitment, retention, turnover and choice of employment. One study shows that effective collaboration is associated with higher job satisfaction (Deloacxh & Monroe, 2004, in Suter et al., 2012). This is also supported by West (2012). Overall, Suter and colleagues found that interprofessional interventions for working professionals positively influenced provider satisfaction and

workplace quality. Provider satisfaction is considered an important quality healthcare indicator. The mechanisms through which interprofessional practice interventions affect the quality of the workplace are diffuse, but it appears that the effects might be mediated through improved interprofessional collaboration and more efficient work processes. There was also strong evidence for cost savings related to patient care, and positive effects on patient outcomes (Suter et al., 2012).

Studies on projects to improve collaboration within Norwegian Health and Care field for children

In a study among employees in six pilot Family's Houses (The pilots and the project is described further in chapter 2.4 The Family's House Model). Most of the participant, 85%, felt that the Family's House Model had, to a great or very great extent, led to more informal collaboration between services, and in overall they thought that both informal and formal collaboration had increased. A large part, 83%, felt that they had increased access to a larger professional network (Haugland et al., 2006).

An intervention aimed at improving interprofessional collaboration and service quality among human service professionals working with children and adolescents in ten municipalities in Northern Norway, were evaluated by Martinussen and her colleagues in 2012. The intervention included the establishment of interprofessional groups and offering courses. Both the districts where the intervention had been introduced, and the comparison group was measured. The difference in perceived collaboration was small, but still indicated that the project had been successful in accomplishing the main goal, i.e., increasing the level of collaboration (Martinussen, Adolfsen, Lauritzen, & Richardsen, 2012).

2.2 Burnout and engagement

Burnout

Burnout is recognized as an outcome of chronic emotional and interpersonal stress on the job. The core symptoms are overwhelming exhaustion, feeling of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment (Maslach et al., 2001). The symptoms relates to both job performances and health. Long-term stress has been found to have negative effects on the brain, and can cause problems with memory and concentration (Sandström, Olsson, Rhodin, Lundberg, & Nyberg, 2005). Burnout affects both the individual and the organization; the situation is often experienced as uncomfortable for the individual, commonly accompanied by physical complaints, and reduced well-being. For the

organization, it can lead to long term sick leaves, high turnover and lower productivity (Maslach et al., 2001). Some of these outcomes is seen as a behavioral coping response (Lee & Ashforth, 1996).

Use of the term burnout began to appear in the 1970s in the United States, especially among people working in human services and health care. Burnout research has its roots in care-giving and service occupations. In this field of work, the core of the job is the relationship between the provider and the recipient, and emotional and interpersonal stressors can characterize some of the challenges met by workers. Research has shown that health care personnel are at risk for developing burnout due to the nature of their work (Demerouti et al., 2000). Later research has shown that burnout can occur in different occupational groups, not only health and service related work (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Maslach et al., 2001).

Burnout is found to be related to anxiety and depression, and individuals who are more depression-prone are more vulnerable to experience burnout (Maslach et al., 2001). Five common elements of the burnout phenomenon has been described. First, there is a predominance of dysphoric symptoms such as mental or emotional exhaustion, fatigue and depression. Second, the emphasis is on mental and behavioral symptoms more than physical ones. Third, burnout symptoms are work-related. Forth, the symptoms manifest themselves in "normal" persons who did not suffer from psychopathology before. Fifth and last, a decreased effectiveness and work performance occur because of negative attitudes and behaviors (Maslach et al., 2001).

The research on burnout in human services has led to a consensus of three core dimensions; emotional exhaustion, depersonalizing and reduced personal accomplishment. This reflects the focus on occupations where workers interacted extensively with other people. For research on other occupational groups more general dimensions has been developed; exhaustion, cynicism (a distant attitude toward the job), and reduced professional efficacy (Maslach et al., 2001). Burnout has been found not to be an absolute state that is either present or absent. It is complex, and the aspects of burnout are present to varying degrees (Leiter & Maslach, 1999). The exhaustion component is the central quality of burnout and the most obvious manifestation of this syndrome. It refers to a feeling of being overextended and depleted of one's emotional and physical resources. Exhaustion is the aspect of burnout that is the most widely reported and that has been most thoroughly analyzed. Even though it is a necessary

criteria for burnout, it does not sufficiently explain the syndrome. Exhaustion reflects the stress dimension of burnout; it does not capture the critical aspects of the relationship between people and their work. There is a strong relationship between exhaustion and cynicism, people use distancing as an immediate reaction to exhaustion. Cynicism is characterized by negative feelings, cynical attitudes and distancing. This dimension can also be seen as a coping strategy; by making distance between oneself and service recipients, the demands seem more manageable. A work situation with chronic, overwhelming demands that contribute to exhaustion or cynicism is likely to wear down one's sense of effectiveness. Feeling exhausted or when helping people to whom one is indifferent, it is difficult to get a sense of accomplishment. The component of reduced efficacy or accomplishment represents the self-evaluation dimension of burnout. It refers to a feeling of incompetence. The lack of efficacy seems to arise more clearly from a lack of relevant resources, whereas exhaustion and cynicism emerge from the presence of work overload and social conflict and a lack of achievement and productivity at work (Maslach et al., 2001).

Outcomes of burnout is, as mentioned earlier, shown to be related to both job performances and health. For the organizations, the lower job performance is caused by: absenteeism, intention to leave the job and turnover. In addition, for the people who stay, it leads to lower productivity and effectiveness at work, decreased job satisfaction and a reduced job-commitment. Burnout can also be "contagious", since workers experiencing burnout can cause greater personal conflict and disrupting job tasks. There is also some evidence that burnout has a negative effect on people's home life (Maslach et al., 2001).

Engagement

Traditionally, the focus of psychology has been on pathology and deficits. However, more attention is being paid to human strengths and optimal functioning in modern research. The concept of burnout was also supplemented and enlarged by its positive antithesis of job engagement. The dimensions energy, involvement and efficacy characterizes job engagement (Maslach et al., 2001). Leiter and Maslach identified the dimensions of engagement as direct opposites of the three dimensions of burnout, and rephrased burnout as an erosion of engagement (1999). Schaufeli and Bakker (2004), argued that instead of being two opposite poles, burnout and engagement are independent, but at the same time negatively correlated states of mind. They defined engagement as: "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (2004, p. 295). They found that

burnout and engagement were negatively related, a finding that was confirmed in a meta-analysis (Halbesleben, 2012). The study of Schaufeli and Bakker illustrated that burnout, as a negative psychological state, and engagement as a positive psychological states, play similar roles in quite different processes. Burnout […] "plays a mediating role in an effort-based energetic process that is driven by high job demands and that eventually might lead to health problems" and engagement […] "plays a mediating role in a motivational process that is driven by available resources and that might lead to organizational attachment" (Schaufeli & Bakker, 2004, p. 310). The authors argued that including the concept of engagement, increased the understanding of employee function. Just as burnout, there are indications that engagement can be contagious; between colleagues or between leader and employee, suggesting that engaged workers influences their colleagues and consequently perform better as a team (Bakker, Albrecht, & Leiter, 2011). Bakker and his colleagues also observed fluctuations in engagement on a daily basis, showing that it is a dynamic and temporary state within the individual (Bakker et al., 2011).

In his meta-analysis, Halbesleben found that engagement was stronger related to resources than to demands (2012). Bakker, Albrecht, and Leiter proposed that a transformational and empowering leadership will both lead to engagement, and they recommended further investigation to fully understand the influence leadership has on engagement (2011).

Job engagement can give an inner motivation that nourishes growth, learning and development for the employee, and at the same time be an outer motivation because they are instrumental to achieving important goals (Schaufeli & Bakker, 2004). There are findings implying that engaged employees make choices and shape their own jobs; they proactively change their job demands and resources. In this way they increase their own work engagement. Commitment, health, performance, and lower turnover intention was found as outcomes of engagement (Halbesleben, 2012). Low sick-absenteeism has also been found as an effect (Demerouti et al., 2001). In their review, Bakker and his colleagues found a possible negative side to engagement; if the workers get overly involved in paid work, work-family conflicts and other negative consequences may occur (Bakker et al., 2011). This was supported by the meta-analysis of Halbesleben (2012).

Preventing burnout and enhancing engagement

Research has shown that people can learn coping skills for their job demands. But, it is not proven that these new skills can prevent burnout, since coworkers do not always have the possibility to decide and make changes in their job situation. To deal with burnout, it is necessary to work with both the individual and the organization; changes in managerial practice and educational interventions (Maslach et al., 2001). Demerouti and colleagues emphasized the importance of assessing and monitoring the workplace to identify problems and propose interventions to prevent or reduce burnout (2000). Schaufeli and Bakker argued the importance of both researchers and practitioners to make a positive difference in organizational context (2004), with the use of interventions shaped by research to improve engagement. Decreasing job stressors above increasing job resources to reduce burnout symptoms was recommended (Schaufeli & Bakker, 2004). The meta-analysis of Halbesleben, reinforced the notion that development of employee resources can be the best mechanism to enhance employee engagement (2012).

The Job-Demands Resources Model.

As described, burnout and engagement are related to demands and resources at the workplace. Demerouti and colleagues has described a model that shows the connections between resources and demands, and burnout and engagement (2001). Job resources and job demands are defined as:

> "Job demands refer to those physical, social, or organizational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs [….]. Job resources refer to those physical, psychological, social, or organizational aspects of the job that may do any of the following: (a) be functional in achieving work goals; (b) reduce job demands at the associated physiological and psychological costs; (c) stimulate personal growth and development."
> (Demerouti et al., 2001, p. 501).

Job resources are also seen by Demerouti and colleagues as factors that protects the health even in demanding situations (e.g., under heavy workload). There can be both external (organizational and social) and internal (cognitive features and action patterns) job resources (Demerouti et al., 2001). Demerouti and her colleagues focused only on the external

resources when they made the model because there is no general agreement regarding which internal resources can be considered stable or situation independent- and which can be changed by adequate job design. Organizational resources include job control, potential for qualification, participation in decision-making and task variety. Social resources refer to support from colleagues, family and peer groups (Demerouti et al., 2001). The original model was further developed by Schaufeli and Bakker (2004). Figure 2 shows the model as it was presented by Martinussen and Adolfsen (2012).

