"Out-reach" services in Norway

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To be ”Nomades” in a modern society.

We use different words about our work;

- **Out-reach**
- **Ambulant, (this is the most common in Norway)**
- **Nomadic**

These are different words about the same way of working.

Geographical challenges! Long travels!

We use ”Nomadic ” to explain our way of thinking.

What is typical by ”Nomades”?

- **They move around to where it is useful to be**
- **They see the whole landscape (context, family, culture, sosio-economic)**
- **They move around slowly, dwelling and shifting position**
- **They cross borders**
- **They use local knowledge and recourses**
- **They are “Nomades” in their head, the Nomadic culture.**

The historic context of Ambulant work.

Tradition from Norway: Schools from 16th century(the teacher moved around to homes, nurses, doctors, home helps etc.)

People moved from the countryside from farms to cities far from origin family with grandparents etc.

From the 1950 and earlier there where built big institutions for special needs, also for children and adolescents. (special schools, child care homes etc.)

This led to that local communities built down the local based help systems.

The idea was that there was something wrong with the child that needed to be cured or repaired by experts in highly specialised institutions.

The need for more specialised help grew with the knowledge of diagnoses.

The children with special behaviour "used up" the people around them.
They became a problem in the local society

The historic .....

Economically it was an advantage for the local municipalities to send children away because it was cheaper. The state or counties paid!

During the 80-90ties there was some voices raising . We need to treat people where they are? (Søren Kierkegaard?)

There was also acknowledged that there where some children that did not fit in. Some explained that they was not motivated, could not benefit from treatment etc.

It was to expensive to have a highly specialised institutional treatment in all small communities.

So the this thinking lead to experiments with "out-reach" units where the professionals was offering treatment where the people lived.

This is maybe the fastest growing part of Mental Health Care for Children in Norway today. Almost every hospital or county have one or more, and the work is more and more oriented out of institutions.

Why do we work like this?

Children have lived in their family and local community for many years and the "problem " they have are showing itself off in this environment.

It is –of little help to take the child away and treat/repair them and so send them back to the same environment that they had before
Institutional treatment also have negative side effects.

If we are going to help the child we must se the whole situation around the child:
- **Family, (including sosio-cultural-economic conditions)**
- **Relatives**
- **Friends/network**
- **School/Kindergarden**
- **Local community**
- **Local helpers**

We must have focus on separating the problem from the child (externalising)
It is a help effective and useful for the child and family because we have focus on using the resources in the child, family and others.
This means we have to tailor the process to the specific child/family

Between and together with?

Out-reach work is a work between us and the child/family and at the same time together with other helpers/schools etc.

Coordinated help and programs to insure that all is working on the task (like MST)

Together we are able to give help that are coordinated with the locals and the family. We can also give supervision and counseling to others.

Together with the child we can make training sessions for increasing skills in behavior.

Together with the family we can improve the parental skills with programs like; PMTO, Webster Stratton.

We can offer family therapy both intensive and over time(follow up)

We are depending on feedback and outcome information from the parents and the child. (COR system. Duncan and Miller)

Important principles in ambulant work(and all work!) Success criteria's!

1. We must be aware of our standing point. Who we are!
2. To see the whole situation the child is in
3. To be and start where the child/family is
4. To communicate dignity in the relation
5. To have a horizontal relation.
6. To have common experiences and do things together
7. To be brave (and at the same time humble)
8. To be flexible in the contact
9. Have belief in change, and be focused on resources
10. To be transparent in contact