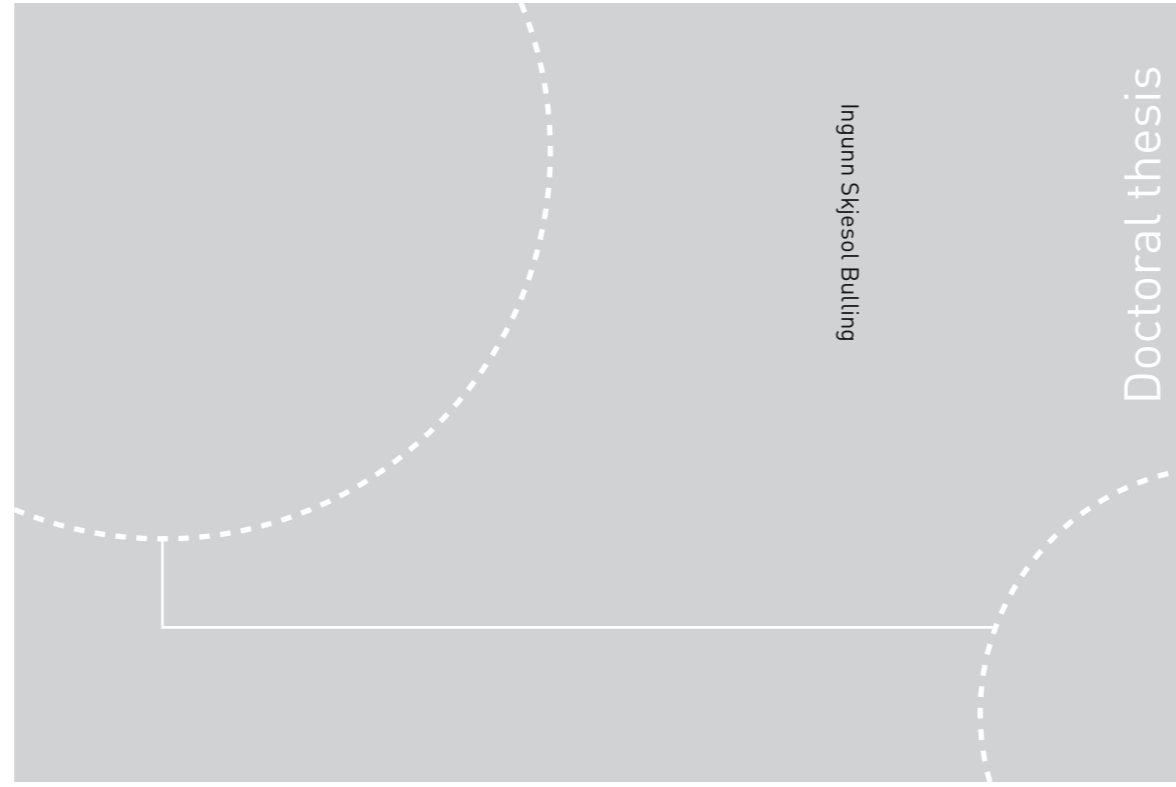


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Ingunn Skjesol Bulling

## Exploring Family Centres

Creating Accessible and Integrated Family Support

 **NTNU**  
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Science and Technology

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**NTNU**  
Norwegian University of Science and Technology  
Thesis for the Degree of  
Philosophiae Doctor  
Faculty of Social and Educational Sciences  
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Creating Accessible and Integrated Family  
Support

Thesis for the Degree of Philosophiae Doctor

Trondheim, October 2019

Norwegian University of Science and Technology  
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*I know who I was when I got up this morning,  
but I think I must have been changed several times since then*

*(Carroll, Alice's Adventure in Wonderland, 1865: Chapter V)*



## Acknowledgements

Some say that writing a doctoral thesis is lonely but my experience of being a PhD student has been filled with generous people and I am so grateful to every person that has supported me in different ways and made it possible for me to undertake this project.

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Finally, thank you to all the people in the family centres that generously let me into their world. This project would not be possible without the participant's willingness to share their knowledge, frustrations and joy. I have learned so much from you and carry your stories with me.

## Abstract

There is wide agreement that early childhood is important in shaping health and social outcomes later in life. This has placed early child development and family support high on the political agenda. Norway has an advanced social welfare system, with comprehensive universal services. Still there are challenges when it comes to coordinating the efforts to support families and children both within the public service system and communities at large and over the last two decades social inequalities in health and wellbeing have increased. In part this has created an impetus to establish integrated services for children and families and more than one third of Norwegian municipalities have established interdisciplinary family centres as a structural response. In this thesis I explore Norwegian family centres to better understand how integrated family support services are organised and made accessible to families and communities.

The research presented in this thesis is based on an inductive qualitative study of family centres in Norway. Through fieldwork, including observation and interviews, undertaken in three family centres in different parts of the country, I explore the perspectives and practices of key actors including managers, professionals and families. The fieldwork was undertaken in two stages. The first stage involved visiting each family centre for eight to ten working days. Using participant observation, I took part in normal work and activities, conducted individual and focus group interviews, took photos and made sketches of the premises. The second stage involved revisiting each of the centres to explore the issues identified in the initial analysis and once again relied on participant observation and interviews. This research approach combined strategies from ethnography and grounded theory, allowing the data generating and analytical processes to interact throughout the study.

This thesis presents three empirical articles focusing on different aspects of the research in family centres, and one methodological article. The first article explores the concept of low-threshold services, describing their distinct character and reflecting upon the thresholds that still create challenges for participation and access. The second article explores the integration processes in one of the low-threshold services: The Open Kindergarden. The Open Kindergarden is a meeting place where children and adults attend together. The third article explores how intersectoral collaboration is constructed in the family centres and provides insights into the challenges and opportunities for



developing new practice. In the fourth article I reflect upon my experience as a novice researcher on the process of negotiating a role repertoire in a multi-setting study.

In the last part of this thesis I draw on evidence from all three centres and present a conceptual model to illustrate how the practices in family centres were co-created by the families, professionals and managers. I go on to discuss the degree to which the centres are able to create accessible integrated services. The model I present combines three practice categories that span organisational boundaries and support families in their everyday lives: intersectoral collaboration, co-created interventions and integrated with the community.

There was variation in the level of service integration and the extent to which activities in the family centres were connected to the local community. Family centres with more clearly defined aims were better at intersectoral collaboration. Prioritizing intersectoral work was challenging for both managers and professionals. Manager's prioritization of intersectoral working made a significant difference to the capacity of professionals to work together to develop new ways of providing services. A particular strength of the family centres was their ability to help families recognise and use their own resources, access community support and therefore reduce the need for professional intervention. The open meeting places in the family centres facilitated both access to professional advice and kin support, allowing the actors to renegotiate their roles and take part in collective learning processes. The family centres interacted with the community they were situated in, but this was done in a patchy and unsystematic way; some services engaged with services outside the centre or the voluntary sector, while others were more internally focused. The full potential of family centres can only be realized if they become a central part of an interconnected community support system for all families and children.

## Sammendrag

Det er bred enighet om at tidlig barndom er viktig for hvordan helse og sosiale forhold utvikler seg senere i livet. Dette har plassert barns tidlige utvikling og familiestøttende tjenester på den politiske agendaen. Norge har et godt utviklet velferdssystem med omfattende universelle tjenester. Likevel er det utfordringer knyttet til å koordinere innsatsene innenfor det offentlige tjenesteapparatet og i samfunnet for øvrig og i løpet av de siste tiårene har de sosiale ulikhetene i helse økt. Dette har vært med på å rette fokus mot å etablere integrerte tjenester for barn og familier, og over en tredjedel av norske kommuner har valgt å organisere familie støttende tjenester i tverrfaglige senter. I denne avhandlingen utforsker jeg familiesenter, med målsetning om å bidra med ny kunnskap om integrerte familie støttende tjenester og hvordan de blir gjort tilgjengelige for familiene.

I denne avhandlingen presenteres en induktivt kvalitativ studie av norske familiesenter. Gjennom et feltarbeid, bestående av blant annet observasjon og intervju, gjennomført i tre familiesenter på ulike steder i landet fikk jeg mulighet til å utforske ledere, profesjonelle og familienes perspektiver og praksiser. Feltarbeidet ble gjennomført i to faser. Den første fasen bestod i å besøke hvert av sentrene i åtte til ti arbeidsdager. Jeg brukte deltagende observasjon for å delta i arbeidet og aktivitetene i sentrene, utførte individuelle og fokus gruppe intervju, tok bilder og laget skisser av lokalene. I andre fase besøkte jeg sentrene igjen for å utforske problemstillinger som ble viktige i de første analysene. I denne fasen brukte jeg også deltagende observasjon og intervju for å generere data. I forskningsprosessen kombinerte jeg strategier fra etnografi og grounded theory noe som gav mulighet til å veksle mellom datagenerering gjennom hele prosessen.

Denne avhandlingen består av tre empiriske artikler som fokuserer på ulike aspekter med familiesentrene, og en metodologisk artikkel. Den første utforsker konseptet lavterskel tjenester. Jeg beskriver karakteristiske kjennetegn ved lavterskeltjenestene og ser nærmere på hvilke terskler som fortsatt utgjør en utfordring for deltagelse og tilgjengelighet. Den andre artikkelen utforsker integreringsprosesser i et av lavterskeltilbudene, Åpen barnehage, en møteplass hvor barn og foreldre deltar sammen. Den tredje artikkelen utforsker hvordan intersektorielt samarbeid blir konstruert i familiesentrene og gir innsikt i utfordringene og mulighetene for å utvikle praksis. Den siste artikkelen inkludert i denne avhandlingen er en refleksjon om min erfaring med å forhandle fram et rollerepertoar i en studie som bestod av mange ulike settinger.

I den siste delen av avhandlinga presenterer jeg en modell basert på funn fra alle de tre sentrene for å illustrere hvordan praksisene i sentrene ble samskapt av familiene, de profesjonelle og lederne. Videre diskuterer jeg i hvilken grad sentrene er i stand til å skape tilgjengelige og integrerte tjenester. Modellen jeg presenterer består av tre praksis kategorier som strekker seg over organisasjonsgrenser og har som mål å støtte familier i deres hverdagsliv; *Tverrsektoriell samhandling, samskapte intervensjoner og integrert i lokalsamfunnet*

Det var variasjoner når det gjaldt nivået av integrering og i hvilken grad aktivitetene i sentrene var koblet til lokalsamfunnet. Sentrene som hadde klart definerte mål hadde mer utviklet tverrsektoriell samhandling. Det var utfordrende å prioritere denne formen for samhandling for lederne og for de ansatte. Ledernes prioriteringer av tverrsektoriell samhandling utgjorde en betydelig forskjell når det gjaldt de profesjonelles kapasitet til å jobbe sammen for å utvikle nye måter å tilby tjenester. En særlig styrke til familiesentrene lå i deres evne til å hjelpe familiene til å se og benytte egne ressurser og få tilgang til støtte fra lokalsamfunnet slik at familiene trengte mindre grad av profesjonell hjelp. De åpne møte plassene i sentrene fasiliterte både tilgang til profesjonell veiledning og likemansstøtte, og skapte et mulighetsrom for å reforhandle aktørenes roller og for å delta i felles læringsprosesser. Familie sentrene samhandlet med lokalsamfunnet de tilhørte, men dette arbeidet var usystematisk. Noen av tjenestene i sentrene samarbeidet med tjenester utenfor sentret eller frivillig sektor, mens andre tjenester var mer internt orientert. Potensialet som ligger i denne formen for organisering av tjenester kan bare bli fullt ut realisert hvis de blir en sentral del av et lokalt forankret integrert system som støtter alle barn og familier.

