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Parenting Support in Sweden: New Policies in Old Settings

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This article sets out to investigate the political development and implementation of parenting support services in Sweden. The object of the analysis is on how parenting support has been organised and how it has been articulated in policy debates, and also key elements of parenting support in practice. The analysis shows that parenting support builds upon a century-long tradition of, for example, pre-emptive health care check-ups and services to parents, counselling and parenting education. There are, however, elements in parenting support policy which mark a clear deviation from this policy legacy. These include the introduction of structured parenting programmes, the growth of the idea of parents as autonomous beings, and the partial relocation of parenting support into new public health goals.

Keywords: Parenting support, public health policy, institutional layering, autonomous parents, Sweden.

Introduction

Parenting support is firmly anchored in the history of the Swedish welfare state. Among the long-standing relevant provisions are services such as the introduction of free antenatal clinics and child healthcare centres which date from the late 1930s, family counselling from the 1950s and parenting education from the 1970s (Lundqvist, 2011; Nyberg, 2012). However, changing living conditions and new ideas of how best to support parents have contributed to a reframing of parenting support, coming to the forefront in the 2000s. Several analyses revealed increasing ill-health among teenagers and youth in the aftermath of the deep economic crisis in the 1990s (SOU, 2000: 91). Consequently, influential experts and leading politicians proclaimed the need to expand the existing family support repertoire with new measures and interventions. Alongside information campaigns, telephone helplines and web-based forums for parents, structured parenting programmes quickly emerged, with the objective of improving the relationship between children and parents, thereby preventing ill-health among children (Sarkadi, 2008; Swedish Government, 2010). Hence, parenting support targets a particular 'problem': the parent–child relationship (Daly, 2015).

How should these new types of intervention be understood in the Swedish context? Do they form an integrated approach to earlier interventions, or do they represent different and potentially conflicting conceptions of how families could be supported? The article traces the political development and implementation of parenting support in Sweden, especially since the mid-1990s but with clear reference to earlier periods also. The focus of analysis is on how parenting support has been organised and how it has been articulated in policy debates, and also key elements of parenting support in practice, such as various

types of service provision and interventions over the period. The following questions guide the analysis: What services and provisions are involved in parenting support? Which drivers and underlying ideas have shaped the development of parenting support? What is new in parenting support in Sweden?

Drawing on Kathleen Thelen's analysis of institutional change as 'ongoing political negotiations' in which modules of continuity and change are inextricably linked, I argue that the emergence of contemporary parenting support involves a process of institutional layering: 'the grafting of new elements onto an otherwise stable institutional framework' (Thelen, 2004: 35). Following Thelen's analytical schema, in which certain amendments not only refine but also potentially alter the route of an institution's development, a core issue for the analysis in this article is to distinguish between layering processes that represent continuity in the development of parenting support policies and those which may act as promotors of institutional change. To identify such processes, various driving forces must be pinpointed. Two are especially important. First, established institutions are challenged when actors from different institutional settings articulate similar and new goals, characterised as 'institutional complementarities'. Second, when analysing the evolution of new interests and goals, the role of 'powerful actors', exemplified by, for example, interest organisations, experts or policy makers, must be taken into consideration (Thelen, 2004: 285–7). In the case of parenting support in Sweden, 'institutional complementarities' are assumed to have developed when the public health perspective emerged as a dominating discourse channelled mainly through the Public Health Agency. The re-orientation of the public health goals was in turn articulated by 'powerful actors' such as policy makers and academic communities, resulting in a reframing of parenting support. Thus, to fully understand the nature of contemporary parenting support, we need to analyse its articulation within different, but inter-connected, institutional settings and the extent to which 'powerful actors' affect and change the trajectory of the field.

With this framing as a point of departure, the following analysis of Swedish parenting support is organised through three main sections. First, the organisation and provision of parenting support are described to reveal current practices. The second section includes an analysis of the historical roots and trajectory of policy development, emphasising grafting and the importance of placing current parenting support in the context of the history of previous policy reforms. The third section covers the changes in parenting support discourses and practices from the mid-1990s, mainly focusing on the emergence of health promotion goals. The article concludes with some overview remarks on Swedish parenting support services and how they relate to the historical trajectory of support to families.