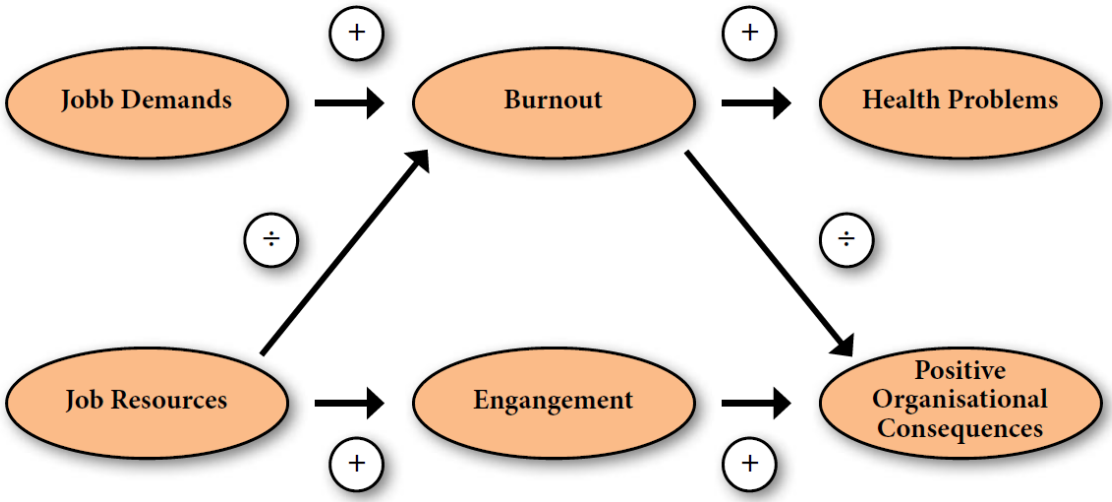

Figure 1 The Job-Demands Resources Model, based on Demerouti et al. 2001 and Schaufeli & Bakker, 2004

In lack of job resources, there will be a reduction of motivation and withdrawal, acting as a self-protection mechanism, hence disengagement (cynicism) is an outcome of shortage of job resources. Burnout is strongly connected to job demands but also to lack of resources while engagement is foremost connected to job resources (Demereuti et al. 2001). This relation is also confirmed by other studies, (Demerouti et al., 2000; Halbesleben, 2012; Richardsen & Martinussen, 2008; Schaufeli & Bakker, 2004). A meta-analysis of 61 studies using MBI, found that demands trigger emotional exhaustion, while resources help to overcome depersonalization and enhances one's self-efficacy (Lee & Ashforth, 1996). Both engagement and burnout are important for the individuals' health while simultaneously being important for the individuals' work performance and attitudes at work. The model (in short called JD-R Model) shows that both reducing burnout and promoting engagement is important not only for the employees' welfare, but also for the outcome of their work. In social and health care, this

is the welfare of service recipient (Demerouti et al., 2001).

The JD-R model shows two processes in the development of burnout. In the first process, the demanding aspects of work (i.e., extreme job demands) lead to constant burdening and eventually, to exhaustion. In the second process lack of resources complicates the meeting of job demands, which enforces the withdrawal behavior. Long-term effect of this withdrawal is disengagement from work. The JD-R model suggests that job demands leads to exhaustion, while lack of job resources led to disengagement. The state when both processes occur and exhaustion and disengagement are simultaneously present represents the burnout syndrome. Exhaustion and disengagement correlate but they are not necessarily casually related to each other, but to the particular working conditions. The general framework in the model seems to remain stable across occupational fields. The model can be used to study different occupations, adjusting the range of potential job demands and job resources (Demerouti et al., 2001). Studies have shown that job resources become salient and more motivational when employees have higher job demands (Bakker & Demerouti, 2007). Thus, work environments with more job resources foster work engagement particularly when demands are high.

Identifying factors related to engagement and burnout

Demerouti et al. (2001) used eleven theoretically derived working conditions to measure job resources and job demands when they made the original JD-R model (see Figure 2). This was in a study with employees from 21 different jobs in three different occupational fields; human services, industry and transport. One of the results of the study indicated structural relationships in the JD-R model of burnout across different occupational groups, although human services seem to fit best to the model. It also showed that specific job demands and resources varied across groups (Demerouti et al., 2001).

The demands suggested in the model were supported in a study of nurses. Poor working conditions seemed particularly stressful when the nurses lacked a good support network and did not have the possibility to discuss and improve their patients' quality of life (Demerouti et al., 2000). Additional job demands and resources has been studied for the health and care field (e.g., Martinussen et al., 2012; Richardsen & Martinussen, 2008; Schaufeli & Bakker, 2004).

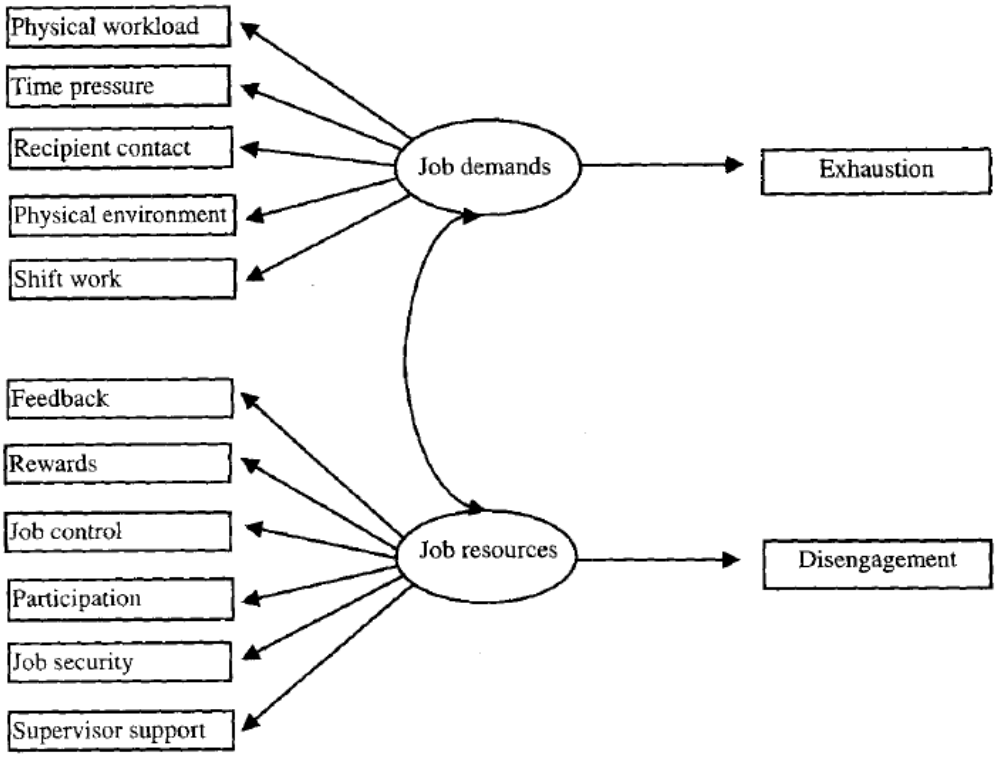

Figure 2 The original Job Demands-Resources Model, Demereuti et al., 2001

The meta-analysis done by Lee and Ashforth (1996) included 61 studies using the MBI. They found that the three dimensions of burnout were differentially associated with different job resources and job demands. The positive correlation between different demands as role conflict, role stress, workload, and emotional exhaustion and depersonalization were strong. Correlation between demands and personal accomplishment were generally weak. The job resources social support, supervisor support, community bond, innovation, participation, unmet expectations and non-contingent punishment correlated negatively with emotional exhaustion. Community bond, team cohesion, and skill utilization correlated negatively to depersonalization. Personal accomplishment correlated positively with work friends, participation and team orientation.

In a meta-analysis Halbesleben (2012) found that the resources social support, autonomy, and self-efficacy were positively associated with engagement. He also found that the relationship between job demands and engagement was weaker than the relationship between resources and engagement. The meta-analysis had an unexpected finding for the relationship between work-family conflict, family-work conflict, and engagement. The conflicts were positively correlated to engagement. The author discusses explanations to this phenomena; it could

relate to the small number of samples in the analysis, and therefore be a spurious result. It could also be that too much engagement can actually intensify work-family and family-work conflicts. If the employee is fully absorbed in work, there can be higher levels of conflicts between work and family roles (Halbesleben, 2012).

Job resources and demands in the Norwegian Health and Care field

Work situations for one profession can vary from one country to another. The health and care field are often public services who are dependent on the political priorities, both concerning funding and legislations. Some of the job demands and job resources may therefor vary between countries. In a Norwegian study of physiotherapist the results were inconsistent with some international studies. The authors saw this as a possible reflection of genuine differences in working conditions across countries (Martinussen et al., 2011).

Some of the job resources that have been studied in relation to burnout and engagement in Norway are autonomy, social support, collaboration, leadership satisfaction, career satisfaction, and future possibilities. Studied job demands are workload, work hours, overtime, work conflicts, work-family pressures, and leader responsibilities (Martinussen et al., 2012; Martinussen et al., 2011; Martinussen, Kaiser, Adolfsen, & Hansen, 2014; Richardsen & Martinussen, 2008).

The job resource autonomy reflects the degree of influence and control the individual has on; what their work tasks are, how they are to be performed, the amount of work, and possibility for developing work skills. Social support reflects the degree of assistance, recognition, information and kindness from coworkers and leader. The job demand workload shows the degree of stress; are there sufficient time and resources available to perform work tasks, can the employee work as planned and without interruptions, are the employee feeling tired after work and to which degree do they take home work problems. Work conflict is to what extent there are conflicts at work with colleagues or leaders. Work-Family Pressure reflects the conflict between responsibilities at home and at work. Another two job resources have been added and used in more recent studies; collaboration and leadership satisfaction. Collaboration describes collaboration with other services; if it is easily obtain, if there are established arenas for collaboration, if the services has agreed on areas of responsibilities and competences, mutual respect, and consensus in problem solving (Martinussen et al., 2012). Leadership Satisfaction reflects how the employee percepts their leader. Does he/she; clearly

describes the objectives of the organization, suggests new ways of improving the services, leads the organization efficiently for the better of the clients and employees, creates strong relations to the local community, and makes the different services collaborate (Martinussen et al., 2014).

In a study of municipal child and adolescent workers, work- family pressure and lack of autonomy was found to predict exhaustion (Martinussen et al., 2012). This was consistent with previous findings (Martinussen et al., 2011), and the latter study also found that social support predicted personal accomplishment. In 2014, Martinussen and her colleagues found that the job demands workload, family conflict and work conflict and job resources as autonomy, social support, collaboration and leadership satisfaction correlated with burnout.

In the same study, workload and family conflict correlated negatively to engagement, though the correlation was weaker compared to the positive correlation the variables had with burnout. All job resources correlated positively to engagement (Martinussen et al., 2014). The correlation was also confirmed by other studies showing that job resources predicted engagement, and that the relation between job resources and burnout were stronger than the relation between job resources and engagement. (Martinussen et al., 2012; Martinussen et al., 2011; Richardsen & Martinussen, 2008). A more recent study found that job demands were related to exhaustion and job resources were related to engagement, job satisfaction and quality (Martinussen et al., 2014).

The Norwegian studies have indicated that the workers list training and further education as a resource which would improve their work. In addition they listed better collaboration, more time to spend with every family, and supervision (Martinussen et al., 2012; Martinussen et al., 2014). A well-functioning collaboration and good leadership was of importance for the employees' perception of their working conditions and the quality of their services (Martinussen et al., 2014).

Collaboration as a job resource

As mentioned, Norwegian health and care workers list collaboration as a job resource. The workers saw a well-functioning collaboration as an important part of working conditions and as a necessity for the quality of their services (Martinussen et al., 2014). The importance of collaboration for service quality is also supported by the coordination reform (Ministry of Health and Care Services, 2009).