## List of publications

### Article 1 - Low threshold services

Bulling IS. (2017) Stepping through the door - exploring low-threshold services in Norwegian family centres. *Child & Family Social Work* 22(3): 1264-1273.

### Article 2 - Integration

Bulling IS. (2017) En mangfoldig møteplass. Åpen åpenbarnehage som integreringsarena. (A diverse meeting place. Open Kindergarten a setting for Integration) *BARN* (ISSN 0800-1669) 35(2-3): 73-87.

### Article 3 – Intersectoral collaboration

Bulling IS and Berg B. (2018) “It's our children!” Exploring intersectoral collaboration in family centres. *Child & Family Social Work* 23(4): 726-734.

### Article 4 – Participant observation

Bulling IS. (in review) ‘You don’t look like a researcher’ Negotiating roles in participant observation. *Qualitative research*.

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## 1 Introduction

I used to lock the door the first thing when I arrived home. It felt safe. We never went out in the afternoon. We just sat in the small apartment. The children became restless and noisy, and I did not know how to calm them. I remembered that we used to watch telly at my cousin's house when I was a child, so I got hold of an old TV-set and put on what we used to watch, horror movies featuring zombies. I knew nothing about raising children. Adults and children did not interact in my childhood. As long as we stayed out of the adults' way things were ok (...). This [the family centre] is where I have learned to be a father. How to comfort them, how to play and laugh and still be the adult, able to set boundaries and explain why. Parenting is hands on here it is not just theory. We parent together. (Father, FC1)

This extract is from an interview with an immigrant explaining how his role as a father changed because he started attending a family centre. His role transformed from being the protector of his family to becoming a father that played a key part in his children's lives. I met him during fieldwork in one of the three family centres that make up the study sites for the research presented in this thesis. He told me how attending the family centre's activities provided him with role models and in time, how he became a role model for other parents. Through a process of participant observation of activities in each centre and interviewing managers, professionals and parents, this research provides insight into the varied understandings of the way this particular model of service provision for families functions, the roles taken by families and staff members and how managers from different sectors facilitated cross-sectorial collaboration to support children, families and communities.

This father's story was one of many that parents shared with me during my research. The families I engaged with came from varied backgrounds. Some of them were born in Norway, others arrived here as immigrants because of work or as refugees. I met families that struggled to pay their bills and others that had never worried about money. They shared willingly, stories of parenthood, of loneliness and love, of despair and joy, of fear and accomplishments. Their reasons for visiting the

centres were varied, and they took different experiences with them when they left, but they all participated in co-creating the setting that enabled their development; through their engagement with each other, professionals and managers they created the family centres.

My interest in family centres started while I was part of a research project on interdisciplinary collaboration targeting children that needed support from more than one service (Bulling, 2011). One of the groups we interviewed consisted of employees from a family centre. Their reflections on the opportunities and challenges of co-locating services intrigued me and I wanted to explore how this particular model of providing family support might provide a different way of thinking about collaboration between different professionals but also with families in a way that recognised and provided greater value for children and their families.

## **1.1 Context**

There is wide agreement that early childhood is important for health and social outcomes later in life (García et al., 2017; Irwin et al., 2007). Universal health services for children are well established in Norway, as is access to publicly provided kindergardens, where more than 90 percent of the children in the age 1-5 attend. Even though these services reach the vast majority of children in Norway some families find it challenging to navigate the system and need more support than these services provide. The public service system, included the services directed towards children and families, are seen as fragmented (Ministry of Health and Care Services, 2017). A lack of communication and collaboration between services and sectors creates inefficiencies and compromises the quality of what is provided (Ministry of Health and Care Services, 2014a; 2014b). Better coordination of services has been aspect of health policies for almost fifty years; evidence that acknowledging challenges does not necessarily change practice. As professionals and services become more specialized, there is a risk that they also become more internally focused; they expend more energy defining boundaries and distinctive responsibilities rather than developing collaborations with other services. If the boundaries are set by the individual services, there may be areas that no one takes responsibility for and opportunities for collaboration are missed. To support children and strengthen

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their environment requires a holistic perspective on service provision and interventions that span the boundaries between sectors and management levels (Glavin and Erdal, 2013).

More than one third of Norwegian municipalities have established family centres. The aim of this organisational form is to promote good health and well-being among children and their families, while strengthening the conditions in which the children grow up (Adolfson et al., 2012). The rationale behind establishing family centres is linked to national policies that emphasise health promotion, early intervention, increased collaboration between services and sectors, as well as providing services in the communities where people live (Ministry of Health and Care Services, 2008; 2012; 2014a; Ministry of Health and Social Care, 1998). Adopting a health promotion approach to the provision of family support services represents a change and creates new ways for service users and professionals to interact (Kunnskapsdepartementet, 2011; Mæland, 2010). Within this new approach the professional role shifts from being the expert that holds the answers and presents predefined solutions, to becoming a facilitator seeking to mobilise assets and self-efficacy (Glavin and Erdal, 2013).

How public services are organised and coordinated is important, but as important is how they interact with other parts of society. Applying a Health in All Policies approach, by promoting public health in all sectors, has been integrated into policy and legislation during the last decade (Folkehelseloven, 2011; Ministry of Health and Care Services, 2012; 2014a). Underpinning this change in orientation is the recognition that the determinants of health are not primarily under the control of the health sector but instead shaped by diverse social and environmental determinants outside of the direct control of any single ministry or government department (Kickbusch and Behrendt, 2013). In 2011, a law on Public Health Work (Folkehelseloven, 2011) was passed. The new legislation made every sector accountable for addressing health issues, assess the health implications of decisions, seek synergies between services, and avoid harmful health impacts, in order to improve population health and health equity (WHO, 2013b). The Norwegian Public Health legislation places a significant responsibility for public health at the municipality level and encourages them to adapt policies and services to better fit their local context (Folkehelseloven,

## EXPLORING FAMILY CENTRES

2011). The municipalities are responsible for monitoring the population's health initiating efforts to promote health and wellbeing and reducing health inequalities.

Despite a strong economy and well-established social welfare services health inequalities in Norway are increasing (Bambra, 2011; Dahl et al., 2014). Education and health are linked; people with higher education attainment have better health status. The composition of the Norwegian population is changing, over the last three decades the ethnic diversity has increased (Goth et al., 2014). Initially migrants settled primarily in the larger cities, but in the last few years municipalities all over the country have reported providing housing for refugees, making smaller communities multicultural. Immigrants come to Norway for work, education, as refugees or link to family members already settled in the county. Both immigrants and refugees report poorer health than the Norwegian population (Kumar, 2008) and this has implications for service provision too. Moving to a more heterogeneous society where the people that need care and support have different cultural backgrounds, religions and languages creates challenges for the social welfare system. Immigrants do not access health and social services at the same level as native Norwegians (Dahl et al., 2014). To provide equal access to services, requires the services to be adapted to the diverse population and consider how to address issues of health literacy, language skills and cultural competence. The Norwegian government is committed to ensuring equal access to services of high quality and health outcomes should be equally good for all parts of Norwegian society (IMDi, 2015).

The municipalities have the responsibility for providing well-coordinated services that are adapted to individual needs and local conditions. Norway is divided in to 422 municipalities that vary in terms of size and demography; the smallest municipality has a population of 200 and the largest, the capital, has 950 000 inhabitants. Municipal governments are responsible for providing education, health care and social services to their inhabitants and family centres are one of the alternative strategies to deliver this for families. Some of the municipalities have vast rural areas, others a high-population density. If the family centres have to be organised in a way that is also adapted to the local context; they differ in the pattern of service provision and the range of interventions they offer.

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Family centres providing family support services are found in countries throughout the world, including Australia, New Zealand, the United States, Japan, France, Italy, Greece, Belgium, the Netherlands, England, Ireland, Sweden, Finland and Norway (Bing, 2012; Busch et al., 2013; Hoshi-Watanabe et al., 2015; Tunstill et al., 2007; Warren-Adams, 2001). Family centres are diverse in the forms of support they offer and their organization; some are run by voluntary organisations, others are a part of the public sector. Wherever they are located family centres typically provide informal meeting places for children and families (Hoshi-Watanabe et al., 2015; Lindskov, 2010). The family centres studied in this research were all inspired by *The Family's house* model.

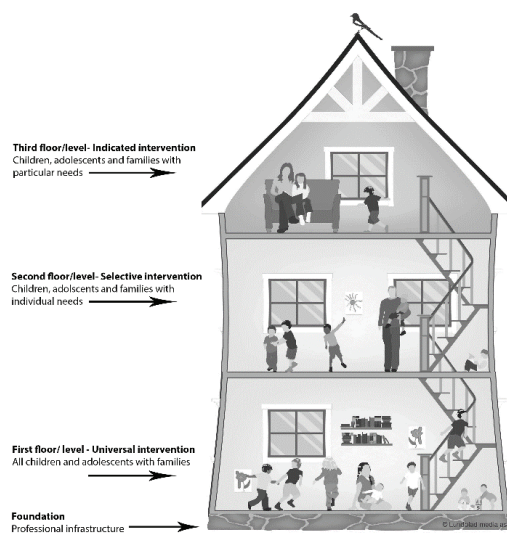
### **1.2 The Family's House model**

*The Family's House* is a family centre model providing coordinated municipal services for children, adolescents and their families. Through co-locating and coordinating health, social and educational services the family house aims to enable the municipalities to offer parents and children comprehensive and readily available support within their communities (Adolfson et al., 2012). Lowering the threshold for contacting family support services is a central concept that underpins the model.

The development of the model was one of the initiatives that followed the Plan for Advancing Mental Healthcare 1999-2008 (Ministry of Health and Social Care, 1998) and was intended to contribute to strengthening families and supporting children and adolescents in their formative environment (Thyrhaug, 2012). The first family houses were established as a pilot project between 2002-2004, initiated by the Norwegian Health Authorities and the first family houses were mostly initiated by professionals. The pilot was inspired by the Swedish Family Centre Model, and adapted to Norwegian conditions (Thyrhaug et al., 2012). Succeeding the pilot Norwegian Health Authorities recommended that municipalities further explore the potential of this model of provision. In 2012 there were 150 family centres established throughout the country, but with large variations in terms of patterns of provision and organisation (Gamst and Martinussen, 2012).