Parenting support in Sweden

Parenting support (*föräldrastöd*) in Sweden is officially defined as 'an activity which gives parents knowledge about children's health, emotional, cognitive and social development and/or strengthening parents' social network', focused on children between nought and seventeen years old (Swedish Government, 2010: 2). Thus, family policy measures such as child allowance, parental leave insurance or financial support offered in cases of divorce (for example, child support) are not included in the conceptualisation of parenting support. Instead, parenting support encompasses services related to what Mary Daly (this issue) argues are 'more directly focused on the exercise or practice of parenting'.

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In the Swedish context, the aim of parenting support is to facilitate all parents to 'provide for children to gain good health and a positive upbringing, and to protect the child against ill-health and social problems' (Swedish Government, 2010: 2). Parenting support in Sweden is thus defined broadly and involves a number of high-profile health-promoting interventions. Support is mainly provided through universal services, but it also encompasses targeted measures, organised and financed by county councils or municipalities, including activities organised in cooperation with civil society organisations. It is difficult to assess the overall costs of parenting support services, especially since many of the activities are integrated in already established institutions such as child health centres or schools. The available evidence indicates that in 2010 140 million SKR (about €14.5 million) was allocated to the Public Health Agency to support a number of parenting support projects working with structured parenting programmes across the country (Folkhälsomyndigheten, 2014).

The organisation of parenting support is complex. Table 1 serves as an introduction to the main providers, organisers and types and modes of services (as defined by the Public Health Agency).

Table 1 Parenting support – providers, organisers and types and modes of services

Providers and organisers	Types and modes of services
Antenatal clinics; child health centres, organised by county councils. Services provided by doctors, nurses, midwives	Parenting groups/parenting education (*föräldragrupper*); health check-ups; various types of counselling/information
Open pre-schools, organised by municipalities and civil society, for example, churches. Services provided by pre-school teachers	Structured parenting programmes; information; counselling (often integrated in family centres)
Social services, organised by municipalities. Services provided by social workers, psychologists	Family counselling; consultation in the area of family law; structured parenting programmes; counselling via telephone lines and internet
Pre-schools and schools, organised by municipalities. Services provided by pre-school teachers and teachers	Cooperation activities between teachers, parents and pupils, e.g. through information meetings etc.
Family centres involving collaboration between antenatal clinics, child health centres, open pre-schools and social services, organised by the municipalities. Services provided by nurses, midwives, psychologists, pre-school teachers, social workers	Counselling; parenting groups; telephone counselling; structured parenting programmes
Child and youth psychiatry, organised by county councils. Services provided by psychiatrists, nurses	Counselling, family therapy, group treatment, counselling via telephone and internet
NGOs, organised by civil society. Services provided by social workers and volunteers	Structured parenting programmes; counselling via telephone lines and internet

Source: Statens folkhälsoinstitut, 2013a.

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These different services are all universal, free of charge and voluntary. The most all-encompassing service is that of antenatal clinics and child health centres, introduced in 1937 as a universal service, and managed mainly by nurses and midwives. Virtually all antenatal clinics offer first-time parents participation in parenting groups (*föräldragrupp*) before the child is born, and the overwhelming majority of parents attend such groups (Statens folkhälsoinstitut, 2013a). After childbirth, the birth clinic reports the birth to a child health centre (the nearest or the one chosen by the parents). Subsequently, the parents are invited to attend a number of child health check-ups provided by child health centres. Child health check-ups were introduced as a universal practice in the 1950s, including home visits in the first weeks after the child was born. These controls are voluntary, but considered by most parents to be more or less compulsory. If parents do not attend these meetings, professionals at the antenatal clinics or the child health centres might critically assess the absence as a sign of risk, ill-health or neglect (Börjesson and Palmblad, 2003). Apart from offering medical advice and support whenever the child is sick, the child health centres also offer support in relation to breastfeeding, vaccination programmes and group sessions in which parents are invited to discuss children's development and needs together with professionals. It is mainly women/mothers who attend these sessions, despite increasing attempts to include fathers (Statens folkhälsoinstitut, 2013a).