In the study of burnout, engagement and service quality amongst human service professionals, collaboration was not found to be a predictor of engagement or burnout (Martinussen et al., 2012). This was inconsistent with previous findings that have indicated a significant, negative correlation between collaboration and burnout (Rafferty et al., 2001). Martinussen and colleagues reason for this inconsistency by their study including a number of other work-related factors, hence the study imposed a stricter test of collaboration. In the same study, collaboration was found to predict service quality (Martinussen et al., 2012). In the study of Child and Family Primal Care in Asker Municipality in 2014, Martinussen and her colleagues found that Collaboration had positive correlation with engagement and a negative correlation with burnout. Collaboration also had a positive correlation with satisfaction (Martinussen et al., 2014).

Demographic factors

Age has been found to predict engagement, which could indicate that engagement increases with experience (Richardsen & Martinussen, 2008). Of the demographic factor, age has been most consistently related to burnout. Among the younger employees the level of burnout is reported to be higher than it is among those over 30 years old; burnout appears to be more of a risk earlier in one's career (Maslach et al., 2001). However, Maslach and her colleagues discussed the problem of survival bias; those who burnout early in the careers often quit their jobs, while those who exhibit low levels of burnout stay (2001). Other researchers have found demographic factors such as age and sex has small, if any impact on burnout (Demerouti et al., 2000; Martinussen et al., 2012; Martinussen et al., 2011).

In a study of workload, stress and satisfaction among Norwegian psychologists, there were no significant differences in how woman and men perceived job-stress. However, differences between sexes were identified in unpaid work (housework) (Østlyngen, Storjord, Stellander, & Martinussen, 2003). Other studies show small correlations or inconsistent patterns regarding demographic factors such as sex and age with burnout and engagement (Demerouti et al., 2000; Martinussen et al., 2012; Maslach et al., 2001). This was also confirmed by Martinussen and her colleagues (2011), but they also found a weak correlation between vitality and ability to engross in the work, with age. The authors suggest that this could relate to job engagement increasing with the employees experience and competence. This correlation was also found by Richardsen and Martinussen (2008).

In the study performed in Norwegian Child and Family Primary Care, 94% of the participants were women (Martinussen et al., 2014). Numbers from Statistics Norway shows that 85% of the employees in the Municipal Child Welfare Service were female (Johansen, 2014), indicating that the share of female in the study from 2014 can be characteristic for this field. Thus, in research within Child Welfare Services, it can be difficult to investigate any gender differences.

2.3 Job Satisfaction

Job satisfaction can be defined as the amount of overall positive affect employees have towards their jobs in relation to all aspects of the employment (payment, advancement opportunities, management style etc.) (Hombrados-Mendieta & Cosano-Rivas, 2013). Bhatnagar and Srivastava (2012) argues for the importance in studying aspects of job satisfaction, as it is seen as an important outcome reflecting the quality of organizational life, and as a necessity to maximize the human resource potential. In health organizations, a better understanding of job satisfaction can increase the level of motivation that is associated with patient satisfaction (Bhatnagar & Srivastava, 2012). The authors argue for the importance of job satisfaction with several reasons; being an indicator of emotional well-being or physiological health, it reflects a good treatment of the employees, and it can be a reflection of organizational functioning (Bhatnagar & Srivastava, 2012). Satisfaction has been broadly discussed in literature where many of the studies examine the relationship between job satisfaction and personal variables and work variables. An increasing number of studies validate the importance of social support on job satisfaction. Several studies have also associated job satisfaction and burnout in social work, a high job satisfaction is negatively associated with burnout (Hombrados-Mendieta & Cosano-Rivas, 2013; Lee & Ashforth, 1996). In the study of Spanish social workers, job satisfaction was found to have a direct positive effect on life satisfaction, and burnout had a negative influence on job satisfaction. The study also found that job satisfaction was a significant predictor of important behaviors like absenteeism and turnover (Hombrados-Mendieta & Cosano-Rivas, 2013).

In an English study, autonomy was found to be positively correlated to job satisfaction and perceived quality (Rafferty et al., 2001). Thylefors and colleagues (2005) sees team climate as an aspect of work satisfaction. In their study, a moderate positive correlation was found between team type and team climate; the closer the collaboration, the more perceived positive team climate (Thylefors et al., 2005). In the study amongst psychologists in Norway,

Østlyngen and colleagues did not reveal any correlation between workload and job satisfaction, but autonomy and social support was found to have a positive significant correlation with job satisfaction. They also found that autonomy, social support, salary satisfaction and experience predicted a large part of job satisfaction, with autonomy as the most important factor (Østlyngen et al., 2003). Martinussen and colleagues found that job demands such as workload, work conflict, and family conflict correlated negatively with job satisfaction, while job resources like support, autonomy, leadership satisfaction and collaboration correlated positively (Martinussen et al., 2014).

A study of child welfare workers found the unexpected correlation between emotional exhaustion and job satisfaction. Elaborative qualitative studies showed that even though some child welfare workers experienced high level of exhaustion, they found the work gratifying and believed in its importance, thus experience job satisfaction (Mandell, Stalker, Wright, Frensch, & Harvey, 2013).

2.4 Family's House

In Norway there are many different service providers that share responsibilities for health, development and welfare of children, adolescents and families. These providers are professionally embedded in various departments and ministries, they are financed differently and they operate within varied legal frameworks.

In a family's and a child's daily life there are multiple arenas like home, school/kindergarten, friends and leisure activities. Experiencing health/developmental problems they are affected and meet challenges in several arenas. These complex challenges requires a service that is capable of identifying the total of issues and at the same time both cooperate with, and develop the various arenas. There has been has pointed out lack of coordination between the service providers, leaving children and families with complex problems without adequate help/service (Ministry of Health and Care Services, 2009). This is one of the reasons the department in 2009 released «The Coordination Reform». One of the goals was to establish frameworks that enables and facilitates complex services.

The Family's House Model

The model offers a tool for interdisciplinary teamwork. It's a model for coordination and cooperation of health and developmental services for children, adolescents and families. The goal is flexible and dynamic services, adapted to the child's and family's needs. Municipal

services like Open Kindergarten, Health Care Station, Educational and Psychological Services and preventive Child Welfare Services can be co-located. It is also common to have cooperation with other professionals such as medical doctors, psychologists, youth units in the police, and non-governmental organizations. In addition to better coordinated services, the goal is also providing help/service at an early stage. The service is supposed to be fast and holistic with a low threshold, and it is considered as preventive and health promoting, and are aimed at all children, not just the most vulnerable (Bing, 2012a). The model in Norway is based on the Swedish model of «Familjcentraler» and adopted as a part of the Norwegian Plan for Advancing Mental Healthcare 1999-2008 (Haugland et al., 2006). There is a close interaction between Norway and Sweden concerning the development of Family's Houses, both within research and practice (Bing, 2012a). The term "Family Centre" is also used for this collaboration model, especially within research outside of Norway.

The services at the Family's House are given in three categories; universal, selective and individual. The universal services are offered to the whole community, similar to a service like the healthcare station. Selective services are given to groups of users that has specific needs. These users are identified through the universal services. Individual services are given to individuals with specific needs. All services are related to the Open Kindergarten where the different professionals participate and introduce themselves, the service they provide and their knowledge to the users and to the other employees. At the same time they get to know the children and the families (RBUP - North, 2008). The Open Kindergarten serves as a pedagogical, open and inclusive meeting place for the parents of young children. The parents/caregivers are given the opportunity to use the kindergarten service whenever they need it, within the opening hours, and there is no need for an appointment. During opening hours, the Family's House offers a meeting place and a secure and stimulating environment, both for children and parents (Thyrhaug, Vedeler, Martinussen, & Adolfsen, 2012b).
In a report made by Ramböll (2014) concerning the Family's House, they found several aspects were the model performed better than traditional health and social services:

- Services that had a better fit according to need
- Easier access to the right professional
- More innovative work
- Better timing
- More access to other parents

- Lower threshold
- More holistic thinking

(Rambøll, 2014, p. 12)

In 2002-2004 a national pilot study was conducted in six municipalities in different regions of Norway by the Regional Centre for Child and Youth Mental Health- North (called RBUP North at that time, now called RKBU North). Both employees and users reported better interdisciplinary cooperation and stronger user involvement. The pilot was considered a success and was continued and spread to more municipalities with part governmental funding (Haugland et al., 2006). The "Coordination Reform" recommended that the local municipalities followed the model developed from the pilot (Ministry of Health and Care Services, 2009).

A brochure was developed in 2008 by RBUP and the six pilot Family's Houses, describing goals, services, and establishment of Family's Houses (RBUP - North, 2008). The goals were described as:

- identifying physical, mental and social challenges for children and their families early on
- making support and services readily
- supporting and strengthening parents in their role as caregiver and mentor
- assisting children, adolescents and their families in strengthening social networks
- developing communication and work methods that encourage children and parents to participate
- developing good, coordinated and interdisciplinary services for consumers
- being available as a neighborhood gathering place
- Distribution of relevant information

(Mørch, 2012, p. 17)