## EXPLORING FAMILY CENTRES

In the descriptions of the Family's house model, the *house* is both a tangible building where different municipal services are co-located, and an abstract house, a way to illustrate the different levels of initiative and interventions. Services that are recommended to include are; pregnancy care, healthcare service for children and youth, preventive child welfare services and pedagogical-psychological services. Tailoring the centres to the local conditions is one of the main principles at the heart of the model. Therefore, there is no fixed description of how the family houses should be organised. Rather, the model emphasizes the importance of thorough planning when establishing a new centre, including several phases; mapping assets and challenges, clarifying economic consequences and management structures, in addition to exploring the professionals' willingness to change their practice (RKBU, 2008).



*Figure 1. Levels of initiative and interventions  
(Adolfsen et al., 2012)*

The abstract house is a three-storey building, where each floor represents a different level of intervention (see Figure 1); universal, selective and indicated (Barry and Jenkins, 2007).

Through providing all three levels of intervention in the same location, the model seeks to facilitate access to the right level of support for the families without bureaucratic and time-consuming processes of referrals and waiting lists. The two lower levels offer interventions both in groups and for individual families, while the third level is directed towards families that need additional support.

The first floor holds the services that are available for all children, adolescents and

families in the municipality. Including pregnancy care, maternity groups and the healthcare service for children. These services have a special position in Norway as they are almost universally

## INTRODUCTION

accessed. Including such services in the model helps ensure that at some point the majority of families with children in a municipality will be in contact with the local family house. An essential concept in the model is to create an organisational structure that lowers the threshold to access family support services. To accomplish this, the first floor often includes meeting places to supplement mandatory universal services; facilities such as an open kindergarten provide a drop-in meeting place for children and their parents. The second floor holds selective interventions targeting the families that need more specialised support, including efforts aiming at promoting social inclusion and equality by providing extra support for families that lack access to resources that are known determinants of health. Examples of interventions on this level are parent-training programs, language courses and peer-support groups for children with parents with mental health problems. On this level, too, interdisciplinary teams typically offer consultations with families, kindergartens or schools as early interventions to prevent problems from emerging. The interventions on this level are sometimes delivered in collaboration with professionals that work outside the family house. The third floor provides services for children and families with complex needs, where it is important to coordinate the services a family receives and secure continuous support over a longer time span. Such provision often requires that the professionals develop plans together with the individual child and their family, to ensure coordinated and individually adapted services. Sometimes there are also group interventions on this level, for families that are experiencing problems. On the third floor it is vital to collaborate with services that are not included in the family house, such as specialist health services (Adolfson et al., 2012; RKBU, 2008).

Central to the model is a commitment by professionals and managers to a common set of values embracing a holistic approach to supporting children and families. This emphasises health promotion, knowledge based practice and ensuring families have an active role as foundational values (Thyrhaug et al., 2011). The model emphasises the need to, not only build a strong foundation when establishing a new family house, but also to maintain these foundations, as they can degenerate over time.



### **1.3 Thesis outline**

This thesis is laid out in the following way:

#### **Chapter 1- Introduction**

The chapter offers a short description of the context of the study, followed by a description of the family house model that inspired the family centres in this study.

#### **Chapter 2- Theoretical framework**

In this chapter I present the theory that shaped my understanding and how through the course of the research and the analysis of my data I refined the theoretical concepts: family support, health promotion, accessibility, interdisciplinary and intersectoral collaboration, and collective learning processes.

#### **Chapter 3- Aims and research questions**

In this chapter I present the aims and research questions that underpin this study.

#### **Chapter 4- Method**

In the fourth chapter I define the methodological framework I adopted and this is followed by a description of the research design of the study. I reflect on the initial negotiation of access, and how I presented myself in the field and this evolved over time; a process that is the topic of the fourth article included in this thesis. I go on to describe the fieldwork procedures that involved combining different methods and data sources; participant observation, individual interviews, focus groups, documents, sketches and pictures. The last part of the chapter explains the analytical process.

#### **Chapter 5- Summaries of the articles**

In this chapter I provide a summary of each of the four articles included in this thesis, followed by the four manuscripts.

Article 1 Stepping through the door - exploring low-threshold services in Norwegian family centres.

## INTRODUCTION

Article 2 En mangfoldig møteplass. Åpen åpenbarnehage som integreringsarena.

Article 3 “It's our children!” Exploring intersectorial collaboration in family centres.

Article 4 ‘You don’t look like a researcher’ Negotiating roles in participant observation.

### **Chapter 6- Creating accessibility in integrated family support**

In the last chapter I present a theoretical model that draws on the evidence from all three family centres involved in the research. In the second section I present a model illustrating the co-creation of family support in the family centres and discuss the extent to which family centres are able to create accessible integrated family support services. Finally, I set out the implications and conclusions of the study.

## 2 Theoretical framework

There has been only limited research conducted on Norwegian family centres (Adolfson et al., 2012). However, the issues I discuss in this thesis are related to other fields of knowledge including health promotion, accessibility, interdisciplinary collaboration and learning processes. Therefore, I have chosen to apply a wide set of theoretical concepts to help understand and refine the theoretical concepts that derived from exploring the family centres. In this chapter I present the theoretical and explore the theoretical concepts that are central to analysing and interpreting the data.

### 2.1 Health promotion

When health is seen as a product of complex and dynamic relations generated by numerous determinants at different levels of governance (Kickbusch and Behrendt, 2013), health needs to be addressed in all parts of society. Health can be defined in different ways. In this thesis health is understood as a resource, rather than a goal in itself; it is the means that enables us to live our lives (WHO, 2013a). Hjort defines health as “the ability and capacity to cope with and adapt to the inevitable difficulties in life”(Hort, 1995: 25). Health can be seen as a resource and a surplus and capacity can be increased to meet future challenges. Importantly such capacity exists not only in individuals, but also at the community level; building capacity is a way of creating individual and collective resilience (Kickbusch and Behrendt, 2013). Actions to strengthen the community focuses on empowerment through their active engagement and participation so communities can identify their needs, set priorities, plan and implement actions to achieve better health and take control of their daily lives (Barry and Jenkins, 2007).

Health promotion research is a combination of research and development that stresses action and encourages multidisciplinary approaches underpinned by core values of equity, participation and empowerment (Eriksson and Lindstrom, 2008). Health promotion work engages with action at different levels ranging from micro applications, such as individual awareness, to macro applications, such as global risk reduction (Vandiver, 2009)

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The health promotion work in the family centres can be understood as a part of the public health activities of municipalities. Acheson (1988: 1) defines public health as: “The science and art of preventing disease, prolonging life and promoting health through the organized efforts of society”. I find this definition also frames health promotion work in a way that fits with the practice in family centres; a part of collective efforts to better the health conditions of the population and build community resilience. The family centres combine health promotion and disease prevention strategies and include prevention initiatives at *universal*, *selective* and *indicated* levels. *The universal level* targets the general population. *The selective level* targets groups that are at heightened risk of developing social or health problems such as young parents, immigrants or families with children with disabilities. *The indicated level* targets people that are already experiencing problems and aims to prevent the problems from becoming more severe.

Barry (2001) modified Mrazek and Haggerty’s (1994) Spectrum of Mental health Interventions to include health promotion that was not part of the original articulation (see Figure 2). According to Barry, the main aim of health promotion is to build strength, resources and competencies, while health prevention seeks to reduce the incidence, prevalence or seriousness of targeted problems; mortality, morbidity and risky behaviour outcomes (Barry, 2001). Even though health promotion and disease prevention are distinct and informed by different principles, the core practices are the same. Despite having different starting points and seeking different outcomes, the two intervention categories share

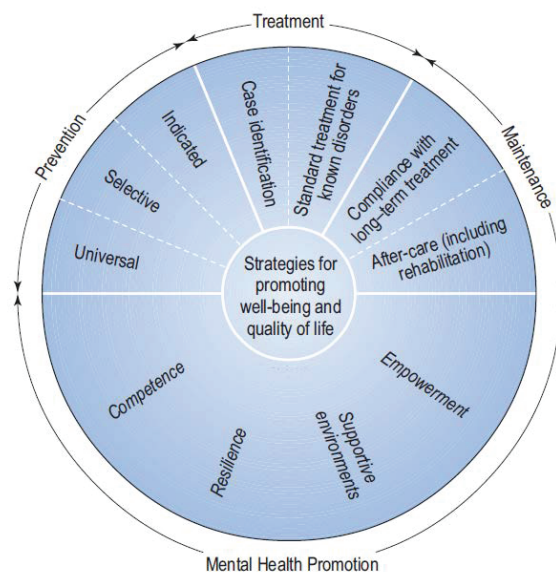


Figure 2. Mental Health Intervention Spectrum (Barry, 2001).

common ground; particularly between universal prevention and health promotion. Barry (2001) argues that there is potential for shared learning between these two constructs. Moreover, the core concern of all the initiatives in the spectrum is an overall goal of promoting well-being and quality of life (Barry, 2001).

## **2.2 Family support**

Family support is a term that covers a range of practices. “It is based on early intervention, which may refer to early in the life of the child and/or early in the emergence of the identified social problem” (Frost and Dolan, 2012: 44). Initiatives to support families can be divided into the different levels used to describe health prevention interventions, *universal, selective and indicated* (Barry, 2001), ranging from limited support for many families, to significant amounts of support for a few families. Family support in the context of early intervention is directed towards families, to prevent the development of further or exacerbated problems, build capacity and provide support if problems have already emerged.

Another way of considering family support is to strengthen the community in which the families live. This can include strategies to provide better housing, increase employment or establish kindergardens. Supporting children and families can also be framed as a common responsibility. Daro (2016b) advocates a public health approach to supporting children and families through a social contract in which we are all accountable for the conditions children grow up in. This does not disregard a family’s responsibility, but rather it highlights that all adults in a community play a role in the creation and maintenance of a supportive environment that protects and enables children to grow. This approach assumes that all children will benefit from a collective investment (Daro, 2016b).

Modern families are diverse and incorporate the complexity of family life that consists of an array of diverse family practices. This study uses family as a fluid and broad notion that encompasses a wide array of different forms (Frost and Dolan, 2012). “Family lives and personal relationships have

changed – from the nuclear family, where men, women and children knew their place, to diverse family forms with increasingly fluid and negotiated relationships” (Williams, 2004: 18). There is a risk that programs and interventions do not take in to account new family constellations. Frost argues that initiatives and policies labelled family support are often only directed towards one parents, often the mother, and that the rest of the child’s close network is not considered (Frost and Dolan, 2012). The family centres invite children and caregivers together as well as parents, grandparents, uncle or family friends who are all welcome to attend activities. In this thesis family support is defined as the support, formal or informal, given to and created by the families in collaboration with professionals and peers.

