Stepping through the door – exploring low-threshold services in Norwegian family centres

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STEPPING THROUGH THE DOOR

- Exploring low-threshold services in Norwegian family centres.

ABSTRACT

Public policies encourage the service system to work in new ways to promote health and increase social equality. This paper presents four categories that show the character of the low-threshold services in Norwegian family centres from the professionals' and parents' perspectives, focusing on accessibility and participation: Easy access, Low level of bureaucracy, Collaborative competences and Inclusive arena. This paper is based on an inductive study in three municipalities that have chosen to establish family centres as interdisciplinary co-located services that aim to offer low-threshold services for children and their families. Data were generated through a fieldwork, and participatory observation and interviews were the main source of data. The methodological framework for the analysis was grounded theory, in which the data generation and analysis interchanged throughout the study, and theoretical sampling set the focus for the fieldwork. Exploring the actor's perspective highlighted both strengths and challenges with the low-threshold services in the family centres. The four elements presented emphasise that the value of these low-threshold services are not found in one single hallmark; rather the value depends on an interaction between different elements that must be addressed when establishing, evaluating and developing low-threshold services in family centres.

INTRODUCTION

Many countries have developed policy frameworks and innovative approaches that involve different levels and sectors of government to respond to the complex needs of families with young children (Kickbusch & Behrendt, 2013). This implies the notion that segregated services in the welfare system are inefficient and create barriers for interdisciplinary collaboration. There is also a focus on supporting the whole family, in contrast to interventions targeting the child. Early childhood support should "include health care, education and social welfare services that are aimed at parents as well as the children" (Marmot et al, 2012). There is a need for knowledge on how we can provide accessible interdisciplinary services for families with small children, in order to promote health and increase social equality.

Low-threshold services (LTSs) have been understood as services for marginalised groups in the society, often as harm-reduction interventions for people with a drug addiction. Research has focused on thresholds for providing health services to people not reached by conventional services (Braine, 2014; Muckenhuber et al, 2011; Rosenkranz et al, 2016). These services have been found to mediated access to resources and health care services (Kappel et al, 2016; McNeil & Small, 2014), in addition to providing a safe environment for drug users. The term LTS has also been used lately by other parts of the service system regarding access to psychiatric treatment, children's health-care centres and interdisciplinary teams. Interventions targeting young children that increase social

equality are shown to have positive economic effects on society at large (Heckman, 2006). Centres where children and families come together have been established in different parts of the world, by both statutory and voluntary sector (Aldgate et al, 2006), and show a variety in services provided in the local community. Even though there is limited knowledge on the parents' and professionals' perspectives on organising services in these centres (Hoshi-Watanabe et al, 2015).

This paper is based on a study of three Norwegian family centres providing different forms of LTS. This paper present four elements that show the distinctive character of LTSs in the family centres from the actors perspective, focusing on what they see as important for accessibility and participation.

NORWEGIAN CONTEXT

Norway is divided into 428 municipalities. They are responsible for providing education, health care and social services to their inhabitants, but they are free to decide how these services are organised. The municipalities represent a large variation of demographics, the smallest municipality has a population of 200 and the largest is also the capital and holds a population of 950 000. Immigrants are resident in municipalities all over the country, although half of the immigrant population is living in the area surrounding the capital city. Some of the municipalities have vast rural areas, others a high population density. Therefore, the services in different municipalities may vary. Although Norway has what is considered to be an advanced welfare system, with comprehensive universal services and social benefits, the social inequality increases (Dahl et al, 2014).

The importance of addressing health and social issues from a new angle has been high on the political agenda in Norway over the last decades (Goth & Berg, 2014). In 2011 new legislations (Folkehelseloven, 2011; Helse- og omsorgstjenensteloven, 2011) manifested a reorientation of the public services, aiming to mobilise the potential in health promotion, early intervention and collaboration with the local community. Public policies focus on the service systems' ability to use the resources more effectively (Meld st. nr. 34, 2012-2013; Meld. st. nr. 26, 2014-2015; Meld. st. nr. 47, 2008-2009). An important part of the policies is to provide services closer to where people live and better designed to reach vulnerable groups. Several municipalities have established LTSs for families and children in interdisciplinary family centres. Research on Norwegian LTSs has focused on low-threshold health care services for people with substance addiction or mental health challenges (Edland-Gryt & Skatvedt, 2013; Elstad, 2014; Åndanes et al, 2008). To my knowledge, there have not been any qualitative studies in the Norwegian family centres conducted to this date. In 2011, the different services provided in the centres were mapped through a survey, showing a wide range of variation in organisational structure and the type of services included in the centres (Gamst & Martinussen, 2012). LTSs working to improve children's mental health are found to often be connected to an interdisciplinary collaboration model (Norvoll et al, 2006). The family centres included in this study are inspired by an interdisciplinary model called the Family's House.