Parenting support also includes open pre-schools, which are often integrated in family centres (see below). Open pre-schools are meeting places for parents with children who do not attend childcare. Since open pre-schools are available to anyone interested, parents do not have to sign up or register their children. The main aim is to offer children good pedagogical activities in close cooperation with adults/parents (Skolverket, 2015). To meet this aim most open pre-schools offer not only structured times and places for meetings, but also structured parenting programmes and counselling. In 2012, Swedish municipalities ran about 460 open pre-schools, in addition to a number of open pre-schools organised by religious communities and other voluntary organisations (Statens folkhälsoinstitut, 2013a).

Parenting support is also offered by the social services in all municipalities. The main types of service are various forms of family counselling (offered as a universal service since 1957) and consultation in the area of family law regarding for example adoption, custody and parenting. Most social service offices also offer structured parenting programmes, mainly as a part of family counselling activities, and counselling via telephone lines and the internet. Parenting support services also include activities provided in childcare centres and schools, especially parenting meetings, or informal support between teachers and parents (ongoing since the 1970s).

Family centres are a rather new location for organising parenting support. A family centre is open to all parents and children, and is usually organised either by municipalities, county councils or civil society organisations. These centres function as platforms for interaction between parents and staff, covering antenatal care, child health care, open pre-schools and social services (and the professions involved include nurses, midwives, social workers, dentists, psychologists, counsellors and medical doctors). Family centres offer both preventive and supportive activities, individually and in groups, for example psychological and/or therapeutic counselling and medical advice, as well as a mixture of universal, and targeted structured parenting programmes (SOU, 2008). Another frequent service offered by the family centres is counselling via telephone lines. The National

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Association for Family Centres (*Föreningen för familjecentralers främjande*) estimated that some 250 Family Centres existed across Sweden in 2013. Most of them had opened in the last ten years.

Parenting support is also considered by authorities to be a part of child and youth psychiatry services, which are run by the county councils. Here, support is mainly offered in the form of psychiatric treatment and family therapy, but also through telephone counselling. NGOs such as Save the Children play a supplementary role, mainly by offering structured parenting programmes and support via telephone counselling and the internet (Statens folkhälsoinstitut, 2013a). Web-based parenting support is also provided by the parents themselves, and functions as an additional important provider (Sarkadi and Bremberg, 2005; Lind, 2013).

Many of the above-mentioned services have been in place for a long time. There are, however, a number of new activities. Structured parenting programmes represent a new element in Swedish parenting support services (Sarkadi, 2008). A recent evaluation of all parenting programmes offered in Sweden shows that 87 per cent of all municipalities (mainly through the social services, but also via pre-schools or schools, and NGOs) and 41 per cent of the county councils/regions offer one or more parenting programme (Statens folkhälsoinstitut, 2013b). Structured parenting programmes are organised as universal prevention, as well as being targeted in orientation and practice. Universal prevention is channelled through a wide variety of programmes, such as Active Parenting, Triple P and Cope. Other programmes, such as Connect, Incredible Years and Komet, target parents who experience various forms of problems in child-rearing. Finally, there are a few programmes (for example, Effekt and New Steps) concerned with issues related to alcohol and drug prevention. These programmes mainly target parents with teenagers, and are offered in association with parenting meetings in schools.