### **2.3 The Theory of Thresholds**

Accessibility to public services is one of the main goals of establishing family centres. This has also become a central topic in the present study. Jacobsen (1982) describes a theory of thresholds to illustrate the mechanisms for the distribution of public initiatives. He argues that there are elements of how we provide services that decrease/prohibit equal access to services. To become a service user there are thresholds that the person has to pass through in order to gain access. He 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) suggests that to receive services, a client has to take an initiative; the services do not respond to needs but rather require requests. The client must make a request through some sort of registration in order to receive support. According to Jacobsen, there are several reasons why people do not contact the service system. Potential service users might feel that the problems they experience are sufficiently severe to be a concern for the system or its representatives; that they are not worthy of the support or benefit. They might not wish to be a ‘burden’ or have the time or energy to make an appointment.

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The *competence threshold* (Jacobsen et al. 1982) illustrates the way that the system requires clients to have certain competences in order to receive support. Reading and writing are examples of skills that affect access to services. A person's ability to formulate the issue at hand in a way that the service providers understand it is a huge advantage in negotiating appropriate services. He describes the public system as consisting of several different bureaucratic systems that use different parameters in their assessments. This makes it difficult for people that are in contact with more than one part of the service system because it requires them to navigate between different sets of requirements. People that know what they can expect, and how the logic of the system works are better able to legitimate their need for support.

The third threshold is the *threshold of efficiency* (Jacobsen et al. 1982), which refers to how the priorities of the professionals might create thresholds that stand in the way of certain groups or individuals accessing services. Jacobsen argues that different groups of clients hold different statuses, and that professionals have a tendency to prioritise some groups over others. There is increasing interest in documenting the effect and resource implications of initiatives that promote access. Clients that are expected to benefit in ways that can be documented and measured are more likely to receive services. In assessing requests for treatment or support, economic considerations often rank higher than individual needs, can result in an unequal distribution of resources where some groups do not get access to a sufficient level of support.

An additional threshold, the *threshold of trust*, was identified by Edland-Gryth and Skatvedt (2015) when studying a low-threshold centre for drug users. They found that passing the threshold of trust was a precondition to being able to cross the other three thresholds. The lack of trust created a barrier for contacting and visiting the centres; clients knew about the service that were available but did not make use of the centre. Other clients visited the centres but did not get the support they needed because they did not trust that staff would act in their best interest, and therefore did not express their needs to staff. The clients may have issues with trusting the services due to previous experience of being excluded, misunderstood or even neglected in past encounters with the public service system.

## 2.4 Interdisciplinary and intersectoral collaboration

As described, family centres aim to provide holistic integrated family support services to a local population. Combining services from different parts of the public service system entails working across sectors, services and disciplines. The practices that reach across these boundaries hold distinct characteristics, challenges and opportunities. Services included in the centres belong in different sectors of the public service system; child welfare, health and education. Therefore, I most frequently use the term *intersectoral collaboration* when I discuss the challenges and possibilities of working across boundaries. However, in addition to being intersectoral such collaboration is often also *interdisciplinary* as the staff represent a wide range of disciplines and competencies. Both structural and interpersonal factors impact on the degree of integration of services apparent in each centres.

Like Bronstein (2003) I understand interdisciplinary collaboration as an interpersonal process that allows professionals to collectively deliver support in a way they could not have done on their own. The diversity of competencies in a collaboration holds the potential for developing new practices. The professionals in this study represent a range of disciplines and an even wider variety of competence. I use professional competence as a dynamic concept, as much formed by work experience and education after obtaining a professional qualification (Irgens, 2007; Skau, 2017). The diverse competence brings different perspectives and areas of knowledge together, rendering possible the development of new practice. According to Bronstein (2003) high quality interdisciplinary collaboration has five core components:

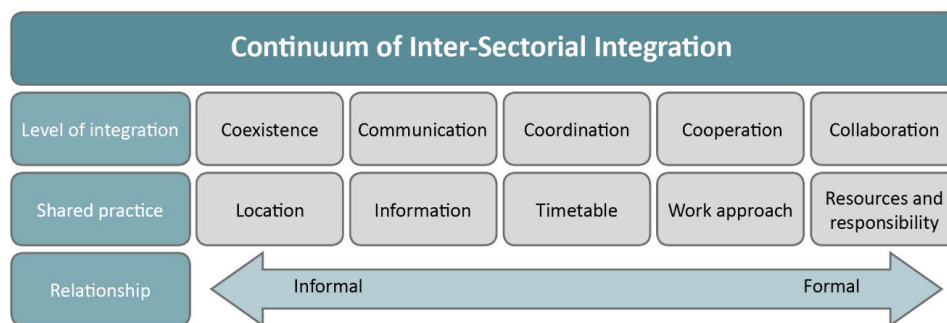
- Interdependence- the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks
- Newly created professional activities- collaborative acts, programs, and structures that can achieve more than could be achieved by the same professionals acting independently
- Flexibility- extends beyond interdependence and refers to the deliberate occurrence of role-blurring



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- Collective ownership of goals- shared responsibility in the entire process of reaching goals, including joint design, definition, development, and achievement of goals
- Reflection on process- collaborators' attention to their process of working together

There are several frameworks developed to illustrate different forms of interdisciplinary collaboration in health and social work that highlight factors that shape practice (Boon et al., 2004; Frost, 2005; Reeves, 2010). Frost (2005) is concerned with the added value of joined up work, and suggests a hierarchy of four different levels of partnership; co-operation, collaboration, co-ordination and integration. In this thesis I focus on collaboration across services and sectors to explore what influences professional's ability to develop shared practice. In my analysis I was inspired by Boston and Gill (2011) who focus on accountability in developing integrated practices. Based on their continuum of inter-governmental integration, I develop a model illustrating the degrees of service integration in family centres (see Figure 3). The model illustrates a continuum ranging from co-existence to full collaboration. The highest level of integration is defined by characteristics such as shared responsibility, shared practice and common goals. At the lowest level, co-existence, there is no formal communication between different agencies in the family centre and instead an emphasis on professional autonomy.



*Figure 3. Continuum of Intersectorial Integration, adapted from Boston and Gill's (2011) model of Inter-Governmental Integration.*

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Boston and Gill (2011) argue that the degree of service integration in the public sector is dependent on an organisation's ability to define the scope of joint work and address issues of accountability. "Without a shared narrative based on a common view of the problem and the purpose of the exercise, inter-agency working will be trapped in low-level co-existence and communication with limited shared responsibility" (Boston and Gill, 2011: 4792). They go on to describe seven dimensions that need to be addressed when defining the scope of the integration of services:

- Duration – the time span of the joint work
- Primary focus – shared policy and/or service delivery
- Societal reach – local or regional, public and/or voluntary sector
- Vertical reach – levels in the organisational hierarchy included in the joint work
- Horizontal reach – divisions on the same organisational level included in the joint work
- Breath – limited to specific transactions or aim towards shared outcomes
- Purpose – the extent of commitment to integration and/or alignment of activities

Clarifying the scope and agreeing the level of intensity of joint work is important, but this is insufficient, according to Boston and Gill. In addition, consideration and establishment of governance arrangements is essential. They divide this latter process into two main design choices: hard factors and soft factors. Hard factors include structural decisions such as who should be involved in the collaboration, what qualifications should they have, who is accountable for what, formalised responsibilities and management structures. Soft factors relate to building trust and the willingness to perform and are exemplified by: framing and reframing the issues that connect the services together, the importance of leadership to building a team, or to unite the staff in a shared common vision or being able to manage conflict.

### **2.5 Collaboration as collective learning processes**

In this thesis I use Wenger's (1998) concept of *communities of practice* to discuss how collaborative practices can be seen as collective learning processes dependent on participation and engagement.

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According to Wenger we all take part in multiple communities of practice. The communities are informal networks of people that share an engagement with the same practice, these communities can be work related or orientated to other parts of our lives. "Through active and dynamic negotiation of meaning, practice is something that is produced over time by those who engage in it" (Wenger, 2010: 2). An important part of this process is negotiating a common understanding of what it means to be competent within the area of shared practice. This includes negotiating a common repertoire of routines, words, artefacts, actions and stories (Wenger, 1998).

Building a community of practice requires members to negotiate a balance between disagreement and agreement. The participants have to agree enough so that they see it as important for them to commit to the community. At the same time, there has to be enough disagreement so that the practices they share do not stagnate. The tensions between different perspectives within a community pushes the participants to negotiate, and in the negotiation lies the potential for new discoveries and the development of new practices.

Through becoming aware of the dynamic of the communities of practice, organisations can gain information about the range of competence they can access. According to Wenger and Snyder (2000) there is potential for managers to cultivate these "fertile organisational forms" although there is a danger that by exerting managerial control they can be destroyed. The value of these informal communities often appears in a different part of the organisation, as the participants take the knowledge, they gain through engaging in the community of practice with them to other aspects of their work.

The concept of communities of practice has been applied across a wide array of fields to explain processes such as peer to peer learning, professional development, interdisciplinary collaboration and the development of new technologies (Wenger, 2010). Concepts that are widely used are also critiqued, one critique has been that the communities of practice are sometimes defined as more inclusive than they are in practice. Mørck (2006) argues that teachers and students are not part of the same community of practice, even though they share the same classroom. The teacher belongs

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to their community and the students to theirs. Together they participate in an activity but with different motivation and their definition of what it means to be competent differs. Teachers and students inhabit different social worlds. Following Mørck's (2006) usage of the term I consider that parents and professionals in the family centres construct separate communities.

A community of practice has boundaries, and it distinguishes between those who are involved and those who are not. In relation to one profession there can be a whole landscape of practices (Wenger, 2010). Within a community of practice there is a shared history of learning, a shared vocabulary and an understanding of what matters and why. Collaborating across community boundaries can be challenging, but also holds the potential for learning. "The meetings of perspectives can be rich in new insights and radical innovations" (Wenger, 2010: 4). Mørck (2006) writes about boundary communities; the space where communities of practice overlap. In these spaces there is potential to establish new connections and collaboration. Her research explores the interaction between social workers and youth in the streets. The youth have their own communities of practice, as do the social workers. When these communities overlap there is potential for transcending marginalized positions. One of the vital characteristics of such processes is that the negotiation of competence is collective processes as opposed to participants negotiating their own position as individuals.