THE FAMILY'S HOUSE MODEL

The Family's Houses are centres that provide interdisciplinary services for children, adolescents and their families in the municipalities. Both health and social services are located together. The first houses were established in 2002-2004 in a pilot project initiated by the Norwegian Health Authorities as part of the national plan for advancing mental health care (helsedepartementet, 1998). The pilot was developed on the basis of the Swedish Family Centre Model and adapted to the Norwegian context (Thyrhaug et al, 2012). After the pilot, the health authorities recommended the municipalities to further explore the model, and a survey from 2012 show that there where established 150 centres throughout the country(Gamst & Martinussen, 2012). The services included in the Family's Houses were health-care services for children, including pregnancy care, preventive child welfare services, pedagogical-psychological services and an open kindergarten. The houses were meant to provide better-coordinated services that supported the whole family. The goal of the work was to promote well-being and good health amongst children, adolescents and their families, and to improve conditions for children and young people (Thyrhaug et al, 2012). The term Family's House implies a tangible building and is also a metaphor for how the services are organised, connected and placed within the model.

The model is illustrated by a three-floor building (see figure 1) in which each floor represents a different level of intervention. The floors also represent different levels of intervention from health promotion and universal interventions to selective and indicated prevention and treatment (Barry & Jenkins, 2007). The first floor holds the services that are available to all families in the municipality, including health-care services for children. This service has a special position in Norway in the sense that almost all families use this service; thus, almost all families with children in the municipalities will at some point be in contact with the Family's House. The second and third floors have other types of services, including interventions provided for families that need more support and help than what is offered on the first floor.

Figure 1

METHOD

This paper presents an analysis of the data from an explorative study in three family centres located in three different Norwegian municipalities., one that is located in one of the capitol's city districts. The study was approved by the Norwegian Social Science Data Services.

Both the analyses and the data-generating process have been guided by grounded theory as a constructivist approach developed by Charmaz (2014). This was chosen for two reasons. First, the methodology acknowledges subjectivity and the researcher's involvement in the construction and interpretation of data. Second, it provides strategies '*of going back and forth between data and analysis uses comparative methods, and keeps you interacting and involved with your data and emerging analysis*'(Charmaz, 2014). Three sites were selected in the initial sampling to provide centres with some similarities: Minimum three collocated services targeting children and families, a formal setting for interdisciplinary collaboration and an open kindergarten. The three sites

represented a variation in density and the demographics of the population. The methods for generating data in this study where participatory observation and interviews. The author had access to the family centres, and participated in the different activities in the centres together with the actors, for eight to ten working days in each centre. The data presented here are interviews with the actors in LTS in the family centres, in addition to informal conversations from participatory observations in the LTSs.

In this study, parents and professionals are seen as co-constructing the LTSs. Thus, this paper includes both perspectives in the analysis. The services are defined as LTSs by the actors, and two LTSs were included from each centre (see table 1). The parents included in this study where using the LTSs. The services is open to all the inhabitants in the community. Since the services does not target one specific target group the service users are as different as the population of the municipality, representing diversity regarding sex, age, ethnicity, employment, education, mental health, wealth and poverty. The professionals included worked in the family centres, either part time or full time employed to run the LTS, or they worked in other services in the centre that collaborate with the LTSs. They represent a diverse group of professions and services. Sixteen individual interviews and one focus group interview with nine participants with parents were conducted. In addition to this the informal conversations from the participatory observation provided a vast variety in the parents voices represented in the data (Fangen, 2011).The professionals were interviewed in eight focus groups in addition to thirteen individual interviews, 52 professionals all together.