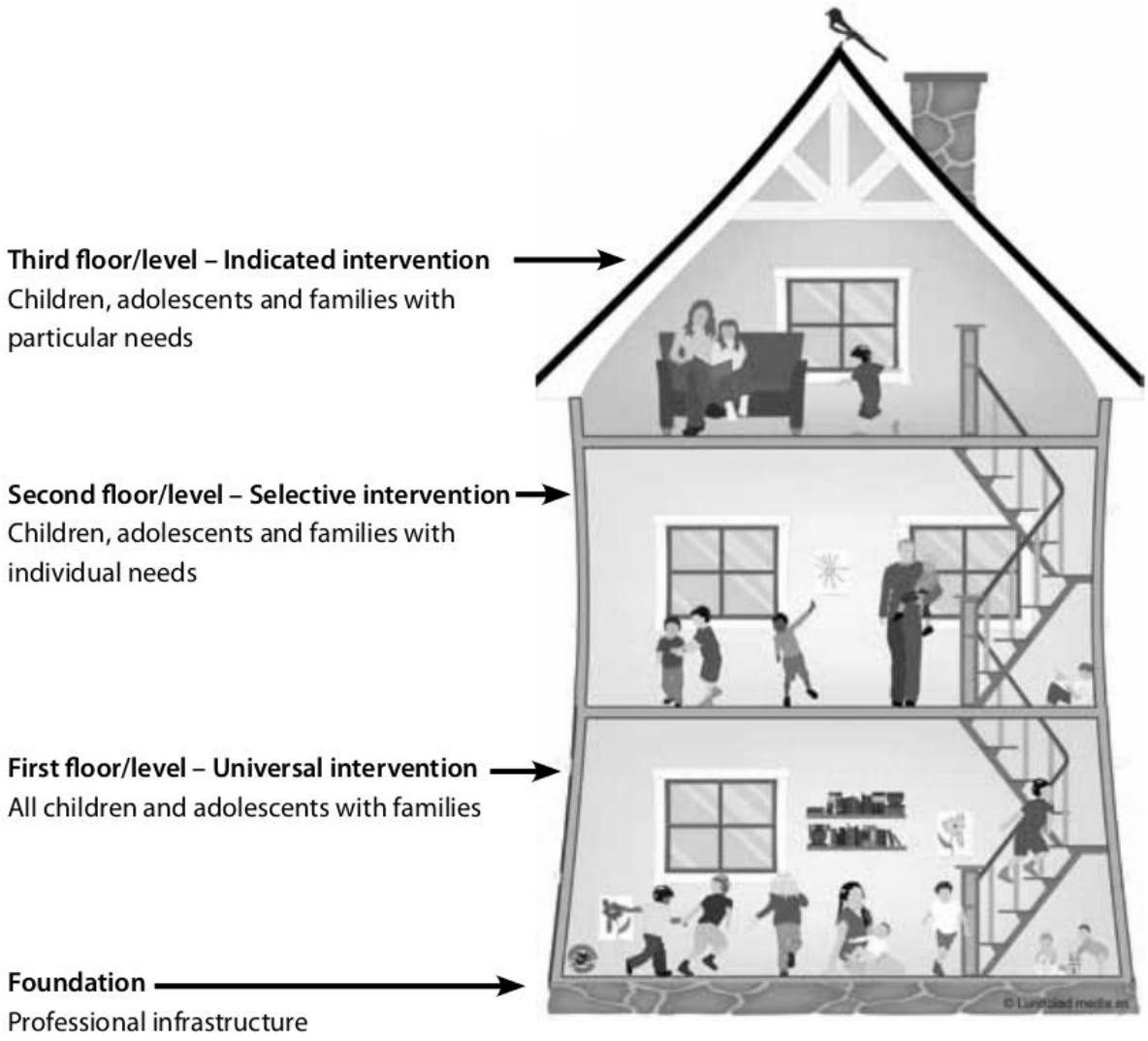

Figure 3 The Family's House Model (From Thyrhaug, 2011)

The brochure emphasizes the importance of all disciplines knowing their specific legal framework, and how the confidentiality will work in an interdisciplinary setting. The leader of the Family's House is responsible for further development of the center, along with administration tasks, organizing guidance, teambuilding etc. (RBUP - North, 2008).

It was also recommended that the staff at the center were given training in teamwork and guidance in interdisciplinary cooperation, both during the establishing process and in the operational Family's House. It was also seen as necessary to make a chart of how the staff share different tasks and responsibilities and to establish cooperation with external partners (e.g., doctors, psychologists, dentists, Social Services, non-governmental organizations) (RBUP - North, 2008).

Bing (2012b) describes that the professional role in the Family's House will vary depending on the task; performing as an expert, host, play leader or circle leader. The staff must continuously switch between these roles. Knowledge advancement is given, as in all social/health related work, through research, political values and legislation. But in addition the Family's House work closely and dynamically with families; they adapt and develop their work in according to the family's need. The work at a Family's House is not static and can be challenging (Bing, 2012b).

For research purposes, a definition of a Family's House was launched by Thyrhaug (2009); it had to contain an Open Kindergarten, a Health Care Station, Pregnancy Control and Care, and Preventive Child Welfare Services and/or Educational and Psychological Services. A total of 14 Family's Houses were identified in Norway by Thyrhaug, but there were several more that had other co-located interdisciplinary services for children and families (2009). A research performed in 2011 discovered 24 Family's Houses and more than 100 organizations that had three or more services co-located (Martinussen & Gamst, 2012).

Description of the six pilot Family Houses

Several studies has been involved the six pilot Family Houses. Haugland et al (2006) did the first study, not long after their establishment. Engaged project managers run the pilot Family's Houses, and they had guidance and counselling from a national project team, and part governmental funding during the establishment period. A network for municipalities with Family's Houses was also formed. Some of the municipalities were chosen for the establishment partly because they already had started developing the interdisciplinary collaboration between their services. Before commencing the establishment, there was several requirements; that the political leadership in the municipality agreed, that suitable locations were available, and that Open Kindergarten together with health and social services for children and adolescents were to be a part of the project. Another requirement was that other services like non-governmental organizations, police, church etc. was available and could participate when needed. In the evaluation of the Houses, both increased collaboration and user involvement was found (Haugland et al., 2006). Thyrhaug (2009) studied both the six original Houses and newer establishments. The original Houses had been running for four to seven years when Thyrhaug performed her study. All of the pilot Family's Houses seemed to follow the original model, but differences between them were also revealed. Thyrhaug found that all of the six houses had a coordinator. Four of the houses had their own budgets, while

two of them had budgets consisting of funding from different municipal agencies. All of the six Houses had established interprofessional teams, and two of the Houses had separate teams working with children in different ages. One of the Houses had weekly meetings for their interprofessional teams, three had every other week, and two of them has monthly meetings. All of the six Houses had regular collaboration with Child and Adolescent Psychiatric Clinic, Municipal Psychological Team, and Municipal Physiotherapy/ Habilitation Services. Three of them also had regular collaboration with NAV (The Norwegian Social Welfare System). One of the Houses also collaborated with a Non-Governmental Organization (Thyrhaug, 2009).

Identifying strength and challenges in the Family's House Model.

Both Thyrhaug (2009) and Martinussen and Gamst's (2012) findings indicated that there were a number of different interprofessional organizational forms, far from all following the Family's House Model in the later establishments. Martinussen and Gamst (2012) also showed that only one-fourth of the organizations had an Open Kindergarten. This is an interesting finding, given the qualitative study by Abrahamsson and her colleagues showing that it is the Open Kindergarten that makes the Family's House more accessible to parents (Abrahamsson, Bing, & Löfström, 2009). Martinussen and Gamst (2012) and Thyrhaug (2009) studies also showed that teamwork was common, indicating that the co-location had increased the interdisciplinary cooperation. A research in Sweden also supported this relation, in addition the staff experienced that co-location led to a more holistic thinking (Abrahamsson et al., 2009). At the same time an increased participation from the users were also identified by Martinussen and Gamst, although there were variances in how much the organizations engaged their users (2012). Martinussen and Gamst also found out that 89% the organizations had a leader that was responsible for the collaboration-model (Martinussen & Gamst, 2012).

Thyrhaug (2009) remarked that even when various services are co-located, more is probably required to make sure that the interdisciplinary teamwork is functioning. Their research also showed that little was done to test the actual quality of the teamwork. Their findings indicated that establishing a full function Family's House, was a demanding process which could take years (Thyrhaug, 2009).

The Swedish study done by Abrahamsson et al. (2009) showed that the integrated services being financed differently, caused challenges for some of the services. The financing of Midwifes and the Child Care Nurses are related to the number of visits they perform (Child

Care Nurses perform examinations on babies and younger children's health and development). At the same time, several of the other services like the Open Kindergarten and the Child Welfare Service does not have financing related to the numbers of families they meet. Being a part of the Family's House includes spending time meeting with colleagues and participating in the Open Kindergarten. This was causing a conflict for the Midwives and the Child Care Nurses who received less time for visits, thus risking a lower finance. This conflict were looked upon by staff as an obstacle and a better financial framework was suggested as an improvement for the Family's House (Abrahamsson et al., 2009).

The different legislations related to the different services are demanding for the staff and their work (Thyrhaug, 2011). The fundamental rules of confidentiality has to be respected despite the interdisciplinary collaboration, as Lassen describes in her information concerning professional secrecy in Family's Houses (2012). Thyrhaug identified a challenge for the employees; it is important that the various professionals develop mutual understanding for the different constraints related to the rule of confidentiality. This to avoid misunderstandings that, in turn can lead to a negative working environment (2012). Legislation defines the users and gives them different rights; if the user is receiving what is characterized as medical assistance, the user is defined as a patient. This leads to consequential patient rights for the user, which is different from when the user is receiving social or pedagogical assistance. This definition and difference in rights can also cause errors and misunderstanding (Mørch, 2012). For professionals in the health and social field, the only way to be able to discuss a case interdisciplinary is to ask for the individuals consent to do so. In emergency situation this consent is not necessary (Lassen, 2012). The need for consent applies both for discussing cases verbally, and for written reports. This indicates that the different services involved in the Family's House, cannot have a shared system for written documentation. Meanwhile, if cases are anonymized, they can be discussed interdisciplinary. Lassen thinks this is used extendedly in interdisciplinary collaboration, but incorrectly; in reality most of the present professionals know who they are discussing, which makes this sharing of information, illegal (Lassen, 2012).

Implementation of an intervention is a process that consists of many important components. The quality of these components is crucial to the effect of the implementation. If an implementation is poorly planned, formulated, executed, safeguarded and evaluated, it is likely that the effectiveness of the intervention will be absent (Mørch, 2012). The components

are; distribution of information, acceptance (creating agency readiness, also called adoption), the implementation in the organization; consisting of political and administrative support and training (introducing guidelines and accessible advisors), and finally, sustainability (Mørch, 2012; Ogden, 2012). The study of Family's Houses (Martinussen & Gamst, 2012) showed that interprofessional teams were established in most of the houses (93%), and that a large part of the teams (39%) did not meet regularly (they met when needed). A total of 34% of the teams met weekly or every other week. A part from these findings and the qualitative research of Haugland and colleagues (2006), there has not been any recent research that shows to which degree the Family's House in Norway work as expected, creating the expected interprofessional collaboration and services with better quality.

Possible differences between Family's Houses in Norway and Sweden

Bing and Abrahamsson (2011) describes in their qualitative research the work performed by social workers in the Family's Houses. Even though the Social Services in traditional settings has legislation to interfere in the private life of their users, the social workers at the Family Centers in Sweden only works with users on a preventive basis. For acute cases and cases were the use of legislation is required, the cases are handed over to a regular Individual- and Family Care Service (similar to Norwegian Child Welfare Services). The Open Kindergarten is also seen as the heart of the Family's House and crucial to get in touch with the families and establish a relationship where the parents voluntarily participates (Bing & Abrahamsson, 2011). Martinussen and Gamst, (2012) shows that there are a lot of co-located services without Open Kindergarten in Norway. For the time, there is no research that shows to which extent the employees representing the Child Welfare Service in the Family's Houses focuses only on preventive work with the families. It can also be difficult to compare a worker in Individual- and Family Care Service in Sweden and a worker in the Child Welfare Services in Norway. There can be differences in the legislation, responsibilities, their education and the societies in general. Thus, there can be some challenges in comparing the Family's Houses in Norway and Sweden.