The most widely available parenting programme in Sweden is Effekt, which is reported as being offered in about 50 per cent of all municipalities, followed by Komet (38 per cent) and Cope (35 per cent) (Statens folkhälsoinstitut, 2013b). It is important to note that these figures are based on programmes that are offered, not on how many parents actually attend. Targeted and universal programmes alike are voluntary, and are offered rather than prescribed. Studies indicate that less than half of all parents express an interest in parenting programmes, and it is mostly women/mothers who participate. The share is much higher for parents with children of younger ages, and those experiencing problems of different kinds, ranging from alcohol, drugs, gaming and excessive or 'risky' internet use (Eriksson and Bremberg, 2008; Möllerstrand *et al*., 2012; Rahmqvist *et al*., 2013). Moreover, a study of parenting programmes in Umeå municipality points to the fact that such programmes define the family as a risk factor, which in turn forces parents to turn to 'experts' instead of trusting their own competencies (Folkhälsomyndigheten, 2014). The report also criticises the assumption that parenting programmes target all 'Swedish families', whereas in reality the participants often belong to specific groups, defined by experts to be in special need of support (such as migrant families or parents with children in so-called 'risk groups'). According to the study, such discourse might very well result in stigmatisation of those who attend, since they are constructed as problematic (Folkhälsomyndigheten, 2014).

The above discussion of the main characteristics of current Swedish parenting support sets the stage for questioning how the development and growth of parenting support should be understood. In the following sections, parenting support services will

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be analysed as an instance of institutional layering, whereby the policies introduced contribute to grafting of already existing support interventions and to the establishment of new elements.

Historical roots and policy development

Both family policy and support to parents are deeply embedded in the history of the Swedish welfare state. They are rooted in population policy which emerged in the 1930s and was first of all a response to decreasing fertility rates and alarming poverty levels among families with children. A number of policy reforms were enacted to prevent poverty and declining fertility. Regarding support to parents, education and information on sexual behaviour were introduced, as well as the establishment of antenatal clinics and child health centres in 1937. In these early days, interventions were deployed as a means to control (poor) parents but also as a tool to change society via the family (Gleichmann, 2004).

Preventive and health-promoting services provided by antenatal clinics and child health centres were developed on a nation-wide scale in the post-war period, and included the introduction of systematic health check-ups of all children (primarily for children up to three years of age) and counselling to families with children with 'special needs' (Wissö, 2012: 20; Zetterqvist Nelson and Sandin, 2013). Such check-ups were not merely exercised in the centres though, as nurses and midwives also visited families with new-born children in their homes to inform parents on best practices in caring for their child. These visits also served to control whether the parents actually followed the advice given by the authorities (ibid.). This culture and practice of monitoring home visits are, as we saw in the previous section, still in place.

The 1960s marked the beginning of a new era in which the concept of the gender-equal family emerged in policy discourse (Lundqvist, 2011; Nyberg, 2012). While policy debates about families mainly focused on how to facilitate women to enter paid work and men to take on caring responsibilities, the conditions and life chances of children were also fast becoming a growing political issue. A debate on the prevention of child abuse took off in the 1960s, and continued in the 1970s when it was complemented by a policy focus on children with poor health as a consequence of parental neglect (Bremberg, 2004; Gleichmann, 2004). Experts and politicians began envisaging not only a gender-equal society, but also a so-called 'children-friendly society', which, it was argued, could only be created by parents (mothers and fathers) in conjunction with their children. This in turn called for increased knowledge about the needs and conditions of children on the part of parents. A part of this could be fulfilled by parental education, guiding parents into a more secure role in a society where social relations were seen as much more frail and hostile than heretofore (Lundqvist, 2011).

With these discussions as a backdrop, the social democratic government in power in 1975 appointed a commission to investigate existing parental education programmes. The commission suggested that parental education should be universal in scope and include education for all parents (mothers and fathers) in connection with childbirth, but also encompass parents with children of school age (SOU, 1978, 1980). It was also important, it was argued, that all education should be voluntary while at the same time-promoting networking among parents in order to counter what was identified as isolation in many families (SOU, 1978). Consequently, Parliament decided in 1979 to introduce

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parenting education to all pregnant women and all parents with new-born children. Some municipalities established programmes in this vein, but it was never realised as a full-scale national initiative, given that far from all municipalities and county councils offered parenting education even a decade later (SOU, 1997). In the 1990s, there was a change.