Another concept I found useful when discussing the interaction across sectors and boundaries was expansive learning (Engeström, 2010). Engeström (2001) uses activity theory as a way to explain the challenges and opportunities provided by inter-organisational learning. "To transform organisational practices, we must learn new forms of activity that are not yet there" (Engeström, 2001: 138). Engeström frames development of new interdisciplinary practices as collective learning processes, using the term expansive learning

In expansive learning, participants learn something that is not yet there. In other words, they construct a new object and concept for their collective activity and implement this new object and concept in practice (Engeström, 2010). Using Engeström's concept, different organisations that work

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together are seen at separate activity systems. Engeström (2001) highlights the need to negotiate a shared objective for a group's common activity while at the same time acknowledging particular activity systems related to individual sectors. Through keeping the connection to their sector while transforming their objectives, an opportunity to develop new practices is created. According to Engeström an activity system is a community of multiple points of view, traditions and interests. When different activity systems interact in networks, the multi-voicedness multiplies. "It is a source of trouble and a source of innovation, demanding actions of translation and negotiation" (Engeström, 2001: 136). The contradictions between the different activity systems are described as a driving force for change.

### 3 Aims and research questions

The aims of this study were to explore the perspectives and practices in family centres in order to gain new knowledge on integrated family support services. The research also explore how support services were made accessible to families and thereby contribute to the development of practices to support children and families.

There is wide agreement that the early years are crucial for a range of health and social outcomes across the life course (García et al., 2017; Irwin et al., 2007). To make a positive impact on a wide range of determinants of children's development efforts need to be coordinated and provided in a way that puts children at the centre of the initiatives (Irwin et al., 2007). Universal systems of assessment and support that reach all children and families at multiple points are seen as a way to strengthen the environment where children grow up and to address inequalities in health (Daro, 2016b). 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: 1017). Even though there is agreement that we need well-coordinated services to support young children, few countries have managed to implement holistic early childhood services (Daelmans et al., 2017). Norway has an advanced social welfare system, with comprehensive universal services. Despite this there are, challenges in the coordination of efforts within the public service system and with the community at large; over the last decades health inequalities have increased (Dahl et al., 2014). These factors made family centres particularly interesting as they are an institutional model that seeks to integrate universal services with targeted interventions to create a seamless family support service but have been the subject of only limited research (Adolfson et al., 2012). The main research question of this study was:

*How do family centres facilitate accessible and integrated family support?*

The overarching research question is broad, as this is an exploratory study in which empirical practice guides the direction of the research that became the topic of the articles. At the start of the

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study I focused on the professional role; how the professionals in on one service collaborated with professionals from other services within the family centre and how they communicated with families. Through participant observation that allowed me to take part in family centre activities and talk to the professionals that worked there, I became interested in the interaction dynamic that occurred in different settings. How the families interacted with each other, how they engaged with the professionals and how the professionals talked about their role being defined by their managers. I started seeing the families and professionals as active contributors to the construction of the family support offered in the family centre. The perspectives of professionals and parents in family centres has received little research attention (Hoshi-Watanabe et al., 2015).

The family centres offer low-threshold services. Research on low threshold services has primarily focused on services for marginalised groups in the society; people who are not reached by conventional services (Braine, 2014; Muckenhuber et al., 2011; Rosenkranz et al., 2016). Low threshold services have been found to mediate access to resources and healthcare services (Kappel et al., 2016; McNeil and Small, 2014). In Norway the research in this area has focused on low-threshold services for people with substance addiction or mental health challenges (Edland-Gryt and Skatvedt, 2013; Elstad, 2014; Elstad and Eide, 2017; Ådnanes et al., 2008). The low-threshold services provided in the family centres had a different target group and emerged from a different setting than had been previously studied. Therefore, studying the perspectives of professionals and participants in the family centre on these services would generate new insights into both accessibility and family support. The research question for the first article included in this thesis is: *What characterized the low-threshold services in the family centres?*

The family centres aim to strengthen the children's and parents' networks through bringing families together. One intervention that was especially concerned with facilitating contact between families was open kindergardens which were visited by families with diverse backgrounds from all parts of the community. A Swedish study demonstrated that participants in open kindergardens exhibited similar variation in socio-economic characteristics as the local community where the kindergarden was situated (Bing and Abrahamsson, 2011). There is only limited research on open kindergardens.

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Family centres provide informal meeting places for parents with young children and professionals (Hoshi-Watanabe et al., 2015; Lindskov, 2010). In user satisfaction studies parents rated the open kindergarden highly and suggested that participating enabled them to establish new relationships and strengthen their social networks (Haugland and Lenschow, 2006; Vedeler, 2011).

Norwegian demography is changing; immigration and globalisation has gradually made Norway a multicultural society (Goth et al., 2014; Goth, 2014). There are significant health inequalities between the immigrant population and those born in Norway. Immigrants rate their health as poorer than the majority of the population, especially when it comes to mental health (Dahl et al., 2014). They are not reached by conventional health and social services to the same degree as people born in Norway. Health literacy skills such as language proficiency and cultural competence have been found to be significant in determining access to health and social services (Broder et al., 2017; Dahl et al., 2014; Ng et al., 2011) However, the concept of health literacy is not adapted to the vulnerabilities of young children (Broder et al., 2017). The open kindergartens provide an initiative where participants can acquire new skills and cultural understandings, in a setting where children are present and not just referred to. Because the open kindergartens attract a diverse group of people and potentially connect the minority and majority population, I was interested in exploring how this setting facilitated integration processes and how such processes support parenting. The research question for the second article is: *How can open kindergarten facilitate integration processes?*

The services that provide support for children and families are fragmented, they are divided into different sectors that specialize in physical and mental health, education, social welfare and or child welfare. These specialized fields have been developed over decades and services tend to use more energy policing their boundaries than they do to initiate collaborations with other sectors (Willumsen and Ødegård, 2015). National policies are challenging services to break these patterns (Folkehelseloven, 2011; Helse- og omsorgstjenesteloven, 2011; Ministry of Health and Care Services, 2012; 2014b). Research on integrated services in Norway has primarily focused on two fields: integrated health care services (Grimsmo et al., 2016; Skråstad, 2014) and coordinated



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services for people with disabilities (Breimo, 2014; Eriksen et al., 2006; Lundebj, 2008)

Internationally, there is little research on how multiagency teams are changing their ways of working (Frost et al., 2005). Most studies instead describe the antecedents of interdisciplinary work and focus on practitioner's interactions and abilities rather than leadership (D'Amour et al., 2005).

The services included in Norwegian family centres varies; health care services for children, pregnancy care, child welfare services, pedagogical–psychological services are often represented and in a quarter of cases, open kindergartens. Despite these differences, all family centres seek to provide holistic family support services (Adolfson et al., 2012). In the Netherlands family centres lower the threshold for interdisciplinary collaboration, from the professional's perspective, although the potential for collaboration is not always fulfilled and the altered structures do not necessarily ensure that professionals adopt new practices (Busch et al., 2013). A Swedish study (Hjortsjö, 2006) found that family centres were not unified organizations; professionals were more concerned with their individual service rather than collaborating with professionals in other sectors within the family centre. These studies highlight the need for more knowledge on how leadership and professional practice in the family centres interlink and how these can facilitate intersectoral collaboration. The third article in this thesis drew on the perspectives and practices of both professionals and managers to consider the challenges and opportunities for developing new interdisciplinary practices in family centres. This article discussed the following research question: *How is intersectoral collaboration constructed in the family centres?*

There is wide agreement that all public services, family support services included, are accountable to provide interventions that are based on the best available research evidence. "However, this presents a major challenge for aspects of our practice where there is little or no research evidence to support our decisions" (Medeiros, 2002: 65). Medeiros emphasises the importance of combining different sources of knowledge to be able to apply knowledge-based care.

The current project sought to develop knowledge relevant to practice. Participant observation was chosen to generate data as it captures nuances of the practices and perspectives of actors in the

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field that might be invisible using other methods. The role of the participant observer is a central issue in the research methodology as they are active coproducers of the resulting data. There is limited literature on the relational aspect of developing roles in participant observation and the impact this has on data. Wadel emphasises the necessity of being aware of the roles the participant observer takes in the field and how they interact with those of the informants (Wadel et al., 2014). The fourth article is a contribution to debates regarding the aggregation of knowledge from fieldwork in multiple sites that rely on using a repertoire of roles to gain insights into practice. The fourth article engages with the following question: *How can a participant observer adopt a role-repertoire to negotiate fieldwork in multiple sites?*

## 4 Research Methods

In this chapter, I describe the research process adopted in this study, focusing on how data was generated and analysed. Furthermore, I show how the analysis guided the development of the research questions. I wanted to explore the family centres from within using an inductive approach that allowed the empirical data to guide both the research and analytical processes. By combining strategies from ethnography and grounded theory in the design of the study, I created a methodological framework that allowed me to pursue the questions and ideas that emerged from interacting with the participants in the context of the family centres.

### 4.1 Methodological framework

This thesis represents a constructivist approach to knowledge, built on the assumption that our shared knowledge is constructed through social interaction (Burr, 2015). I understand knowledge as situated and located in particular positions, perspectives, and experiences (Charmaz, 2014: 448). In this thesis, I do not attempt to explain causality or to provide a representation of a singular reality. Rather, I aim to provide an interpretation of the practice and perspectives in the family centres, to contribute to further development of theory, practice and policy.

If we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, privileges, perspective, and interactions into account as an inherent part of the research reality. It, too, is a construction (Charmaz, 2014: 53).

My perspective and the way I interact analytically with the participants in the study and the data I have constructed form the interpretations that are presented here. The family centres are explored through my observations and questions. I have made choices of which questions to pursue and which to let be. However, the choices have not been made in a vacuum but instead relate to my interaction with the participants in the study and my reading of the literature. Going back and forth

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between analysis and data generating meant that my understanding was a product of testing out analytical questions through new observation and conversations with the actors. As the study progressed, this interaction process also included discussing preliminary analysis and ideas with participants in the study. Therefore, I see these data and the analysis presented here as co-constructed through interactions with the participants, framed by the structural conditions and the emergent situations (Charmaz, 2014: 463).

When designing the study I sought a methodological approach that would allow me to gain first-hand experience of practice in the centres. I wanted to sit at the table with the professionals when they deliberated on difficult decisions and take part in centre activities together with the families they supported. This led me to engage with the methodological literature on ethnography and participant observation. I started to plan fieldwork in a way that maximised my opportunity to learn from people in the family centres (Spradley, 1980) by taking part in their context (Fangen, 2011) and seeking to see the unseen (Patton, 2015). I found that ethnographic fieldwork permitted me to broaden my data by combining participant observation with other methods for generating data. I wanted to explore the practice taking place in the family centres from a range of different perspectives by including documents and interviews with families, professionals and managers.

In terms of data collection, ethnography usually involves the researcher participating, openly or covertly, in people's daily lives for an extended period of time, watching what happens, listen to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefact- in fact gathering whatever data are available to throw light on the issues that are the emerging focus (Hammersley and Atkinson, 2007: 18).