The process of analysing interchanged with data collecting throughout the study, and analytical ideas where written out in memos, and tested through initial coding. The flexibility in Charmaz methodology provided a possibility to explore new questions that emerged through the research process and gave direction to the participatory observation and interviews. Comparing codes, and recoding the material formed categories that were further developed through theoretical sampling(Charmaz, 2014) at the last stage of generating data. The content of the categories were refined through interviews with both professionals and parents when revisiting all three sites at the end of the study. The interviews where documented through audio recordings and notes. NVivo 11 qualitative data analysis software(Qualitative Solution and Research International, 2015) where used to organise field notes and audio files, transcribe the interviews, code the material and write memos throughout the study. It provided a structure that made it possible to navigate easily in a large amount of data.

One limitation of this study is that the parents who do not use the LTSs in the family centres have not been included. Their perspectives have been represented through others. Further studies that include this group can give more insight into the thresholds of participation.

Table 1

FINDINGS

This paper does not provide a definition of LTS; rather, it presents a concept of four categories that emphasize how these services differ from traditional public services from the perspective of the

parents who use the services and the professionals who work in them. The categories are easy access, a low level of bureaucracy, collaborative competences and an inclusive arena.

EASY ACCESS

The actors perceived the LTSs' location in the centre of the community as important for participation. Parents describe that walking distance made it easy to combine visits to the centre with their daily routine of walking the children in a stroller for their nap. Others depended on a car or public transport; they did not seem to mind the distance, although they appreciated the fact that they could combine the trip with other tasks. Other families were excluded by the distance. Living expenses in the countryside are lower than in the cities, and families with low incomes can afford better housing in the rural areas. The challenge is often transportation, as many cannot afford a second car and public transportation is often scarce.

> What we have struggled with the most are the marginalised mothers. Taking the bus here is not an option. We investigated this for a Polish family with only one car in which the mother did not have a licence to drive, so we tried to figure out how to take the bus here; that was not possible. She could get here, actually, but not until the middle of the day. It was not feasible; it was not functional. (Professional)

Co-location with other services was seen as an advantage. Parents described being able to combine a visit to open kindergarten with consultations in the health-care centre. Professionals described contact with other services in the same building as being more frequent than with services located elsewhere. The opportunity of asking a short question or to introduce a parent to another part of the service system was made more manageable by short distances in a hectic work setting. One of the public nurses in the health-care centre stated, '*I often follow them down, instead of just saying, "There's this open kindergarten". It takes an effort to cross that threshold; so, often, you have to sit down and explain'*. This was seen as a way of ensuring they understood the information and to increase the chances for them to attend the LTS.

The most frequent source of information on the LTSs was the public health nurses, often through the maternity groups. Many of the parents had received some form of information about the LTSs but did not quite comprehend what they were. '*I did not ask more about it when I was there; there is so little time in those sessions'* (Mother). Some participants actively searched for information about LTSs, constantly assessing the offers available. Others were more apprehensive about attending. *'I was not sure it was for me'* (Mother). Too seek more information, the parents used the Internet, although several thought the information on the websites was insufficient. The professionals also thought this was a problem. Complicated systems made updating the information on the official website a task that few mastered, and the information was only available in Norwegian. Another frequently mentioned source of information was acquaintances. This was especially important in the Norwegian cafe. *'I heard about this place from the wife of my husband's colleague' (Mother).*

The actors perceived the services being free of charge as important to keep the threshold for participation low, especially for families with low incomes. A professional stated the following:

> Those who show up at the Norwegian café are those in our society today, at least in Oslo, who have next to nothing. They have no one else; they are on the outside of the system. They are on the outside of everything.

This was confirmed by the participants at the Norwegian café: '*I come here to learn Norwegian, to talk, to learn. It's free; you can just come*' (Mother). The lack of entrance fee and a free cup of coffee were also important for the parents attending the open kindergarten: '*We are so grateful that we can come here with our children and sit down and have a cup of coffee, and there is fruit for the children. We know it costs money, but I hope this service will continue*' (Father). One of the open kindergartens began to charge an entrance fee. An educator that worked there saw this as constructing a threshold for participation.