Interprofessional collaboration in the Family's House

Although it is becoming accepted that no single discipline can provide complete care for patients with long-term conditions, interprofessional collaboration is not always achieved, as seen in a review of nursing studies (Xyrichis & Lowton, 2008). The Family's House is one of many examples of interagency collaboration in health and social care in which the beneficence of teamwork has been taken for granted (Abrahamsson, 2007). In a research

performed in a Family's House a year after the house was established showed that the frontline workers (Social Advisor and Pre-School Teacher) had constructed a symbolic wall in the middle of the house named "us and them" ("them" being the Midwives and District Nurses); collaboration turned out to be more challenging than expected. This symbolic wall was made of several issues, some of them were on a management level while other were on an individual level. The time available for collaboration was not always seen as sufficient, and lack of administrative routines were needed to make collaboration activities a part of the obligatory routines for all partners. On the individual level, the workers were explaining that the symbolic wall was evident when prioritizing the family's needs; the health care personal focusing on needs from a public health point of view, while the social worker and the preschool teacher were more focused on social prevention and vulnerable families. According to Abrahamsson, the diverse focus is caused by the difference in background in the disciplines. Even though there were tensions in the collaboration, the workers also reported that the present of the other disciplines gave a relief when working on complex matters. Altogether, Abrahamsson identified tensions that derived from administrative and managerial procedures, economic incentives for collaboration, professional education and development, organizational culture and personal preferences (Abrahamsson, 2007).

In the study of Swedish Family's Houses (Rambøll, 2014), many of the employees reported that they did not have enough time to collaborate and they also felt that they lacked the necessary resources to reach their goals. Ramböll also revealed other potentials for improvements; a better distribution of areas of responsibilities and roles, lack of functional premises, and employees requesting more knowledge concerning collaboration. They also discovered that the collaboration often was run by an enthusiast; leaving the organizational learning at a minimum. Another finding was insufficient support of collaboration by leadership. Their report showed that some aspects of collaboration was functioning, others were not. Ramböll questioned if the expected added value of the Family's House Model are fulfilled in Family's Houses in Sweden.

2.5 Research aims

With the challenges in the Norwegian Health and Social Fields for those working with children and adolescents, and the possibilities described in the Family's House Model, three main purposes of this study are formulated.

1. The introduction of the Family's House Model needs to be investigated as there are challenges with both new interventions and collaboration. Does the model enhance collaboration as expected? This leads us to the first aim of this research:
- *Assess the level and describe collaboration in the Family's House.*

Research shows that interventions can increase the experienced collaboration. The hypothesis is that the employees at the Family's Houses experienced a higher level of experienced collaboration, thus an increased level of collaboration is expected compared to other Norwegian samples.

2. Due to the fact that those working in traditional Child Welfare Services often experience a high level of burnout, it is interesting to see if there are any differences in experienced burnout, engagement and job satisfaction between the professions working in the Family's House. Hence, the second object of research is formulated:
-Examine differences between child welfare workers and other health professionals in burnout, engagement and job satisfaction.

Child welfare workers in the Family's House still handles sensitive and difficult questions, and has some clients who are reluctant and unwilling to meet them. The expected findings is that child welfare workers experiences higher degree of burnout, and lower degree of engagement and job satisfaction.

3. Job resources and job demands are precedents of burnout and engagement. Some cross-professional resources and demands have been identified, but there are additional job demands and resources related to specific professions. Given the described expected positive effect of interprofessional collaboration, it is necessary to test if collaboration can be seen as a job resource for those working in the Family's House. Other possible demands and resources are also interesting to test as predictors. This gives the third research question:
- *Is it possible to predict burnout, engagement, and job satisfaction based on job demands and resources including collaboration?*

The theory is that resources like autonomy, social support, leadership satisfaction, and collaboration, together with demands like workload, conflict, will predict burnout, engagement and satisfaction predicts burnout, engagement and job satisfaction. The expectations are also that the identified job resources and demands will support the JD-R model, were the relationship between resources and engagement are stronger than the relationship between engagement and demands. Further, the relationship between burnout and demands are stronger than burnout and resources. The expected findings are shown in Figure 4.

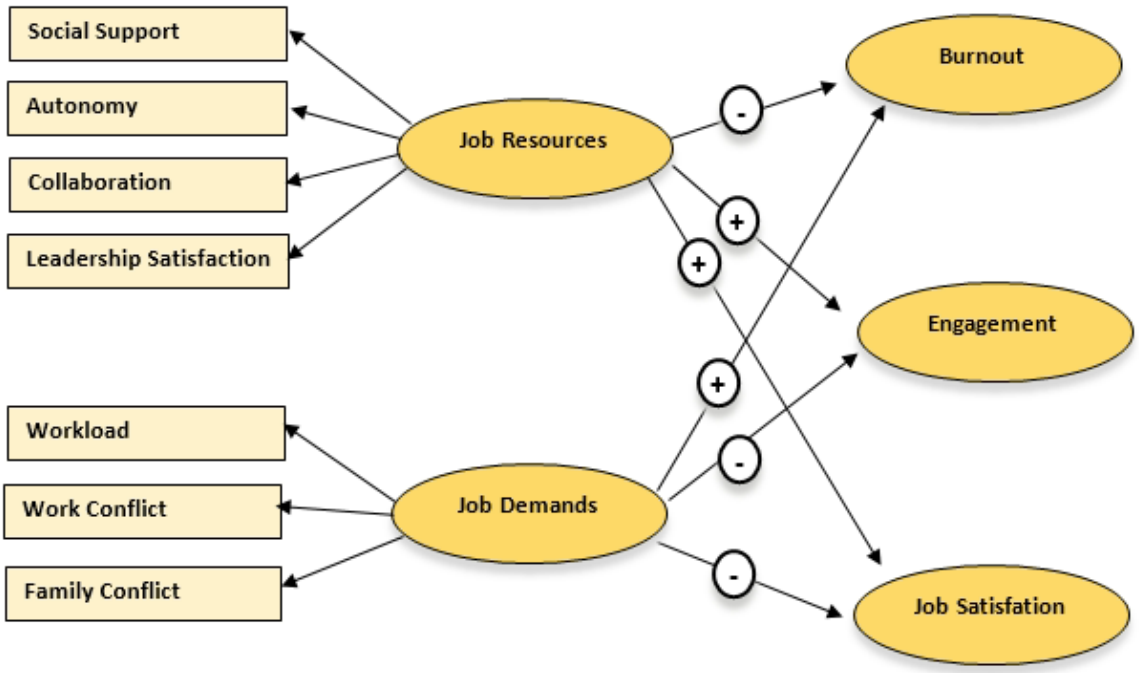

Figure 4 The JD-R model with Job Satisfaction

3. Methods

The data was collected in 2008 as part of a study of the six pilot Family's Houses in Norway by Monica Martinussen and Frode Adolfsen (For more information about the pilots, see Haugland et al., 2006). Descriptive data from the study was presented at the Nordic Family Centre Conference in Helsinki in 2010, and was published in the conference proceedings (Thyrhaug, Vedeler, Martinussen, & Adolfsen, 2012a).

3.1 Participants

All of the employees of the six original Family's Houses in the pilot project were invited to participate in a questionnaire survey. In total, 71 people responded to the survey, of which 91% were female. The response rate was 51%.

3.2 Measures

Demographics and general information

The demographic variables were age and gender. Concerning work life, respondents were asked about employment status, experience in the Family's House, and type of service. The questionnaire also had some general questions regarding the respondents' perception of working in the Family's House.

A Short version of the Total Workload Questionnaire

A subset of scales from the Norwegian version of the Total Workload Questionnaire assessed job demands, resources and Job Satisfaction. The original Swedish version was developed by Mårdberg, Lundberg and Frankenhaeuser (1991). The Norwegian version is in short called TAB (from Norwegian: "Total Arbeids-Belastning"), and was first used in a study by Østlyngen et al. (2003).

Job demands

The factors in job demands were Workload, Work Conflicts and Work-family Pressures. The items were derived from TAB and measured on a seven- point Likert scale. Workload was measured with both positively and negatively formulated items like "I feel like I am drowning in all the information that is given at work" and "To which degree do you feel that you have enough time to execute all your tasks at work?". Cronbach's alpha for Workload was .85. Two items measured Work-Conflicts, both items negatively formulated like "I often experience conflicts with my colleagues at work". Cronbach's alpha was .75. Work-Family Pressure were

also measured by two negatively formulated items, e.g., “I often feel conflict between my work and my family or other obligations”. Cronbach’s alpha was .82.

Job resources

Autonomy, Social Support, Collaboration and Leadership Satisfaction represented job resources, and were assessed on a seven point Likert scale. Seven items developed in TAB was used to measure *Autonomy*, with items like “to which degree do you have an influence on choosing your work tasks?”. The Cronbach’s alpha for Autonomy was .82. *Social Support* was measured by eight items developed by Himle, Jayaratne, & Thyness (1991). The items assessed to which degree supervisors and co-workers provided emotional support, recognition, practical assistance and information support, with formulations like “how true is it that your co-workers help you finish difficult tasks?” The answers were given on a four-point Likert scale, rating from “Absolutely not true” to “Very true”. Cronbach’s alpha was 0.80. Eight items developed by Martinussen et al (2012) measured *Collaboration*. Both positively and negatively formulations were used to avoid response bias, with formulations like “the different services do not know what the others do” and “collaboration between services are characterized by mutual respect”. The items were rated on a five-point scale, rating from “not at all” to “to a large degree”. The Cronbach’s alpha was .73. Perception of *Leadership Satisfaction* were assessed by seven items, e.g., “The leader/ coordinator for the Family’s House describes exciting new opportunities for the organization” and “the leader/coordinator takes account of both service requirements and staff needs when implementing major changes”. The items were used in Shipton et al. (2008) for a study on hospitals, but was modified for a better fit to Social Services by Martinussen et al. (2014). One item was additionally altered for a better fit to the Family’s House; “describes the goal for the Family’s House clearly to the employees”. The answers were coded on a five-point scale, with 1 being “not at all” to 5 representing “to a large degree”. Cronbach’s alpha for Leadership Satisfaction was .87.

Burnout

The level of burnout was assessed by the Maslach Burnout Inventory General Survey (MBI-GS). It was developed from the original Maslach Burnout Inventory- Human Service Survey (MBI-HSS), which was designed for people working in the human services and health care (Maslach et al., 2001). The MBI-GS also assesses all three of the core dimensions, but in broader terms than the MBI-HSS; with respect to the job and not just to the personal

relationships that may be a part of the job (Maslach et al., 2001). The survey was introduced in 1996 and has been used in a number of studies covering various professions. The studies showed consistency for the three factor structure cross-nationally and across professions (Maslach et al., 2001). A Norwegian version of MBI-GS was tested in Norway, and the validity and the factor structure was confirmed (Richardsen & Martinussen, 2005). This study includes respondents without patient contact (i.e., leaders, administration), and MBI-GS was chosen to measure burnout. The MBI-GS has three subscales; Exhaustion, Cynicism and Professional Efficacy, which each is rated on a seven-point scale rating from 0 (never in the past year) to 6 (every day). Exhaustion was assessed by five negatively formulated items, like "I feel emotional drained by my work". The Cronbach's alpha was .82. Cynicism was also measured by five items, e.g., "I have become less interested in my work since I started this job". The Cronbach's alpha was .70. Six positively formulated items assessed Professional Efficacy, with an example like "In my work, I am sure that I get things done effectively". The alpha for Professional Efficacy was .83. Even though Professional Efficacy is a part of Burnout, it is a positive dimension. Hence, Burnout is characterized by high scores on Exhaustion and Cynicism and low scores on Professional Efficacy.