To be able to gather data that throws light on the issues that emerge from fieldwork, I needed to find a balance between planning and leaving the design open enough to be able to pursue the possibilities that emerged. I feared that structuring a detailed plan for the process of generating data prior to the study would weaken the inherent exploratory design. Devault and McCoy (2012) describe the process of ethnographic inquiry as being like grabbing a ball of string, finding a thread

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and then pulling it out. They argue that this makes it difficult to specify an exact plan in advance as it is impossible to judge which string to pull.

While I was searching for strategies to help me adopt the right level of planning, I was reading methods literature on grounded theory. According to Charmaz (2014), using grounded theory as a research strategy provides an abstract theoretical understanding of the studied experience; building levels of abstraction directly from the data. Charmaz (2014) approach to grounded theory appealed to me for two reasons. First, she emphasises the importance of engaging with the data by starting the analysis from the beginning of a study. She suggests the need for connecting analysis and generating data and seeing these as interdependent processes where one informs the other. This approach leads to the direction of the study being led by the empirical data, rather than through pre-set hypotheses or theoretical perspectives.

Grounded theory begins with inductive data, invokes iterative 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: 33).

Grounded theory gave me a way of thinking about flexibility within a research design. It also provided me with a way of thinking about the difference between designing a study and conducting it in terms of what aspects needed to be predefined. I needed a starting point, a place of departure, for my exploration; what Spradley (1980) calls locating a social situation. "In doing participant observation you will locate yourself in some place, you will watch actors of one sort or another and become involved with them; you will observe and participate in their activities" (Spradley, 1980: 39). To balance the need for planning with a desire to keep the design relatively open I found the concept of initial sampling useful. "Initial sampling gets you started; theoretical sampling guides where you go" (Charmaz, 2014: 387). Making a distinction between initial sampling and the choices that are made once the fieldwork started made it easier for me to move forward in planning the study.

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The second reason why I found Charmaz's approach to grounded theory useful conducting ethnographic research was that she understands knowledge as constructed through social interaction. Thus, the researcher is understood as an active player in the construction of data and this must be acknowledged in the analytical process. This approach aligns with the way subjectivity and reflexivity are stressed in the ethnographic tradition (Fangen, 2011; Hammersley and Atkinson, 2007; Spradley, 1980; Wadel et al., 2014). The researcher takes part in a social situation and thereby influences the setting. This participation is not seen as diminishing the value of the data but instead the experience of the researcher is regarded as data in its own right (Hammersley and Atkinson, 2007; Wadel et al., 2014). However, adopting this approach requires the researcher to have a reflexive perspective on his or her own position; reflecting upon how it may have influenced the situation and how this might inform the study.

### **4.2 Planning the study**

When writing the proposal for this study I established a collaboration with the Research Group for Mental Health Prevention and Promotion at the Regional Centre for Child and Youth Mental Health and Child Welfare- North, (RKBU North), located at The Arctic University of Norway in Tromsø. The centre support the municipalities, aiming to improve quality of services for children, adolescents and their families. They carry out research projects in addition to providing education, courses and network meetings for the professionals that work in the services.

#### **4.2.1 Initial sampling and recruitment process**

I first made contact with the Preventive and Health-Promoting Measures research group at Tromsø University in spring 2013 as they started working on the SKO study- *Collaboration and service quality in services for children, youths and their families* (University of Tromsø, 2019). The project examined family centres and other forms of interdisciplinary collaboration in municipalities using surveys data. The participants in the research group knew the field I was going into and contributed with valuable insights to the process of identifying sites for my fieldwork.

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To explore how the actors, leaders, professionals and families, in the family centres interacted and collaborated I planned to conduct fieldwork in three sites; three family centres. I aimed to ensure comparability within the dataset by selecting family centres that met three inclusion criteria: (1) a minimum of three co-located services targeting children and families, (2) a formal setting for interdisciplinary collaboration and (3) an open kindergarden. Family centres aim to provide locally adapted services for children and their families. Thus, services and activities provided in a family centre are likely to vary dependent on where the centre is situated. To ensure variation in the population served by the centres, I identified sites in different parts of Norway including both urban and rural areas (see Figure1).

RKBU North is both a research institution and a support centre for municipality service development. Engaging with them provided access to a network of collaborators in family centres and was vital in gaining access to the research sites. When recruiting participants for the SKO-study the research team contacted family centres throughout the country. They offered to visit the centres to provide information about the study and discuss how the survey would be distributed to the professionals and the families in the family centres. They offered to include my study as a part of their recruitment plan. Therefore, the initial contact with the family centres was made by one of the staff at RKBU. Based on the mapping of family centres conducted in 2012 (Gamst and Martinussen), we prioritized a list of family centres that met the inclusion criteria and represented areas that had different local population demographics. All three centres at the top of the list we prepared were interested in participating in both studies.

### 4.2.2 The three sites

The first centre (FC1) is located in Steinkjer (see Figure 2), a municipality with a population of 21 800 (Statistics Norway,



Figure 4. Fieldwork sites

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2018b). The municipality has one town where two thirds of the population are resident while the remaining live in rural areas surrounding the town. Seven percent of the population were immigrants (Statistics Norway, 2018a). The proportion of low-income families in the municipality is close to the national average (NIPH, 2018). The services provided by FC1 were co-located in the city hall, except for the open kindergarden, which shared premises with a regular kindergarden within walking distance. The family centre was led by a team of service managers (see Table 1).

The second centre (FC2), in Ringsaker, served a population of 33 600 (Statistics Norway, 2018b) in a municipality with two small towns surrounded by rural areas. A total of 15,5 % of the population were immigrants (Statistics Norway, 2018a). The proportion of low-income families the same as the national average (NIPH, 2018). FC2 was organised into three divisions, one in each town and one in a small community in a rural area. All three divisions had health care services for children and an open kindergarden and provided counselling and parent training programs for families. The main division was located in the largest town with co-located health care services for children, maternity care, physiotherapy, psychological pedagogical services and the open kindergarden, while the child welfare services had premises in another building in the town. Like FC1 the family centre in Ringsaker was led by a team of service managers.

*Table 1. Management structures in the family centres (article 3).*

			Health sector	Education sector	Child welfare sector
Family centre 1 (FC1)	Team of service managers	Children and family* Psychological pedagogical services Child welfare services	X	X	X
Family centre 2 (FC2)	Team of service managers	Health care services for children Psychological pedagogy services Child welfare services Mental health	X X	X	X
Family centre 3 (FC3)	Director	Team of service managers			
		Health care services for children Special pedagogical help Physiotherapy and occupational therapy Family projects**	X X	X X	

Note. St.dev = standard deviation.

\*The service consists of health care services for children and psychological pedagogy services.

\*\*Focuses on integration and Norwegian language training.

The third centre (FC3) was located in the capital, Oslo, in the city district Grünerløkka. The city



district is densely populated, with 56 300 inhabitants (Statistics Norway, 2018b), and has during the last ten years experienced stronger population growth than the rest of the city. A large proportion of the growth has been young adults and immigrants. The immigrants constituted 35% of the total population. Compared to other city districts, and the national average, Grünerløkka has a higher percentage of rental housing and cramped living conditions. It also has a high number of low-income families, but at the same time the level of education is higher than the city average (Oslo kommune, 2017). The family centre was a seven-storey building with health care services for children, maternity care, physiotherapy, psychology, pedagogical support, projects aiming to promote Norwegian language skills and an open kindergarden in the basement. The children's welfare services were not included in FC3. A director with a team of services managers led the family centre.

All three family centres included services from both the health and educational sectors, and two of them also included child welfare services (see Table 1). Therefore, all three family centres combine services from different sectors, each of them with specific legislative requirements, regulating their mandate and dictating practice. assignments.

### **4.3 Negotiating access**

My first contact with the centres was at a meeting with the family centre managers to negotiate their participation in the study. The contact person at RKBU North arranged the meetings at which both studies were presented. I arrived together with three members from the research group from RKBU North. The managers presented the family centres, focusing on which services were included, how they managed the centre and what they saw as the challenges for families in their area. One of the members of the research group presented the SKO-study, and I presented this study. The presentation focused on the aims of the study and how the data gathering was planned. After the presentations we discussed what participation would entail for the staff and families in the centres, and how we could ensure that the participants were informed about the research. Before we left, the managers had provided me with formal permission to do the fieldwork, a contact person in the family centre and a provisional date for my first visit.

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Burgess (1984) stresses the importance of keeping detailed field notes from the initial encounters in the field to aid the development of the research design and shape the research questions. My first encounters with the managers in the family centres represented the first small steps towards developing my research questions and a coding framework. I gathered information from the way they talked about the centres and this led me to choose what meetings and activities I wanted to participate in at the start of the formal fieldwork. This is a sequence from one of the first memos:

They talk a lot about low threshold services. How do they define a low threshold services? What characterizes the families that make use of these services in the centres? Memo (27.03.2018 )

After I had visited all three family centres it was clear that the concept of low threshold services would be a central topic in my thesis. All the managers, professionals and parents, used the term low threshold service, but it was not clear how it was defined. And I became increasingly interested in what thresholds were still present.

The initial visit was the first step of negotiating access. The next step was done by email communication with the contact persons I had identified in each of the three family centres. The emails outlined when and where I was to observe and how the staff members should be informed of the study and the timing of my first visit. As I arrived at the family centre for the first day of observation, I was sure that they were expecting me. I was wrong. A description of my first encounter with the family centres as a fieldworker is presented in Article 4, and how this made me realise that negotiating access was something far more complex than getting approval from the management of the services I wanted to observe.

As my fieldwork progressed, I found that negotiating access in two stages was an efficient way to distribute information about the study and at the same time start defining a role as an observer that fit the specific situation I wanted to explore. The first step was to communicate with the managers and discuss how best to inform the professionals in the family centre about the study and where I would start my observations. The second step was to find a gatekeeper (Hammersley and Atkinson,

2007), a professional working in the setting I was to observe. I found that having pre-observation conversations with them was time well invested. I often framed these conversations as informal interviews where the professionals told me about their work. We also discussed my role as an observer, how I would participate in the setting and how we would inform the families about the study and their right to decline to participate. The process of negotiating access, was in large part what Hammersley and Atkinson (2007) refer to as manoeuvring oneself into a position to be able to generate data, this is described in the fourth manuscript.

#### 4.4 Fieldwork

The fieldwork was conducted in two stages (see Table 2). The first stage involved visiting each of the centres for eight to ten working days. This stage of the fieldwork included several different methods for generating data. I collected documents, did participant observation of..., conducted individual and focus group interviews with managers, professionals and families, and took photos and made sketches of the premises. Theoretical sampling (Charmaz, 2014) guided the choices of which meetings to attend, what activities to participate in and whom to interview.

The first stage gave me access to the families, the professionals and the manager’s perspectives, as well as first-hand experience of the activities. Furthermore, it gave me insight into the context of the family support services; the policies and

Table 2. The two Stages of the Fieldwork

	Sites	Data sources
<b>Stage 1</b> April 2015-February 2016		Participant observation
	FC1	Informal conversations
	FC2	Individual interviews
	FC3	Focus group interviews
		Documents and webpages
		Sketches and photos
<b>Stage 2</b> March- June 2016	FC1	Participant observation
	FC2	Informal conversations
	FC3	Individual interviews
		Focus group interviews

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guidelines, the organisational structure and the buildings and local community where the family centres were located.