They lost many of the participants with the lowest incomes. The professional was worried about excluding the families that needed the service the most, and as a contradiction to the name, it was no longer 'open'. One year later, there was no longer an entrance fee, and the educator saw a clear increase in the visitation numbers; the families had returned. Then, some parents felt it was too crowded and therefore did not attend.

LOW LEVEL OF BUREAUCRACY

The parents all talked about the value of *'just dropping by*'. Daily life with small children can be unpredictable, and the flexibility in the LTSs was highly valued by the families.

> It is nice to eat your food together with someone, which is another reason to come here. You do not have to stay here all day; you can come here, just stop by, and then leave. You do not have to sign up or let them know you are coming in advance; it is low threshold, so you can just drop in. (Mother)

To be able to come and go when it suited them led the parents to make frequent use of the services. The parents with the youngest children especially emphasised this. They felt it was challenging to plan activities around children's sleeping schedules. One of the educators working with immigrants upheld the lack of formalities as central to participation.

> One of the efforts we have made for it to be a low-threshold service in concrete terms is that you can simply drop in; you do not have to make a phone call or register anywhere or apply for anything (Professional)

The professionals had different perspectives on how flexible the services should be: 'We are not a drop in salon!'(Professional). This statement began a discussion in the group of nurses, and they all agreed that they were quite flexible and found a solution when parents contacted them but that they did not have the resources to provide a service that was available without an appointment. The LTSs with a more formalised form were placed a step higher on the prevention ladder. These services strive to lower the threshold through shortening the time from contact to action.

> We have no waiting lists here. On Thursdays, we go through the new cases and distribute these; we try to choose two from various professional backgrounds, and then, one of us has the main responsibility to make appointments, find two or three possibilities and call to make the appointments right away. (Professional)

The actors found it important that the person who held the concern or the question could make direct contact with no demand for a referral from a specialist. Some of the services had applications or request forms, but the professionals helped the parents to complete them, or sometimes they were not completed at all: *'We have an application form, but you do not need to fill it in to get through that door'* (Professional). The focus was instead on getting started with the case and often some form of early intervention.

The short waiting time was important from the professionals' perspective. '*The ideal is for these kids to be allowed to practically start the day after they have been to the health-care centre*' (Professional). Some traditional services were connected to the LTSs through formal or informal paths, which provided the families with rapid support when needed. Other services had long waiting lists, and the professionals in the LTSs perceived their resources as difficult to mobilise when attempting to intervene at an early stage: '*You will be waiting for several months before the case will be followed up because we are segregated and each service is led as one unit*'' (Professional). From the parents' perspective, a short waiting time was important because they had already waited before they made the request, hoping for the challenge to pass. The quick response provided a feeling of being taken seriously.

COLLABORATIVE COMPETENCES

Being able to meet professionals they were familiar with was an important motivation for participation for the parents*: 'It is positive that it is the same person that has the responsibility here; then, there is no confusion, and you get the same answer to the same question'* (Father). The continuity was important for all of the parents; for some, the professionals became important parts of their network. Some LTSs had systems in which professionals from other services visited and answered questions from the parents. Most of the parents appreciated these visits, but some felt that they only became more confused due to the different advice from different professionals; they did not know which advice to follow. *'I know there is no instruction book on how to raise children, but still*' (Father). In addition to answering questions, the professionals in the open kindergartens facilitated conversations and activities between the participants. A father said, '*At first, I did not understand what she did, but after a while I started to see it; she intervenes at the right time, and then she moves to someone else*' (Father). To be a facilitator for kin support was an important part of the professionals' work.

The professionals in the LTSs also guided the families to other parts of the services system: '*I think it is important that when we sense that there is something more severe here, something we cannot handle in this context, we ask the parents for approval to involve other resources*' (Professional). The professionals in the LTSs know the system and the families well and are able to guide the families in the process of seeking more extensive help.

> It becomes a broader referral when it comes from us, either way it does. It will have information that would not have been there, if, for example, it came from the health-care centre. (Professional)

Some of the parents were in contact with the family centre for several years and described the professionals in the LTSs as door openers to the rest of the public services and central to the parents' motivation to seek further support for their families.