Engagement

To assess engagement, the self-report questionnaire Utrecht Work Engagement Scale short version was used (UWES-short version) (Schaufeli, Bakker, & Salanova, 2006). The original scale included the three dimensions of work engagement and consisted of 17 items. The UWES has demonstrated good factorial validity across occupations and cross-nationally, and the three dimension often correlated highly (Schaufeli et al., 2002b). The short version has nine items, three for each dimension. The items are rated on a seven-point scale, indicating rate of occurrence from "not the past six months" to "daily". The items are focusing on emotional states, with formulations like "I am enthusiastic in my work". Both the original and the short version has been tested in a Norwegian version by Nerstad, Richardsen, and Martinussen (2010). The fit indices for the short version was slightly better than for the longer version, and the authors recommended that the shorter version to be used in a Norwegian population. Cronbach's alpha for Engagement were .88.

Job Satisfaction

Satisfaction with the job was also assessed by items from TAB. It was measured by six items with formulations like "how interesting do you find your job?". The answers were coded on a

seven-point scale, rating from “not at all” to “to a large degree”. Cronbach’s alpha for Job Satisfaction was .75.

3.4 Procedure

The questionnaires were distributed to the Family’s Houses via the local coordinators and returned anonymously to RKBU-Nord via mail. The participants were informed of the purpose of the study in an information letter, and that the participation was voluntarily. Participation was considered as confirmation of consent.

Since the study was considered not to contain any information that could be linked to a person (i.e., personal data that can help identify a person), there was no application submitted to the “Norwegian Data Protection Official for Research”. The questionnaire had previously been considered by REK (Regional Ethics Committee), and was not considered a study on health, but a work-environment study and therefore did not need approval from REK.

3.5 Statistical Analyses

The data was analyzed in Statistical Program for Social Sciences, SPSS (v. 21.0). Cronbach’s alpha was used to assess the reliability, and was calculated for every scale as a measure of internal consistency. Two independent samples t-tests were run to examine mean differences in scores. The first t-test was performed to examine the difference between mean scores in Collaboration in the current study and Collaboration in previous studies in Norway. Since the only data available from the earlier studies were mean (*M*), standard deviation (*SD*) and sample size (*N*), an internet based calculator was used (Graphpad, 2015). The second independent samples t-test was run to see if there were any significant differences in Burnout, Engagement and Job Satisfaction between professionals working in Child Welfare Services and other services. Hedges’ *g* was calculated as a measure of effect sizes for differences in mean scores (www.polyu.edu.hk, n.d.). Hedges’ *g* is a standardized mean difference which shows the magnitude of an observed difference or effect (Field, 2013). A Hedges’ *g* of .30 is considered a small effect , .50 is moderate while .80 is considered a large difference according to Cohen’s criteria (1988). Bivariate correlations between the different variables were calculated. The statistical power of the study was calculated with a free internet calculator (Statstodo, n.d.). The power is the ability of a test to find an effect, and is calculated with sample size, the found correlation and alpha level. If the power of the study is .80 or larger, it is considered as sufficient power to detect any effect that might have existed (Cohen, 1988). The power of the study was examined, and the calculations showed that the correlations

needed to be .30 or higher to have sufficient power. Finally multiple hierarchical regression analyses were performed, testing how much the independent variables (demands and resources) would predict the dependent variables (Satisfaction, Burnout and Engagement). The regression analysis included three blocks of independent variables: first age, then job resources and finally job demands.

4. Results

The respondents represented different professions at the Family's House. A total of 29 % of the respondents were employed through the Child Welfare Service (n = 20), while the other large group of participants are employed through the Health Care station (n = 33). Further descriptive data is presented in Table 1.

Table 1 Descriptive statistics for demographic variables (N=68-71)

		N	%
Age	<30 years	6	8.6
	31-40 years	20	28.6
	41-50 years	26	37.1
	51-60 years	16	22.9
	>60 years	2	2.9
Experience	<1 year	4	6.3
	1 to 2.5 years	23	36.5
	3 to 4.5 years	13	20.6
	5 to 6.5 years	10	15.9
	7 to 8.5	11	17.5
	>9 years	2	3.2
Type of service	Child Welfare Service	20	28.4
	Health Care Station	33	46.5
	Educational and Psychological Services	1	1.4
	Open kindergarten	5	7.1
	Maternity Care	3	4.3
	Other	8	11.4

Due to the low percentage of men participating (9 %), no analysis concerning gender were performed.

The general questions concerning the respondents' perception of working in the Family's House, showed that almost 80 % of respondent felt that the Family's House had to a large and very large degree, contributed to a better formal interdisciplinary collaboration. Further, 80% said that the model had, to a large and very large degree, contributed to more opportunities for informal collaboration. Close to 50% said that they had, to a large degree, learned more about the other municipal services.

The assessment of Collarboration gave a slightly higher mean in the current study compared to the other Norwegian studies (results are presented in Table 2). The samples labelled "Model District" is a comparison group from a study of an intervention for improving interprofessional collaboration (Martinussen et al., 2012). The "Child Participation" samples are from a study on child participation, where the level of Collaboration for employees at the Municipal Child Welfare Service were assessed as a part of the study (Vis & Fossum, 2013). All three studies assessed Collaboration with the same measure. The independent t-tests showed that the differences in level of Collaboration between the studies, were significant. According to Cohens criteria (1988) the effect size between current study and the Model District was considered a strong effect, while the compared to the Child Participation study, the effect size was moderate.

Table 2 Differences in experienced Collaboration between Model District, Child Participation and current study.

Study				Compared to current study	
	M	*SD*	*N*	*t*	Hegdes' *g*
Current study	3.49	0.40	70		
Model District sample	2.92	0.38	56	8.13*	1.45
Child Participation sample	3.30	0.30	38	2.56*	0.51

*Note: *p <.05 (two-tailed).*

The second independent samples t-test was used to examine if there were any significant differences between those working in the Child Welfare Services and other services in the current study. The results are presented in Table 3. Significant differences were found for Cynicism and Satisfaction. Those who are employed by the Child Welfare Service, experienced less Cynicism and a higher level of Job Satisfaction. The differences in Cynicism and Job Satisfaction between groups were medium to large according to Cohen's criteria for effect sizes (1988). Since age has been found to correlate with Cynicism in some studies (Maslach et al., 2001), a supplementary t-test on age and experience were run. The test did not show any significant differences between the groups.

Table 3 Differences between employees in the Child Welfare Service and others concerning Burnout, Engagement and Job Satisfaction

	Child Welfare Service (*N*=20)		Other services (*N*=50)		*t*	Hegdes' *g*
	M	*SD*	*M*	*SD*		
Exhaustion	1.64	1.23	1.33	1.02	1.08	-0.29
Cynicism	0.35	0.47	0.78	0.68	-2.56*	0.68
Professional Efficacy	4.45	1.05	4.69	0.71	-1.10	0.29
Engagement	4.58	0.88	4.44	0.88	0.66	-0.16
Job Satisfaction	5.92	0.59	5.54	0.61	2.37*	-0.63

*Note: *p <.05 (two-tailed).*

In the Table 4, bivariate correlations between variables are presented. The results showed that Collaboration was not significantly correlated with the dimensions in Burnout, nor to Engagement, or to Satisfaction. Collaboration was very close to having a significant negative correlation with Exhaustion (it would have been significant with a one-tailed test). Concerning job resources, both Social Support, Autonomy, and Leadership Satisfaction were correlated with Job Satisfaction, while only Autonomy correlated significantly with Engagement. Regarding the dimensions in Burnout, the job resource Autonomy had a positive significant correlation with Professional Efficacy, while Leadership Satisfaction had a significant, negative correlation with Cynicism.

Both Workload and Work-Family Conflict were significantly correlated with Exhaustion, which is considered to be the main dimension in Burnout.

Table 4 Means, Standard Deviations and Bivariate correlations for Variables in the Study (N = 69-71)

Variables	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12
Demographics														
1. Age	-	-												
Job Resources														
2. Social Support	3.37	0.44	- .16											
3. Autonomy	5.22	0.80	- .11	.46**										
4. Collaboration	3.49	0.40	.00	.14	.31**									
5. Leadership Satisfaction	3.71	0.52	- .09	.39**	.26*	.38**								
Job demands														
6. Workload	4.19	1.06	.02	.01	-.20	-.20	-.02							
7. Work conflict	1.44	0.58	.17	-.34**	-.19	-.15	-.23	.05						
8. Work-Family Pressure	3.08	1.41	-.01	-.08	-.21	-.27*	.03	.45**	.21					
Burnout														
9. Exhaustion	1.45	1.10	.09	-.01	-.21	-.23	.15	.41**	.21	.47**				
10. Cynicism	0.67	0.67	.38**	-.16	-.20	-.15	-.26*	.10	.06	.10	.39**			
11. Professional Efficacy	4.62	0.82	.07	.16	.32**	-.11	-.09	-.21	-.03	-.09	-.22	-.04		
Engagement														
12. Engagement	4.48	0.81	- .14	.22	.24*	.07	-.04	.12	-.14	-.08	-.34**	-.24*	.48**	
Satisfaction														
13. Job Satisfaction	5.64	0.62	-.21	.37**	.56**	.12	.26*	-.02	-.02	.03	-.23	-.43**	.31**	.47**

Note:*$p < .05$; **$p < .01$. (two-tailed)

Hierarchic regression analysis was used for testing a model for predicting Burnout, Engagement and Job Satisfaction. The results are displayed in Table 4. Age explained a significant part of the variance in Cynicism, but did not explain any significant part of the other dependent variables. Job resources explained 27% of the variance in Job Satisfaction. Of the individual variables was Autonomy a significant predictor. Job demands explained 19% of the variance in Exhaustion, with Workload as the only significant individual predictor. The job resource Leadership Satisfaction was also a significant individual predictor for Exhaustion. In total, the variables explained significant parts of both Job Satisfaction and Exhaustion, respectively 35 % and 32 %. No significant part of the variation in Professional Efficacy, Cynicism, or Engagement were predicted by the variables.

Table 5 Hierarchical multiple regression analysis for predicting Burnout, Engagement and Job Satisfaction (N= 67)

	Exhaustion		Cynicism		Professional Efficacy		Engagement		Job Satisfaction	
Variables	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.00		.14**		.01		.02		.05	
Age		0.08		0.37**		0.14		-0.08		-0.15
Step 2 Job Resources	.13		.07		.14		.07		.27**	
Autonomy		-0.03		0.03		0.27		0.19		0.46**
Support		0.06		-0.02		0.16		0.13		0.12
Collaboration		-0.20		-0.09		0.03		-0.13		-0.04
Leadership Satisfaction		0.26*		-0.22		-0.24		-0.12		0.10
Step 3 Job Demands	.19**		.01		.04		.02		.03	
Workload		0.27*		0.06		-0.22		0.15		-0.01
Work Conflict		0.17		-0.08		0.03		-0.06		0.12
Work-Family Pressure		0.19		-0.02		0.10		-0.06		0.14
Total R^2	.32**		.22		.19		.11		.35**	

Note:*$p < .05$; **$p < .01$.
All coefficients were taken from the final stage of the regression analysis.