Parenting support in a new political landscape

The profound economic crisis in the early 1990s worsened the living conditions of virtually the entire population in Sweden. The most noticeable change was the increasing incidence of various kinds of disadvantage. Along with higher unemployment, conditions of employment altered in many respects. Negative working conditions and short-term employment became more common, and progressively larger groups suffered financial difficulties and dwindling incomes (Palme, 2002: 9–10).

This was the situation in which the social democratic government again called for an investigation of existing parenting education and support. The commission directives took as a starting point the worsening conditions among families in the wake of the crisis, exemplified by increasing numbers of divorces and lone parenthood, high unemployment among parents and young adults. With these problems as a backdrop, the brief of the commission was to suggest how parenting education in the future should be conceived and organised and, if there was a need, for new measures in parenting support (SOU, 1997).

An important novelty in the 1997 commission report was the suggestion that parenting support should cover all children and youths up to eighteen years of age. In addition, a broad panorama of arenas for parenting support was suggested as an ideal. The antenatal clinics and the child health centres were advised to not only organise parenting groups but to provide special support to fathers in order to strengthen their role as fathers. It was also recommended that parenting support be delivered via childcare centres, pre-schools and schools, and involve especially cooperation between parents and teachers. In addition, professionals working with children and parents in other contexts, such as social work, family counselling, psychiatry and sports, should engage in the development of parenting support, most often articulated in the form of self-organised parental groups (*föräldragrupper*) but also in the forms of targeted support to fathers, migrant parents, parents of disabled children and parents who adopted children (SOU, 1997: 19–30).

Layering processes are obvious: most of the recommendations were already in place, such as parenting groups organised by antenatal clinics and child health centres, counselling and cooperation between parents and teachers in schools. Nevertheless, the commission did indicate new opportunities for approaching parents and for devising parenting support, mainly resulting in a discursive change. By comparing generations, the report argued for the importance of highlighting the needs articulated by the parents themselves. Parents in the 1990s, it was argued, no longer accepted the public authorities' decisions of what was to be considered 'good parenting': 'todays' parents are less predisposed than previous generations to accept instructions and directives from experts and authorities. Instead, parents of today want to search for information and knowledge themselves, on their own terms and from their own needs' (SOU, 1997: 64). Thus, the report made a distinction between parents and the perception of parenthood in

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different cohorts. In contrast to older generations, the younger generation wanted to decide themselves how to bring up their children and how best to practice parenthood, indicating a discursive shift towards what Nikolas Rose calls the 'responsible autonomous family' (Rose, 1999). In this context, a concept of empowerment was called for: 'the power of the individual'; in the commission's words: 'the I/you-relationship must be the focus rather than the more paternalistic one where the expert decides what people need' (SOU, 1997: 42).

In the same vein, it was argued that the concept of 'parenting education' could be perceived as old-fashioned: 'Society should not only educate parents but also create opportunities for parents to develop in their roles as parents and to strengthen their competence and ability to take responsibility. It is all about supporting parents in their parenthood' (SOU, 1997: 46). Consequently, the commission suggested the wording 'support in parenthood' (*stöd i föräldraskapet*) rather than 'parental education' (*föräldrautbildning*). However, even if the report argued for a re-evaluation of how to conceptualise parents and their needs, state interventions were still practised and endorsed. Support in parenthood in the 1997 report thus stressed the importance of acknowledging parents' own needs, while at the same time emphasising the role of the state as a provider of parenting support, albeit that it should be designed according to the wishes of the parents (SOU, 1997: 19). Consequently, the state was exhorted to withdraw from some of its previous engagements and open up to two different models: one emphasising the importance of state intervention in supporting parents through activities organised by, for example, antenatal clinics, and a second highlighting the role of the individual and autonomous parent and her/his ability to gain and process knowledge on her/his own (Gleichmann, 2004; Littmarck, 2012).

Implementing the national strategy

The commission report was followed up by a re-orientation in public health policies in the early 2000s. The background to this development was once again the negative trends in public health, which also affected children and youth. An increasing incidence of psychiatric and psychosomatic problems among children and youth triggered the reform (Swedish Government, 2002). Against this backdrop, the then social democratic government introduced new goals for public health policies in 2003. The main aim was to enable the entire population, including children, to gain good health on equal conditions (ibid.), and the Public Health Agency became the main actor in implementing these goals together with the National Board for Health and Welfare, thereby paving the way for 'institutional complementarity'.