There is also an element of being a part of a system that has low thresholds for contact between professionals in different parts of the centre that are present in the descriptions from the professionals. The psychologists were very clear that this was an important part of their job.

> I partake in discussions; is this child welfare or child psychiatry? Should we advance this case? How much is there really to worry about? Yeah, so I am involved in a lot of these types of discussions. A considerable part of the position involves guidance of other professionals. (Professional)

The physiotherapists also talked about being accessible for other professionals, both internally in the centre and externally to educators in the kindergartens and the schools in the area. Many of the professionals had experienced that their colleagues did not know their areas of competence: '*It is person-dependent; some people use us a lot and know what we can do, while others are still discovering what we can do*'(Professional).

INCLUSIVE SETTING

The inclusive setting category is composed of two elements: inclusive meeting places for families without prerequisites and the role the families are given when receiving support from the LTS.

The actors describe the meeting places as important to enable people new to the community, or who does not know other parents with small children, to expand their network. The arena provided a possibility to meet other adults, and receive social support in parenting, and everyday life, in addition to being an arena for the children to develop new skills, meet other children and play.

> To be honest, first of all, I think it is most of all for me. It is about getting out of the house and meeting people. I was ill at the beginning of my parental leave, so I never got to meet my maternity group. This is more of a way to meet someone else, because there is a lot of alone time with the baby during the parental leave. (Mother)

The social interaction in the LTSs varies. Sometimes the contact is in the moment; other times, the participants develop friendships that extend the family centre activities. The parents seek different sorts of relations; some parents are satisfied with short span of interaction; other parents wish for more: '*It would be nice to meet someone I could make a play date with to go to the park so the kids can play*'(Father).

The professionals described the meeting places as an arena where everybody is welcome: '*We do not set any prerequisites; if you have a child from 0-3 years old, independent of the role you have – grandmother, nanny, mother, father, aunt – you can come. You do not have to fit in or anything'* (Professional). This contrasts with their descriptions on who they wish to prioritise:

> There is a great diversity among the inhabitants of this district, concerning class and such, and if I were to choose, then of course I would say that I would prefer to reach the families who have socio-economic challenges. Maybe you are a newcomer in Norway; maybe there are linguistic issues. Maybe many family members are living in a small apartment; maybe you are insecure about your upbringing, like, where those parameters are set. I would rather that we reach those than the academic couple with a large network, a high level of education and a large apartment. (Professional)

At the same time, the professionals are aware that they cannot detect all families in need of support from known risk factors. Therefore, many wish to uphold a wide target group for the LTSs. They want to include families that would not receive help from the system *'because it is not serious enough, or it is the early stages of a developing issue. That is where we come in*' (Professional). Another reason for upholding the wide target group for the LTSs comes from the professionals' experience. They have tried different groups targeting specific risk factors in the past with varied success. These groups are described as less dynamic than groups including participants with different challenges and resources. Parents were also concerned with the composition of the groups. They saw the diversity of the group as beneficial and thought a more homogenous group would have restricted the discussions and made it less useful. However, the setting does not include everyone. Many of the actors know somebody who does not attend the LTSs because they feel intimidated by other '*more successful parents*' (Mother) or feel uncomfortable in the small talk setting that is '*a little bit like a cocktail party*' (Professional).

The inclusive setting also represents the relationship between the professionals and the families in the LTS. Both professionals and parents upheld this as a very important way of lowering the threshold for participation. They intend to preserve the autonomy of the families. A professional in the prevention family team stated, '*We always consult with the parents; we do not do anything without hearing them out*'. They wish to include the families in their discussions and reflections, out of respect, and because they find it more likely to promote change. This is in accordance with the parents' experience of interacting with the team: '*They are open and curious, not judgemental. We discuss different approaches and find solutions together*' (Mother).