The second stage of the fieldwork involved revisiting the three centres. This time the focus of the data gathering was the explication of the categories identified in the initial analysis, using participant observation and interviews. In the first stage I had talked to parents in informal conversations as a part of the participant observation, during the revisit I undertook individual interviews with parents, in addition to individual and focus group interviews with professionals.

### **4.4.1 Participant observation**

The main source of data in this study was generated through participant observation. I was given access to meetings, individual consultations, group activities and meeting places. After some time, I was able to adopt different roles during the participant observation; sometimes as a researcher, other times as a professional and occasionally as a parent. The process of establishing a role repertoire (Wadel et al., 2014) as a participant observer is described in Article 4. I show how context, expectations and competences influenced the negotiation of research roles, both for me and the participants in the study. The role-repertoire provided me with the possibility of moving between different levels of involvement and thereby accessing different forms of information. The article also documents the challenges of being a participant observer in a setting with a wide array of activities and a large number of people.

The observations were documented through field notes. I tried to write the notes as close in time to the observation as possible, as the quality of a field note “diminishes rapidly with the passage of time (Hammersley and Atkinson, 2007: 274). In meetings with the professionals or management I wrote on a notepad or on my computer and was able to make detailed notes during the situations I was observing. In other situations, I could not write notes while observing, like when I was playing on the floor, doing jigsaw puzzles, reading to the children with children, or drinking coffee with parents. I always had a notepad nearby and often retreated to a different room or the hallway to

write down brief accounts of my observations before returning to the setting, and then later the same day I would expand the descriptions, making them more detailed. As the research progressed, I found that I wanted more detail in my field notes and started using a digital recorder for the situations when I could not sit down to write for longer periods of time. It made it possible to capture a more detailed description of the situation. I went through the audio file later the same day and wrote comments and extra details where I noticed that something was missing.

The field notes changed character over the course of the fieldwork. At the beginning of the research the field notes consisted of descriptions of the rooms, how many people were present, where they sat and what they talked about. As the study progressed, I became more selective in what I was focusing on in the observation. I started recording the interaction between two children and their parents and “forgot” the rest of the room, or focused on who talked in a meeting, rather than emphasising what they said; my observations became more about interaction and less about describing the context where the interaction took place. The focus of my observation changed and shaped my analytical approaches to encompass new elements within the setting and these became more significant (Hammersley and Atkinson, 2007). One of the big shifts in my approach was attending to the interaction between the parents in the open kindergartens and how the everyday life activities seemed to promote contact between people who would not usually communicate in another setting. After this aspect of the fieldwork became a primary analytical focus, the field notes included detailed descriptions of interaction between the participants in the various activities within the open kindergarden. This approach helped me understand the triggers for contact and the ways conversations developed over time.

#### **4.4.2 Individual and focus group interviews**

In addition to the conversations that were a part of the participant observation, I conducted formal interviews and focus groups with key informants in all three family centres. The interview data was based on transcription of digital and analysed using NVivo 11 qualitative data analysis software (Qualitative Solution and Research International, 2015). In total I conducted interviews and focus

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groups with 61 professionals, 11 managers and 25 parents in this aspect of the study. The managers that attended individual interviews also participated in focus group interviews in the second stage of the fieldwork. One professional attended two individual interviews, and five professionals participated in focus group interviews as well as individual interviews. Therefore, in total I collected interview data from 97 individual informants across all three family centres.

*Table 3: Interviews and focus groups by family centre and category of respondent*

	Sites	Individual interviews			Focus groups		
		Professionals	Managers	Parents	Professionals	Managers	Parents
<b>Stage 1</b>	FC1	2	1		7	3	
	FC2	6	1		6	3	
	FC3	7	5		11	5	
Number of informants		<b>15</b>	<b>7</b>		<b>24</b>	<b>11</b>	
<b>Stage 2</b>	FC1			4	11		
	FC2	1	1	5	8		
	FC3		1	6	8		9
Number of informants		<b>1</b>	<b>2</b>	<b>16</b>	<b>27</b>		<b>9</b>

During the fieldwork I conducted 41 individual interviews (see Table 3). The interviews were held in the family centres and ranged from 30 minutes to 2 hours. Interviews with professionals or managers took place in their offices or in meeting rooms in the family centre. The parents were interviewed in the open kindergardens. Two of the parents were unable to meet at the scheduled time due to their children becoming ill. They still wanted to participate in the study, and the interviews were therefore conducted by telephone. The interviews with professionals and managers were conducted in both stages of the fieldwork, whilst the interviews with the parents were held only in the second stage.

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The parents were recruited through the family centres and were given an information letter about the study and the interviews in particular (see Appendix 2).

The aim of the individual interviews was to encourage participants to tell me about their experience of the family centres. I sought to make the interview setting “an interactive space to enable the participants views and insights to emerge” (Charmaz, 2014: 187). I saw these “conversations with a purpose” (Burgess, 1984: 102) as a co-construction and sometimes it was clear participant’s had not reflected on some of the issues we discussed before the interview. I asked them to elaborate on terms or phrases that they mention or that I had heard during my participant observation: “What makes this a low threshold service in your opinion?” “What do you think is important for enabling families to participate in your activities?” “What would you like professionals from other parts of the centre to know about the work you do here?” I also asked respondents to clarify issues that had emerged through of the initial analysis: “How did hear about the open kindergarten?” “What is important for you choosing to come here?”

I conducted 16 focus group interviews. This involved 24 professionals in six focus groups in stage one and 27 professionals in six focus groups in stage 2. I also conducted 3 focus groups with all 11 managers in stage 1 and nine parents from one family centre in stage two (See Table 3). The inclusion criteria for participating in the focus groups was that they shared a common experience, such as having attended the same low threshold service, were managers in the family centre, or worked with the same target group. The focus group interviews covered three central topics: “Interdisciplinary work in the family centre,” “What characterises the work in the family centre?” “What characterises a low threshold service?” The topics were the starting point for the discussion within the focus groups. Once one participant started talking the others commented on his or her statements. I wanted them to reflect upon the interaction and practices in the family centres and allowed them to talk amongst themselves as much as possible. Focus group interviews are a method of facilitated conversations where participants can gain new insights (Halkier, 2016). Because the researcher takes a less prominent position than in a one-to-one interview, focus groups have the capacity to enable participants to explore topics related to their own practice (Barbour and Flick,

2007). Several of the professionals and managers stated that they found the discussion in the focus groups useful for developing practice in their family centre, as it had created awareness of aspects within the family centres they had not reflected on previously.

#### **4.4.3 Documents, sketches and pictures**

To understand the context of the family centres and how they interacted with other parts of the public service system I analysed policy documents and guidelines as these documents shape the actor's construction of reality (Hammersley and Atkinson, 2007). At the start of the fieldwork, I asked the family centre managers to provide all the documents they saw as central in defining the way the organisations functioned. I received organizational charts, guidelines, budgets and municipal policy documents, in addition to those relating to the process of establishing the family centres. Whenever someone mentioned a document, a set of guidelines or a scheme I had not yet seen I asked for a copy. The documents were therefore always linked to one or more of the study participants who could give me more information about how the particular documents were used and how they understood their importance for the practice in the family centre. During the study, I became interested in the ways the family centres distributed information to the families that they provided services for. I took pictures of the information that was hung on the walls in the family centres and screenshots from their web pages.

I was also interested in the way the services within the family centres interacted with each other. As a part of exploring these processes I made sketches and took pictures of the premises, noting the proximity of the services, how rooms were used, who shared areas for making coffee or eating lunch, how the waiting zones for the families were organised and signs on doors and facades.

#### **4.5 Analytical memos**

In this section, I provide an account of the analytical process adopted in this research. As already described, the analysis was guided by grounded theory. This constructivist approach meant that the



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analytical process started when I first visited the family centres and was iterative with the data generation throughout the study.

Our research journey starts as soon as we begin collecting data; doing comparative analysis and developing categories advances our progress (Charmaz, 2014: 38).

Analytical memos have been an integral aspect of the analytical process, as a way to capture emergent ideas and developing them into codes and concepts to help understand my data.

Concepts are abstract ideas that account for the data and have specifiable properties and boundaries. For constructivists, concepts provide abstract understanding of the studied phenomenon and are situated in the conditions of their production in time, place, people and the circumstances of the research process (Charmaz, 2014: 650).

I found writing memos useful when developing the characteristics of codes and categories. This approach became a way of clarifying the connections between different parts of the dataset. Some of the memos were short, capturing questions or ideas I had when I was in particular situations that did not allow me to sit down and write at length. I came back to these memos when I was back at my desk or had time in between observations or interviews. I wrote memos in a digital notebook called Evernote. This meant that I always had access to the memos, as they were synchronised between my computer, my iPad and my phone.

In addition to writing memos, I frequently used the digital recorder on my phone to make verbal notes. As I speak much faster than I write this provided me with the possibility of capturing a train of thought quickly in between other activities and I could do so while driving or walking. Some of these memos were transcribed, while others were kept as audio files. The program made it possible to tag the memos with keywords making it easier to navigate in the extensive written or recorded data in this study.

Memo-writing creates an interactive space for conversing with yourself about your data, codes, ideas, and hunches (Charmaz, 2014: 324). The memos became important in reflecting on how my

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prior experience as a professional and a lecturer played into the analytical process. My analytical perspective has been influenced by the knowledge and experiences that I had prior to entering the field. This might be regarded as a conflict when applying a grounded theory approach as it may mediate how the data is generated and understood. I believe that this thesis provides insights in to both the conceptualisation and practices that occur in family centres. However, I do not think it is the only valid interpretation. Reflecting on the connections I made to my prior experiences and knowledge in the memos made it possible to choose when to follow these tracks and when to put them aside and look for alternative interpretations of the situation. My aim has been to be explicit about my preconceptions and face the challenges that these may bring to the process. Acknowledging them in my analytical memos was a way of creating transparency as to what influenced my analysis. Hammersley and Atkinson write about the importance of being clear and reflexive about how our prior understandings of a phenomenon plays into the interpretation of data.

Besides obscuring the importance of strategies for generating concepts and models, overemphasis on the role of creative imagination in the development of analytical ideas also leads us to forget the function that our existing knowledge of the social world, and our reading of relevant literature, can perform in this process (Hammersley and Atkinson, 2007: 309).