5. Discussion

5.1 Findings

With the knowledge of strenuous working conditions for child welfare workers and lack of collaboration in social and health care services for children and adolescents in Norway, several organizational aspects of the Family's House Model were investigated in this study. One aim of the study was to investigate the level of collaboration within the Family's House Model. Another objective was to see if there were any differences between child welfare workers and other professions regarding Burnout, Engagement and Job Satisfaction. A third aim was to investigate if job resources and job demands, including Collaboration, could predict Burnout, Engagement and Job Satisfaction among employees in the Family's House.

Assessing Collaboration in Family's Houses

The result showed a higher level of collaboration compared to the Model District study (Martinussen et al., 2012) and to the Child Participation study (Vis & Fossum, 2013), which were findings as hypothesized. Even though all three studies were performed in Norway, most of the participants were woman, and the same instrument was used for assessing Collaboration, there are also some differences between the groups. The Model District study included many pedagogical professionals (teachers and pre-school teachers) in addition to Municipal Health and Social Services, which makes this group different from the employees at the Family's House. The group from the study on child participation included only employees at the Child Welfare Service. There could be some differences in how the professions perceived collaboration; hence, it has an impact on the assessed levels of Collaboration. Still, this finding gives some indications that Family's House Model could have a positive impact on interprofessional collaboration.

In general, the respondents seemed to agree concerning Collaboration. All respondents seemed to have a more or less positive perception of the interprofessional collaboration. The mean was 3.49 on a scale from 1 to 5, which is equivalent to an agreement between "to some degree" and "to a large degree" concerning positive statements of Collaboration. There were few scores on minimum or maximum. However, when it came to a statement concerning lack of arenas for collaboration and communication, more than 20% disagreed with this statement, and almost 50% agreed to a very small degree. Hence, it seems like a large part of the respondents in the Family's House in this study felt they had access to arenas for

communication and collaboration. The assessed work conflict with colleagues and leaders was low.

In the more general questions concerning employees' views, most of the respondent felt that the Family's House had contributed to stronger formal and informal collaboration. Half of the respondents felt they had learned more about other municipal services.

Available arenas and opportunities for collaboration and communication, a low level of conflict, and increased knowledge about the collaborating services could be some of the aspects that make the collaboration stronger in the Family's House Model. Nonetheless, employees felt that there were potential for improvements; more than half of the respondents felt that better collaboration would be important to do a good job.

Differences between professions

Those working with Child Welfare Services in the Family's House, experienced a significantly lower level of Cynicism and a higher level of Job Satisfaction, compared to those working in other services. The differences may be described as medium in terms of effect sizes. The results suggest that child welfare workers experienced more positive working conditions than the other groups. This result was not expected based on previous reports on stressful working conditions in the Child Welfare Services (The Norwegian Labour Inspection Authority, 2013). In order to explore if the variance could be explained by differences between the two groups, possible differences in age and experience were examined. No significant difference was found; hence, the differences in Job Satisfaction and Cynicism between groups could not be explained by these demographic variables. Since the group "others" is predominantly health care workers, the result could reflect that the health care workers as a group, experienced a higher degree of Cynicism and lower Job Satisfaction, related to the nature of their work tasks and working conditions. Another factor that complicates the understanding of the perceived Cynicism and Job Satisfaction for child welfare workers, is that the tasks they perform in the Family's House are not assessed in this study. In the Swedish model, the social workers in the Family's House works with families only on preventive basis. When use of legislation is necessary, the cases are handed over to the regular, municipal social services. It is unknown how this work in the Family's Houses in Norway; during the gathering of data, both cases were observed. If the majority of child welfare workers in this study only work with families on a counseling level, they are likely to

have meetings with more cooperative and positive clients, which could be expected to affect their working conditions in a positive way. Another possible explanation is that the Family's House and the organization offer support that may buffer some of the demands inherent in the work as a child welfare worker.

Factors predicting Burnout, Engagement and Job Satisfaction

Collaboration was expected to be a job resource (Haugland et al., 2006; Martinussen et al., 2014). Meanwhile, the findings on Collaboration are inconsistent. There is a weak, almost significant correlation to Exhaustion, but no correlation with Engagement or Job Satisfaction. The close to significant correlation between Collaboration and Exhaustion shows a possible relationship between the variables. This gives some indication that increased Collaboration could diminish Exhaustion, which would be a result supporting the expected findings. As an individual factor, Collaboration did not predict any of the dependent variables. Collaboration had some correlations with the other job demands and resources. It had a positive correlation with the job resource Leadership Satisfaction. There is a possibility that employees see leaders that creates an environment for collaboration as good leaders. It also correlates positively with Autonomy, which is consistent with earlier studies (Rafferty et al., 2001; Thylefors, 2013). The findings could suggest that when given the possibility to choose, collaboration could be a chosen method. It could also be that collaboration creates a working environment with more Autonomy for the employees. Another suggestion is the explanation from Rafferty and colleagues (2001); working well with other members of the team is strongly associated with being able to act with Autonomy. The variable Collaboration has a low variance in the current sample with almost 90% (n = 61) of the responses between the value 3 and 4 on a Likert scale ranging from 1 to 5. All of the scores are between 2.5 to 4.24 which gives scores the small range of 1.74. This low variance is likely to be affecting correlations and predictions by reducing the estimated associations.

Age was a significant predictor for Cynicism, but explained a small and non-significant part of the variation in the two other dimensions of Burnout. Cynicism can be seen as a coping behavior; creating a distance between oneself and the work (Leiter & Maslach, 1999). It is possible that with time, the employees learn Cynicism as a coping strategy in their work. Earlier findings concerning the relation between age and Cynicism, have been inconsistent; some studies had shown small and negative correlations (e.g., Martinussen et al., 2011;

Maslach et al., 2001), and some show no correlations (e.g., Schaufeli, Bakker, & Van Rhenen, 2009). Maslach and colleagues (2001) argued that the positive correlation is to be interpreted with care; those who do not experience burnout early can be "survivors" that experiences low levels of Burnout even when job demands are high. Those who burn out early in their careers tend to quit their jobs, resulting in the problem of survival bias.

The JD-R model shows that high job demands and lack of job resources are related to Burnout, while job resources are related to Engagement. The relationship between job demands and Burnout are stronger than the negative relationship between job resources and Burnout, and the relationship between resources and Engagement are generally stronger than the relationship between demands and Engagement. (Demerouti et al., 2001). The bivariate correlations in this study confirms the JD-R model to some degree concerning Burnout: Workload and Family Conflict were positively correlated with Exhaustion, while Cynicism had a negative correlation with Leadership Satisfaction. Exhaustion is the only dimension in Burnout that is predicted by the job resources and job demands, with Leadership Satisfaction and Workload as significant individual factors with a positive association. A positive association between Workload and Exhaustion is consistent with the literature (e.g., Lee & Ashforth, 1996) and it fits well with the expectations in this study. Meanwhile, Leadership Satisfaction predicting Exhaustion was not anticipated. The finding is difficult to interpret and understand. Could it be that feeling satisfied with your leader, inspires you to work harder, leading to higher levels of exhaustion? When assessing Leadership Satisfaction, several aspects were included; if the leader clearly describes the objectives of the organization, suggests new ways of improving the services, leads the organization efficiently for the better of the clients and employees, creates strong relations to the local community, and makes the different services collaborate. A leader that is creative, makes the organization work efficiently, and makes liaisons with other organizations, is also likely to make the employees maximize their contribution, i.e., increasing their job stress. The relation between the employee and leader, which is not assessed in the scale, could be an important work condition affecting Exhaustion. Even though the employee sees the leader as a good leader for the organization, it could be that employee does not feel they have a good relationship with their leader, hence the leader is not being a good leader for them (e.g., employee not feeling appreciated, recognized or respected). Another plausible explanation could be related to the phenomenon identified by Mandell and her colleagues (2013), where they found child welfare

workers experiencing both Job Satisfaction and Exhaustion simultaneously; they worked hard but at the same time they felt satisfied with their jobs. In multiple regression analysis, there is a risk that the *suppressor effect* may occur. This is when a predictor has a significant effect but only when another variable is held constant (Field, 2013). This way, the result from a regression analysis can be misinterpreted. This could be the case also in this study. Nonetheless, there was also a positive (but non-significant) relation between Leadership Satisfaction and Exhaustion, indicating that there might be an association between the variables, and that the result in the regression analysis not necessarily is a result of the suppressor effect. There could be the possibility of Leadership Satisfaction being a job demand and not a job resource, as assumed. Meanwhile, Leadership Satisfaction has a positive significant correlation with the other job resources, and to Job Satisfaction. It does also correlate negatively to the Burnout dimension Cynicism. This indicates that Leadership Satisfaction is related to positive notions of work, and therefore not a job demand. The results from this study suggest that being satisfied with your leader can occur simultaneously as you are feeling a higher level of exhaustion. With the unexpected relationship between Leadership Satisfaction and both positive and negative notions of work, there is a possibility that the processes are more complex than predicted in the JD-R Model; There could be that some variables acts as job resources in some settings, and job demands in others.

Leadership Satisfaction and age were the only variables that correlated significantly with Cynicism, Leadership Satisfaction negatively, age positively. The expectations were that the job demands would have a positive association with Cynicism, while the job resources would have a negative association. The results show that all three job demands have positive correlations with Cynicism, and the job resources have negative correlations with Cynicism. All of the correlations (except from the one with Leadership Satisfaction), are week and non-significant. Except from Leadership Satisfaction, no individual variable predicted Cynicism, neither did all the variables in total. The general level of assessed Cynicism is very low (M = 0.67). It seems like the respondents in this study did not experience much Cynicism. The dependent variable also had a very low variance; almost 80% of the respondents had a score below one (on a scale from zero to six). Low variance gives less and weaker correlations and predictions, and this can be one of the reasons behind the few significant findings.

Most of the job demands and resources had weak and non-significant correlations with

Professional Efficacy (PE), except from Autonomy where a positive significant correlation was found. This goes well with expected findings. The job demands and resources did not predict PE. The variance in PE was not so low that it could explain this lack of prediction and correlations. The results therefore suggest that the job demands and job resources does not predict Professional Efficacy.

The job resource Autonomy was also the only independent variable that correlated significantly with Engagement. The correlation was consistent with the JD-R model and the expected findings. Bakker and colleagues (2011) saw that engaged employees proactively made changes in their job situation, confirming the coexistence of Autonomy and Engagement. Nevertheless, neither Autonomy nor the job resources and job demands in total, did predict Engagement.

Autonomy predicting Job Satisfaction is also consistent with earlier findings (e.g., Rafferty et al., 2001; Østlyngen et al., 2003). The resources Social Support and Leadership Satisfaction did also have a positive correlation with Job Satisfaction. Job resources having a positive relation to Job Satisfaction was consistent with expectations. Meanwhile, job demands were not found to predict Job Satisfaction. The findings concerning the significant (and close to significant) negative correlation between Job Satisfaction and the dimensions in Burnout, reflects earlier studies (Hombrados-Mendieta & Cosano-Rivas, 2013; Lee & Ashforth, 1996).