DISCUSSION

The findings show both strengths and challenges with the LTSs from the actors' perspective. The inclusive setting category holds descriptions on how the professionals meet the parents in the LTS. The actors, both professionals and parents, talk about interaction that preserve the parents' autonomy in their encounters with the service system while at the same time providing support to handle the challenges the families experience. This is in compliance with the new policies and legislations for the health and social services (Folkehelseloven, 2011; Helse- og omsorgstjenensteloven, 2011; Helsedepartemnetet, 2004; Helsedirektoratet, 2010; WHO, 2013), which emphasises an increased focus on user involvement and empowering people to take action in their own lives. Parents attending the LTSs were diverse; they had different experiences with public services. Some were apprehensive before contacting the services as to what the consequences might be. This is also found in LTSs provided to people with drug addiction and mental health problems (Edland-Gryt & Skatvedt, 2013). The actors describe interaction in the LTSs as being characterised by equality and respect.

In addition to focusing on the importance of equality, the actors highlight the high competence in the LTSs as an important strength. Accessible professionals with relevant competence was an important premise for participation and trust. Edland-Gryt and Skatvedt (2013) showed how trust is particularly important for people with drug problems and mental health disorders, as a condition to cross other thresholds. In this study, trust is connected to competence and continuity. Knowing they can come back to the centre and meet the same person gives them a sense of stability in their parenting role. In this setting, collaborative competences involves both the professionals ability to interact with the participants in the LTS and to know how and when other services should become involved. Some of the professionals experience a close connection and easy access to other services in the centre; others perceive their position to be segregated and the contact with other professionals as incidental and dependent on individual relations. This implies that providing LTSs in a family centre can lower the threshold for contact between professionals (Busch et al., 2013), although the formal connection is not sufficient to ensure this. Integration of services for children and their families can be seen as stages moving from coexistence, in which the services operate segregated from each other, through coordination, collaboration and into integration as the highest level of commitment (Kickbusch & Behrendt, 2013). A process like this depends on governance and time to develop collaborative competences needed to heighten the level of integration.

The analysis shows that the actors perceive the services as low threshold; nevertheless, their accounts also highlight that there are thresholds present that may stand in the way of accessibility and participation. They can be seen in light of the theory of thresholds in service provision by Jacobsen et al (1982). The theory describes three different types of thresholds: the registration threshold, the competence threshold and the threshold of effectiveness.

The threshold of registration (Jacobsen et al, 1982) shows that to receive services, the client has to take an initiative; the services do not respond to needs but by request. The client must make a request through some sort of registration to receive support. LTSs are designed to lower the threshold of registration, represented in this study both by the category of easy access and a low level of bureaucracy, through, for instance, a drop in services and no demand for referrals or applications. Even though, there are still thresholds for registration. The lack of public transportation in rural areas is one example of thresholds that represent a hindrance to participation and possibly also one that increases social inequality because it excludes the marginalised parents in the community with low income and limited social networks.

The competence threshold (Jacobsen et al, 1982) illustrates how the system requires the clients to have certain competences to receive support. The analysis in this study show that the threshold of registration and the threshold of competence intervene. A threshold for registration can be a lack information about the services. An important source of information is through the Internet, and an insufficient level of information on websites may stand in the way of participation. To be able to make use of information requires two levels of competence: language ability and the ability to understand what the information implies, which is health literacy (Goth & Berg, 2011; Nutbeam, 2008). When the information is delivered in Norwegian and the prerequisite is an understanding of the Norwegian welfare system, in addition to not being updated, the thresholds for participation can become too high.

The third threshold is *the threshold of efficiency* (Jacobsen et al, 1982). This threshold shows the problem with clients receiving insufficient levels of support because of priorities by the professional. In this study, this is shown by the ambivalence between striving to provide universal open settings that include a wide target group and the responsibility professionals feel to prioritize the high-risk families. High-risk families seem to be defined as a worthy target group for health and social services, thus diminishing other families. Fuller (2006) has created the term *rankism* to show how people misuse the power their position or rank given to them. Fuller describes rank as something that shifts at different times, and in different contexts, you can be somebody in one setting and nobody in another setting. The problems of people who are clearly not in the high risk group are several times through this study referred to as less important than the problems of the families who 'really need us'. This raises the question of whether the successful families with high income are not worthy of support from LTSs. Depression is shown to have low prestige amongst physicians (Album & Westin, 2008), and this study may imply that depression and other mental issues represented in the highly educated and high-income families are ranked low by several of the professionals in the LTSs. The professionals perceived responsibility to prioritize high-risk families stand in contrast to their narrative of the added value diversity in the groups bring. The open inclusive arena, without prerequisites, render interaction across social barriers possible, and acknowledges the notion that the population approach to prevention work has high value for the society at large (Mackenbach et al, 2013; Rose, 1981). Narrowing down the target groups for the LTSs in the family centres may change the setting altogether, and the dynamic to which the actors all refer may crumble.