The centre-right government in power between 2006 and 2014 continued this approach. The rationale was that more children and youth than ever before experienced sleeping problems, depression, headaches and so forth (Swedish Government, 2007a). To address this, the government allocated funding for health-promoting measures in municipal settings. Children, youth and their parents were targeted as particularly important in pre-emptive public health interventions. As a consequence, the government suggested a long-term national strategy for state support for parents (ibid.).

Christian Democrat Inger Davidsson (former home secretary) had the task of outlining such a strategy (SOU, 2008). The strategy emphasised that all parents with children between nought and eighteen years old should be offered parenting support. The support

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was to be voluntary and developed with the parents' needs in mind, just as was argued in the 1997 report. The idea of acknowledging parents' needs was thus well established in political circles. The government's emphasis on freedom of choice provided another principle of its approach: 'The government wants to enhance the freedom of choice for families by reducing the national political steering. Family policy should create good preconditions for families to cope with their everyday life according to their own desires and needs, and not force children and parents into politically dictated templates' (Swedish Government 2007b). Ideas of freedom of choice for families thus coincided with ideas introduced in the late 1990s which emphasised the role of the individual and the autonomous parent.

The 'National strategy for developing parenting support', as it was labelled, was implemented in 2010 (Swedish Government, 2010). Its overarching goal was to prevent ill-health among children and youth by offering parents support in the upbringing of their children. The strategy operated with three aims: to offer all parents parenting support while the child is between nought and seventeen years old; to increase cooperation between various actors engaged in parenting support; and to increase the number of health-promoting arenas and meeting places for parents, as well as the numbers of service providers who are educated in 'health promoting, universal and evidence-based structured parenting programmes' (ibid.: 3). Again, inter-connectedness between different institutional arenas is emphasised, as is the role of 'powerful actors' in the form of academic communities with education and expertise in child-rearing (teachers, doctors, midwives and so forth). In other words, cooperation is pivotal to the strategy. Interestingly, cooperation is perceived to extend beyond municipal or county council institutional arenas. In the implementation of parenting support, a space is opened up to civil society in the form of associations, religious communities or adult educational associations. This development can be seen to flow from the ideology of freedom of choice, but it is also a municipal strategy to lower the costs in times of severe cutbacks in welfare services in general and in support to parents in particular (especially in relation to parenting support activities offered by child health services and social services).

Throughout the strategy, gender equality is stressed as an overall perspective in that all services are to be informed by gender-equality perspectives. However, it is not clear how gender-equality perspectives should inform parenting support services. Even if the strategy stresses the importance of mothers and fathers sharing parenting support activities equally (without critically assessing the underlying assumption of pinpointing nuclear families), there is no discussion of how this approach should be implemented. Instead of gender-specific considerations, the overall focus of the parent–child relationship is placed on the gender-neutral parenting support services. This is particularly obvious in the structured parenting programmes, which operate on a gender-blind approach. That is, the focus is on the relationship between the parents and the child (Daly, 2013), and not on relations between parents and on parents and children as gendered beings.

To sum up, discursive, political and policy developments over the last fifteen years have resulted in a somewhat different approach to parenting support services. Following the introduction of the idea of the autonomous parent and a re-orientation in public health, new forms of services (web-based forums and structured parenting support programmes) and new forms of organising support (family centres and an increasing presence of civil society organisations) have emerged.

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Conclusion

Parenting support is nothing new in the Swedish welfare policy mix. Emerging under the auspices of population policy, it traces its origins back to the 1930s. Later, parenting support, developed in different policy fields, aligned with the gender-equal ambitions of welfare policies in the 1960s. However, some elements of contemporary parenting support represent a profound change in the political articulation of how to support parents in their child-rearing.