Almost all of the job resources and job demands concern the perception of how they influence the work life for the individual respondent, except Collaboration and Leadership Satisfaction, which both have a focus on the impact they have on the organization. These two scales are also the least tested scales in relation to Burnout and Engagement. This could be some of the reasons why few relations were found between these two variables and Burnout, Engagement and Job Satisfaction, and why the variables do not fit with the JD-R model as expected. Some findings was consistent with the JD-R model; job resources and job demands predicted both Job Satisfaction and Exhaustion. Meanwhile, the assessed job resources and demands did not predict Cynicism, Professional Efficacy, or Engagement. This finding is not in line with the JD-R model (Demerouti et al., 2001), and therefore inconsistent with hypothesized findings. The pilot Family's Houses were established in municipalities who had already started their work with interdisciplinary collaboration. The Houses were supported during establishment,

and had guidance, both through the national project management, but also through a network that were formed by the national project group (Haugland et al., 2006). Political agreement, fulfilled requirements before establishing, the committed local project managers and the guidance during establishment, could lead to well-run Family's Houses. In general, the results from this study shows low level of Burnout, strong Engagement and a high Job satisfaction, and could be a result of well-functioning Family's Houses.

5.2 Strengths and limitations of the study

The response rate (51%) corresponds to rates in similar studies (Martinussen et al., 2011; Østlyngen et al., 2003) and to a meta-analysis of research in clinical psychology and counseling (Van Horn, Green, & Martinussen, 2009). The questionnaires were mailed to a coordinator and left for his/her distribution to their colleagues; it is unknown how many potential respondents who actually received a questionnaire. The response rate can therefore be seen as conservatively estimated. In this study, 91% of respondents were female. Another study within similar professions, had 94% female respondents (Martinussen et al., 2014). This could be related to women being more prone to participate in surveys (Spitzmuller, Glenn, Barr, Rogelberg, & Daniel, 2006). It can also be characteristic for the gender gap in this field; in Child Welfare Services 85 % of employees are female (Johansen, 2014). It is unknown if those who refused to participate had any common characteristics, i.e., they were not randomly distributed. Some studies has shown that respondents experiencing work overload will less likely participate (Barr, Spitzmuller, & Stuebing, 2008). However, this study did not examine the prevalence of heavy workload; it focuses on the relation between working conditions and Burnout, Engagement and Job Satisfaction. Even if those with heavy workload did not participate (they could have left the job, or are on sick leave), it is still possible that it did not interfere with the results in this study. A low response rate is more likely to have a larger influence on the result when the research is studying the occurrence of a phenomenon, and have less influence when the aim of the study is to reveal correlations and predictions as in this study.

A Cronbach's alpha between .70 and .80 is by many considered as an acceptable level, but these general guidelines need to be considered with caution (Field, 2013). With a Cronbach's alpha ranging from .70 (Cynicism) to .88 (Engagement), the scales in this study can be considered acceptable. Cronbach's alpha shows the consistency between the items in a scale,

but the number of items also has an impact; a higher amount of items will result in a stronger Cronbach's alpha. The scales used in this study ranges from two items up to nine (Engagement). Engagement has a strong alpha, and the other scales with seven, eight or nine items all have an alpha higher than .80, except Collaboration, which is assessed by eight items and has .75 as the level of alpha. Collaboration is also one of the more recent object of research within the JD-R model, and the scale that has been least tested. Nonetheless, even with a weaker alpha for Collaboration, the reliability of the study is considered high.

Regarding validity, almost all of the scales have been tested and adapted to the Norwegian population (Nerstad et al., 2010; Richardsen & Martinussen, 2005; Østlyngen et al., 2003). Collaboration and Leadership Satisfaction were created for the Norwegian population. Even though they are not broadly tested, the formulations of the questions can be regarded as quite direct, leaving a small possibility for misinterpreting the questions. Nonetheless, the items in the scales focus mainly on organizational impacts, and not on factors concerning the individual respondent. It could be that this causes some of the weak correlations and lack of prediction with personal feelings like Burnout, Engagement and Job Satisfaction. There is also the risk that the items in the scale measuring Collaboration, is too general and does not cover the full nuances existing in the population, thus explaining some of the reasons for the low variance. Given the low variance, the scale assessing Collaboration needs to be further tested to ensure that it covers the full range of perceived collaboration. The data is collected using one method; a self-measuring questionnaire. This gives the risk of mono-method bias; where the correlations between variables are artificially high because the same method was used for assessing all of the variables. The self-measuring questionnaire asks for the respondent's perception of the topics. If more objective measurements had been included, it would have strengthened the validity of this study. Validity can also be affected by confounding variables, which are unknown variables affecting the dependent variable.

Even though the examined job demands and resources are tested, both cross-professionally and cross-countries, comparing models and studies in other countries cannot always be done straightforward. In a research study among physiotherapists, Martinussen and her colleagues (2011), had findings that were in contrast with findings from other countries. It indicated genuine differences in working condition across countries for physiotherapist. This may also be the case for results for this study, as differences in e.g., legislation, how municipal health

and social services are structured, how the Family's Houses are organized, and culture, are likely to affect the working conditions.

A possible limitation of this study is the low variation on some of the variables. Since correlations are dependent on variance, it is likely that the low variance, affects the correlations with the other variables, and predictions of dependent variables. The sample size of this study was relatively small, ($N = 71$), resulting in a low statistical power for detecting small correlations and estimating regression equations with the number of predictors included in this study. A larger sample size would have increased the statistical power and possibly resulted in more significant findings.

The current study examined specific job resources and job demands. It did not examine other possible variables that may predict Burnout, Engagement and Job Satisfaction. For example, a study has shown that performance feedback and opportunity to learn, are positive predictors that act as job resources (Schaufeli et al., 2009). It is possible that the employees in the Family's House experience additional or other resources and demands as important for their work conditions. Further, some of the findings were opposite of what was expected; e.g., Leadership Satisfaction predicting Exhaustion. It could be that the JD-R model is not complex enough; not including adequate job resources and demands, and is not sufficiently complex to give a realistic explanation of the relation between work-related conditions in the Family's House and affects Burnout, Engagement and Job Satisfaction.

The arrows in the JD-R model suggest a direction of the causality. A cross-sectional study is not able to confirm causality; it shows only relation between the variables. Since this study is cross-sectional, the suggested causality in the JD-R model cannot be confirmed.

This research studied the six pilot Family's Houses. The pilot Houses were well supported during establishment, were run by enthusiastic leaders, and followed the description of the model. Later establishment of Family's Houses has shown a great variety in how they are organized and run (Martinussen & Gamst, 2012; Thyrhaug, 2009). Therefore, it can be difficult to use findings from this research to make assumptions of newer Family's Houses.

5.3 Future studies

The statistical power of this study was not considered strong, due to a low number of participants. Having a larger sample size would give more statistical power where even smaller correlations and predictions could become significant, thus revealing more information about the population. For future studies a larger sample size would be recommended.

The data to this study was collected from six Family's Houses that were a part of a pilot project. Future research on the Family's House, e.g., testing the model's effect on collaboration, can be difficult when it is unknown to which extent the organizations apply to the original model. In future research, it is necessary to study how the Family's Houses are structured and organized.

In this study the work tasks of child welfare workers has not been revealed. To fully assess and understand their working conditions in the Family's House, the question concerning preventive vs mandatory support could be essential. Meeting families who are welcoming advices and support versus those who received enforced support would present different way of working for the child welfare worker. It is also possible that meeting families who are negative, is more emotional demanding to the worker. To be able to study and evaluate the Family's House Models' impact on Child Welfare Workers work life, future studies needs to reveal the work tasks they are performing at the Family's House.

According to Thylefors (2013) there are several requirements to make an interprofessional team function optimal. How the interprofessional collaboration is organized (meeting-points, communication, responsibilities etc.) in the Family Houses, is to some degree revealed by Thyrhaug (2009). A more profound understanding of the Collaboration that takes place in the Family's Houses, would be valuable information in the creation and the improvement of the model and similar interprofessional models. Another important aspect of Collaboration, is the personalities of the team members (Martinussen & Adolfsen, 2012). To develop the understanding of Collaboration in Norwegian health and social services, it would be necessary to further investigate how the collaboration is conducted, and how personalities of team members affect collaboration. Given the low variance of Collaboration, the scale also needs to be further tested to ensure that it covers the full range of perceived Collaboration.

The unexpected finding of the relationship between Leadership Satisfaction and Exhaustion raises several questions. Is Leadership Satisfaction to be seen more as a job demand rather than job resource? The relationship between Leadership Satisfaction and Exhaustion needs to be further investigated, keeping in mind that the current JD-R model might not show the full complexity. This study investigated four job resources and three job demands. It is also possible that there are additional job demands and job resources, e.g., feedback and opportunity to learn, suggested by (Schaufeli et al., 2009). To confirm the direction of the associations between the variables, longitudinally studies revealing causality will also be necessary. For a more profound understanding of work conditions' influence on Burnout, Engagement and Job Satisfaction, future studies should include research on additional job demands and resources, investigate the possibility for more complex processes, and include longitudinally data.

One of the purposes for the Coordination reform, was to increase the quality of the services (Ministry of Health and Care Services, 2009). For an extensive evaluation of the Family's House Model, future studies should therefore also assess the quality of the produced services.

6. Conclusion

This study has examined several aspects of working conditions in Family's Houses in Norway. The aim of the study was to investigate the level of interprofessional collaboration, and how the child welfare workers perceive their working conditions compared to employees in other services. Another objective of the study was to see how job demands and resources, including interprofessional collaboration, predicted Burnout, Engagement and Job satisfaction in the Family's House, according to the Job-Demands Resource Model.

The results indicated a general positive perception of collaboration in Family's Houses compared to the results from two earlier studies in Norway. Contrary to hypothesized findings, child welfare workers did not seem to have a higher level of burnout or any indications that they carried a heavier burden at work than professionals from other services at the Family's House; in fact, they experienced less Cynicism and more Job Satisfaction. Collaboration was not found to predict Burnout, Engagement or Job Satisfaction. Meanwhile, the variance in Collaboration was very small and this could cause lack of correlations and predictions. The regression analysis showed that significant parts of the variation in Exhaustion and Job Satisfaction were predicted by the job demands and job resources. Inconsistent with expected findings, Leadership Satisfaction had a positive relation with Exhaustion. Due to a small sample size, the study is considered to have low statistical power, and few significant findings were revealed.

This study contributes to the research of organizational structures and factors that affects work life. Given the challenges the Child Welfare Services experiences, the subject of how to decrease burnout and increase positive job feelings like engagement and job satisfaction, is an essential field to study. The complex problems clients experience requires coordinated services. Studies on organizations that enhance interprofessional collaboration, and factors that make employees last and perform well, is important to be able meet the challenges and needs. This knowledge is important for politicians and for leaders when developing efficient and healthy services for clients and employees.

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