IMPLICATIONS FOR PRACTICE

Thresholds for participation was a concern for the professionals in the LTSs, and they had taken measures to lower them, nevertheless there were still thresholds present. Some the professionals were aware of, others they had not considered. This study shows the importance of mapping thresholds from different perspectives, because they do not appear the same from different angels. To recognize the co-construction of the LTSs, including both professionals and parents, requires an open reflective dialog on thresholds for participation and strategies to lower them.

This study also show the challenge of working with health promoting and prevention strategies in a system that is used to focusing on risk and treatment. When the professionals struggle with who their target group is, they struggle with a change in perspectives. Working with health promotion for all, implies improvisation, flexibility and uncertainty. They cannot measure an outcome. Therefor it is vital to keep discussing who their target group should be, and how they can work in new ways to promote health in the local community. Given the possibility, they can develop new health promoting practise in the field of family support.

A challenge in the further development of the LTSs in the family centres will be to highlight their unique position as a link between the community and the public services. The participants hold the value of LTSs in the family centres. By stepping through the door, they contribute to connecting public services to everyday life, where health is created and lived by people (WHO, 1986) and where social work has its purpose.

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Figure 1

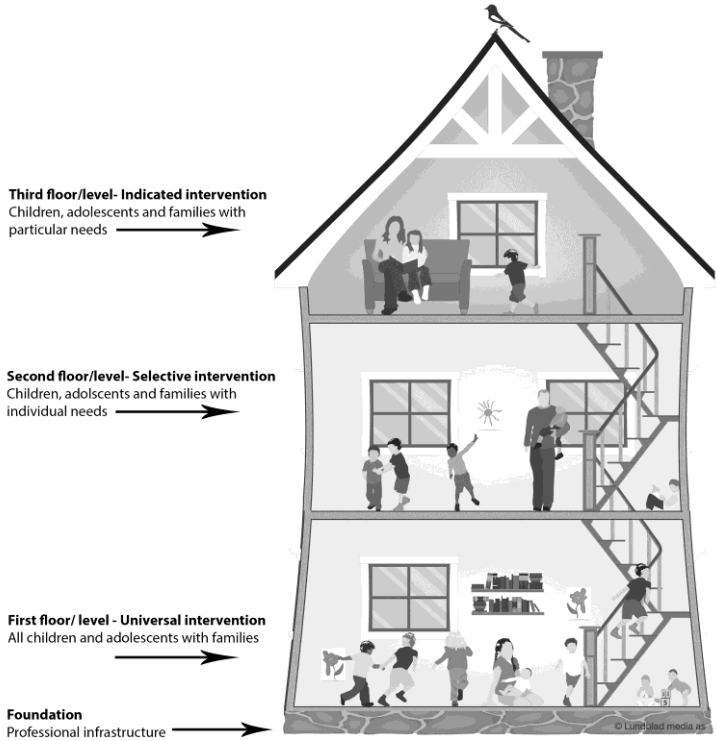

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Table 1 Low-threshold services

Family centre	Low-threshold services	
1, 2, 3	**Open Kindergarten**	Meeting place where children up to the age of six and their parents or other caregivers attend together. They can come and go during hours. The activities are similar to regular kindergartens; in addition, they can meet different professionals from other services in the centre.
1	**Preventive Family Team**	Interdisciplinary team that provide counselling for parents with children at the age of 0-5 years. Parents and professionals can contact the team. The team collaborates with the kindergartens and health care for children.
2	**The Incredible Years Universal**	Parenting training program focusing on strengthening parenting competence. The course is a universal prevention intervention and is offered to parents with children at aged 2-6 years without known risk factors.
3	**The Norwegian café**	Drop-in language course for immigrants with limited skills in Norwegian. The café collaborates with a part-time kindergarten specialising in language and social skills; parents can attend the café while the children are at kindergarten.