I have argued that the development of parenting support involves institutional layering, including grafting but also potentially altering of institutional trajectories (Thelen, 2004). Parenting support forms an unstable coalition with the Swedish gender-equal and family-friendly legacy, sometimes operating in relative harmony with it, sometimes departing from it and forming a potentially deviating policy strand.

Parenting support builds upon a century-long tradition of pre-emptive health care controls and services to pregnant women and first-time parents, counselling and parenting education run by municipalities and county councils. These services were universal in the post-war period and therefore integrated in already established forms of family, social and education policy interventions. They were in alignment with the gender-equal ambition of welfare politics, as they addressed both parents, depicting both women and men as objects of policy intervention for the sake of enhancing the workings of families. They are still part of the powerful gender-equal policy legacy in Sweden.

There are, however, elements in parenting support policy which mark a clear deviation from this policy legacy, hence contributing to a partial reframing of the conceptualisation and practice of parenting support (and of the gender basis of Swedish social policy). These include the introduction of structured parenting programmes, the growth of the idea of parents as autonomous beings and the partial relocation of parenting support into new public health goals. The latter, especially, acted to detach parenting support from the gender-equal ideology present in, for example, early parental education.

Part of the reframing of parenting support is driven forward by powerful actors such as experts and academics working in governmental commissions, who introduced the new discourses of the autonomous and competent parent. Parents, it was argued, did not need authorities to tell them how to raise their children. The best competence was instead lodged in the parents. Another important backdrop to these new elements of parenting support was the hike in ill-health among the young in the 1990s. This prompted the introduction of policies to support parents in their parental practices, turning parenting support into an instrument for enhancing public health. This in turn made the Public Health Agency the driving actor in parenting support, reducing the dominance of the National Board of Health and Welfare, which until then had been the dominant policy actor in the field. The National Strategy of 2010 codified ill-health as the leitmotif for parenting support, again in marked contrast with earlier periods when economic and social challenges were seen as the main reason to support parents. This change in focus can be seen as a result of the re-orientation in public health policies, which together with the discourse of the autonomous and competent parent have contributed to a reframing of parenting support. Hence, two strands operate in parallel. What remains to be seen is whether the articulation with gender-equal policies will continue to dominate, or whether the strong focus on ill-health within the realm of public health policies will form the basis

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for how to formulate support to parents. If the latter becomes the case, notions of the 'gender-equal family' are bound to change in Sweden.

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References

Börjesson, M. and Palmblad, E. (2003) *I problembarnens tid*, Stockholm: Carlssons.

Bremberg, S. (ed.) (2004) *Nya verktyg för föräldrar – förslag till nya former av föräldrastöd*, Stockholm: Statens folkhälsoinstitut.

Daly, M. (2013) 'Parenting support: another gender-related policy illusion in Europe?', *Women's Studies International Forum*, 41, 1, 223–30.

Daly, M. (2015) 'Parenting support as policy field: an analytic framework', *Social Policy and Society*, forthcoming.

Eriksson, L. and Bremberg, S. (2008) *Kartläggning av föräldrars erfarenhet och intresse av föräldrastöd*, Östersund: Statens folkhälsoinstitut.

Folkhälsomyndigheten (2014) *Slutredovisning av uppdrag kring ett utvecklat föräldrastöd, Uppdrag att fördela stimulansmedel till utvärdering och utveckling av föräldrastöd*, Östersund: Folkhälsomyndigheten.

Gleichmann, L. (2004) *Föräldraskap mellan styrning och samhällsomvandling: En studie av syn på föräldrar och relation mellan familj och samhälle under perioden 1957–1997*, Stockholm: HLS förlag.

Lind, J. (2013) *Föräldrastöd on-line: En analys av ett digitalt diskussionsforum för föräldrar*, Research Report on Childhood and the Study of Children (2013: 1), Linköping: Linköpings universitet.

Littmarck, S. (2012) *Hur görs barn, barndom och föräldraskap i de statliga satsningarna på stöd till föräldrar? En diskursanalys av den samtida politiken kring föräldrastöd*, Research Report on Childhood and the Study of Children (2012: 9), Linköping: Linköping universitet.

Lundqvist, Å. (2011) *Family Policy Paradoxes, Gender Equality and Labour Market Policies in Sweden 1930–2010*, Bristol: The Policy Press.

Möllerstrand, A., Gustavsson, M. and Osvaldsson, K. (2012) *Vad tycker föräldrar om föräldrastöd. Enkät i Valdemarsviks kommun*, Research Report on Childhood and the Study of Children (2012: 8), Linköping: Linköpings universitet.

Nyberg, A. (2012) 'Gender equality policy in Sweden: 1970s–2010s', *Nordic Journal of Working Life Studies*, 2, 4, 67–84.

Palme, J. (2002) *Welfare in Sweden: The Balance Sheet for the 1990s*, Stockholm: Socialdepartmentet.

Rahmqvist, J., Wells, B. M. and Sarkadi, A. (2013) 'Conscious parenting: a qualitative study on Swedish parents' motives to participate in a parenting program', *Journal of Child and Family Studies*, 11, 8, 1–11.

Rose, N. (1999) *Governing the Soul: The Shaping of the Private Self*, London: Free Association Books.

Sarkadi, A. (ed.) (2008) *Föräldrastöd i Sverige idag – vad, när och hur? Kartläggning och behovsinventering inför regeringens nationella strategi för 2009/2010*, Underlagsrapport, Östersund: Statens folkhälsoinstitut.

Sarkadi, A. and Bremberg, S. (2005) 'Socially unbiased parenting support on the internet: a cross-sectional study of users of a large Swedish parenting website', *Child: Care, Health And Development*, 31, 1, 43–52.

Skolverket, (2015) *The Swedish National Agency for Education – Mission and Role*, http://www.skolverket.se/skolformer/annan-pedagogisk-verksamhet/oppen-forskola [accessed 15.02.2015].

SOU (1978) *Föräldrautbildning 1. Kring barnets födelse 1978: 5*, Stockholm: Socialdepartementet.

SOU (1980) *Barn och vuxna. Barnomsorgsgruppens slutbetänkande om föräldrautbildning, 1980: 27*, Stockholm: Socialdepartementet.

SOU (1997) *Stöd i föräldraskapet 1997: 161*, Stockholm: Socialdepartementet.

SOU (2000) *Hälsa på lika villkor – nationella mål för folkhälsan, 2000: 91*, Stockholm: Socialdepartementet.

SOU (2008) *Föräldrastöd – en vinst för alla. Nationell strategi för samhällets stöd och hjälp till föräldrar i deras föräldraskap, 2008: 131*, Stockholm: Socialdepartementet.

Statens Folkhälsoinstitut (2013a) *Föräldrar spelar roll. Handbok i lokalt och regionalt föräldrastödsarbete*, Östersund: Statens folkhälsoinstitut.

Statens Folkhälsoinstitut (2013b) *Så arbetar kommuner, landsting och ideella organisationer med föräldrastöd*, Östersund: Statens folkhälsoinstitut.

Swedish Government (2002) *Mål för folkhälsan 2002/03:35*, Stockholm: Socialdepartementet.

Swedish Government (2007a) *En förnyad hälsopolitik 2007/08:110*, Stockholm: Socialdepartementet.

Swedish Government (2007b) *Vårdnadsbidrag – familjepolitisk reform 2007/08:91*, Stockholm: Socialdepartementet.

Swedish Government (2010) *Nationell strategi för ett utvecklat föräldrastöd: En vinst för alla*, Stockholm: Ministry of Social Affairs.

Thelen, K. (2004) *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*, Cambridge: Cambridge University Press.

Wissö, T. (2012) *Småbarnsföräldrars vardagsliv. Omsorg, moral och socialt kapital*, Göteborgs universitet/Samhällsvetenskapliga fakulteten: Institutionen för socialt arbete.

Zetterqvist Nelson, K. and Sandin, B. (2013) 'Psychodynamics in child psychiatry in Sweden, 1945–85: from political vision to treatment ideology', *History of Psychiatry*, 24, 4, 308–25.