### 4.6 Coding

The study data was organised and coded using NVivo 11 (Qualitative Solution and Research International, 2015). This program allowed me to compare different parts of the dataset using the same codes. I could easily alternate between looking at the extracts from one interview and a report that were linked to one particular code. I read through documents, screenshots of web pages, transcripts and field notes. I listened to the audio files and examined the pictures and sketches. The first codes I applied derived from the early memos I had made at the beginning of the fieldwork. Then new codes emerged from rereading transcripts or field notes and memos. I coded part of the dataset with the same codes, e.g. all the professionals in one centre or all the managers I had

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interviewed. Then I made a mind map of the codes and used the reports to consider if codes should be merged or divided. Next, I applied the new refined codes to another part of the dataset and looked for contrasts, similarities and aspects that surprised me. The process of coding data in NVivo was an important part of developing the concepts that were reflected in the articles, but as important as the systematic approach to the coding and comparing different parts of the data, was playing with creating tentative categories and models.

Although tools may help, constructing theory is not a mechanical process. Theoretical playfulness enters in. Whimsy and wonder can lead you to see the novel in the mundane. Openness to the unexpected expands your view of studied life and subsequently of theoretical possibilities (Charmaz, 2014: 471).

All through the study, I have collaborated with another PhD fellow that works in the same department. From the time of writing the proposal to writing up the present thesis we have held workshops every one to three weeks. The workshops focused on topics that were relevant to our research process. For me, this has been an important setting to test out the strength of my categories and how I could communicate the concepts I developed through the analysis.

Data collection is followed by analysis. Analysis leads to concepts. Concepts generate questions. Questions lead to more data collection so that the researcher can learn more about those concepts" (Corbin and Strauss, 2015: 168).

Analytical insights often occurred in other situations than at my desk. During the study I have presented preliminary analysis and results in different settings and to varied audiences. To give something back to the family centres that allowed me to learn from their practice and take part in their activities, I present my findings at a seminar in each of the centres. When these seminars were held I was still writing up the articles. The reactions and questions from the staff became an important part of how I understood the data. I had similar experiences when I presented my work at academic and professional conferences or delivered lectures to students. The clearest example of

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this was when I gave a paper at a seminar for staff in a family centre that was not part of my research.

While presenting today I suddenly became aware that they use the term “mandate” in a different way than I do. This might also be the case for the participants in my study. (Memo, 05.09.2017)

Going back to the interviews and checking what the informants had said given the new understanding of what they might mean by *mandate* I found that I had misinterpreted their statements. The presentation of my work in progress and the questions and responses from diverse audiences became an important part of the process of validating the data.

### 4.7 Theoretical sampling

The initial sampling consisted of setting up criteria for identifying the family centres to include in the research and planning the first week of fieldwork. I adopted a theoretical sampling approach to identify the sites and then guide the choices of whom to talk to, which meetings to attend, and what activities to take part in within each family centre. When researchers sample theoretically, they identify and select places, people and situations that will provide information about the concepts they want to learn more about (Corbin and Strauss, 2015: 168). The first questions I was interested in related to what professionals meant by low threshold services and how they interacted with the families in the settings that they defined as low threshold. I wanted to explore the different settings that were understood as low threshold services to see if I could understand if they had a distinctive character that differed from traditional services provided to children and families.

During the first stage of the field work I visited the three family centres sequentially. This meant that questions and ideas that I gained in exploring the first family centre influenced the choices I made when I visited the second and third centres. When I had been to all three family centres I became aware of elements with the first two centres that I had not realised were significant when I was there. This was largely to do with the fact that the third centre was located in a city, while the first two were in small towns. One example of the difference was that both the availability of public

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transportation and the impact of house prices on residential patterns varied between the sites made the threshold of distance different in each family centre. This realisation made me go back to the field notes describing conversations with parents in the family centres, to look for statements about how they travelled to the centres. This led to the decision to interview parents that attended low threshold services in all three centres during the second stage of the fieldwork.

I chose to use approach the recruitment of parents for the interviews in the second stage of the fieldwork using purposive sampling. Based on the first stage I selected two low threshold services in each family centre to explore further in the second stage (see Table 4). I emailed the contact person in each of the centres and asked them to recruit parents that attended at least one of the specified low threshold services. I also asked to talk to both men and women, as my initial analysis showed that they had different motivations for attending the low threshold services. Breckenridge and Jones distinguish between purposeful sampling and theoretical sampling in this way:

While a purposeful sample is selected at the outset of the study for a predetermined purpose, theoretical sampling progressively and systematically tailor's data collection to serve the emergent theory. Theoretical sampling is thus always purpose-driven; the sample is selected for the *purpose* of explicating and refining the emerging theory (Breckenridge and Jones, 2009: 118).

Following their definition, the sampling was purposive as it was driven to "elaborate and refine categories in your emerging theory" (Charmaz, 2014: 379). I chose the inclusion criteria it would provide me with data to strengthen the theoretical concepts I was developing. However, Breckenridge and Jones (2009) emphasise the need to be aware that socio-demographic characteristics do not automatically provide relevant data to the emerging theory. The men and women did elaborate different motivations for participating. However, their accounts were about their roles as parents and the challenges they faced; primarily this related to aspects of their situation rather than their gender.

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*Table 4: Low- threshold services (Article 1)*

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 provides 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 specializing in language and social skills; parents can attend the café, while the children are at kindergarten.

### 4.8 Ethical considerations

This study was approved by the Norwegian Social Science Data Services (see Appendix 1), and data was maintained in line with the Personal Data Act (Personopplysingsloven, 2000) and guidelines from the Norwegian University of Science and Technology (NTNU, 2019). The data was encrypted and handled confidential. I was the only one that used the audio files, and the transcriptions were anonymized.

The managers and professionals working in the family centres were informed about the study through staff meetings and email correspondence. When conducting interviews with managers and professionals I started each interview with information about the study, how the data material would be stored, and their right to withdraw their consent up until the point of publishing. Their consent was done verbally and recorded at the start of the interviews. The parents were recruited through a contact person at the family centre. They received an information letter explaining what the intention of the study was, how the data would be stored, and their right to withdraw from the study (see Appendix 2). The letter included a written consent which they signed at home or before the interview started.

Ensuring sufficient information about the study and the families right to decline to participate or withdraw from the study was a topic that required ongoing attention when undertaking participant observation. I collaborated with the staff in the centres to help me spread information in the group activities. This was especially challenging when I attended activities where the families arrived and left on different times. Another issue was the language barrier, since there were families present with low Norwegian. Issues concerning informed consent during the participant observation is thoroughly reflected upon in Article 4.

#### **4.9 Limitations**

This thesis has documented variation in practice, organisation and management between these three organisations. It is likely that there is even more variation across the more than 150 family centres within Norway.

The family centres are diverse and include a wide array of initiatives intended to support families and children. The data was generated by sampling sites to observe and respondents to interview in order to explore low threshold services. As with any research that relies on sampling some aspects of activities in the three family centres were under-represented such as consultations in the Children's Health Care Service or meetings in the Pedagogical and Psychological service.

This study explores the perspectives and practices within three family centres, therefore the voices of parents that were not in contact or did not attend during the fieldwork are not included in the study. All three family centres collaborated with organisations in the community, and their voices are also not reported in this study.

## 5 Summaries of the articles

In this section, I will present summaries of the four articles included in the thesis. The first three articles are empirically based and explore three different themes at the heart of the research: accessibility, intersectoral collaboration and integration processes. The analysis presented in the articles focuses on different aspects of practice in the family centres. The first article considers low threshold services in the family centres from the perspective of parents and professionals. The second article focuses on the interaction in the open kindergarten and discuss how this context has the potential to promote integration processes. The third article explores intersectoral collaboration and draws on managers and professionals practices and perspectives. The fourth article is a methodological reflection on the process of developing and enacting different roles in participant observation.

### 5.1 Article 1 – Low-threshold services

Bulling IS. (2017) Stepping through the door - exploring low-threshold services in Norwegian family centres. *Child & Family Social Work* 22(3): 1264-1273.

The topic of this article is the low threshold services provided in the family centres. Establishing low threshold services in municipalities has been one of the strategies intended to increase equality in health care. In this article I present elements that illustrate the character of low threshold services from the perspective of the professionals and the parents in the family centre's I study, focusing on what they saw as important in encouraging accessibility and participation.

The data used in the analysis was generated through participant observation, interviews and focus groups. The family centres had several different services that were described as 'low threshold services'. For the purpose of this article two services from each of the three centres were sampled; six services in all were considered. The services included were three open kindergardens, an interdisciplinary team, a parenting training program and a language course. Data from both parents



and professionals were included in the analysis. The parents were users of one or more of these low threshold services, and the professionals were those who worked in one or more of them.

The findings show that both parents and professionals see the services as having a low threshold for participation. Despite being low, there were thresholds for participation that were practical, for instance a lack of public transportation or access to information about opening hours. In addition, there were less tangible thresholds such as parental uncertainty about the purpose of a service or the consequences of participation.

I argue that it is necessary to address a wide variety of elements when establishing and further developing low-threshold services in family centres. Variation in context, user needs, and demographic characteristics require each family centre to create an open dialogue including both professionals and services users to map the most appropriate thresholds for participation. This dialog is also vital to find strategies to lower the thresholds that are still present.

## **5.2 Article 2 - Integration**

Bulling IS. (2017) En mangfoldig møteplass. Åpen åpenbarnehage som integreringsarena. (A diverse meeting place. Open Kindergarten a setting for Integration) *BARN* 35(2-3): 73-87.

The open kindergardens are meeting places for children and their caregivers located in the family centres. Strengthening family social networks is one of the main goals of the work in the open kindergardens. This article presents the analyses of participant observation in five open kindergardens. In this article, I explore integration at the relational level and discuss how open kindergardens can promote integration processes.

The diversity of those who attended the open kindergardens provides families with opportunities for social mobility. The interaction between participants in the open kindergardens demonstrates how children act as important mediators in the initial contact between adults. When children were playing on the floor together with the adults small comments to the children developed in to

## SUMMARIES OF THE ARTICLES

conversations between their parents across a wide variety of topics. The open kindergardens also provided many of the parents and children with an opportunity to develop their language skills. The participants helped each other to understand by translating words and phrases and gesticulating to help provide explanations. Through being together in play or sharing a meal the families got to know aspects of each other's culture as well as different ways of how to raise children. This provided parents with the opportunity to reflect upon their own choices. The professionals became mediators in these processes, connecting people, participating in conversations and then pulling back to let the parents talk.

In this article, I consider integration to be the process of connecting groups and individuals and that anyone can feel left out. Thus, settings that helped support the integration of immigrant families were seen as beneficial for all families visiting the family centres. Conceptualising integration in this way makes it a common responsibility and emphasises the opportunities for the development of new social connections for all families that visit the open kindergardens. Networks that include people with different backgrounds, experiences and social capital create the potential to become a strong support system for all children as they grow up.

I argue that open meeting places that include a wide variety of people contribute to an experience of belonging. To enable integration processes it is vital to establish settings where minority and majority populations meet and interact. There is a need to investigate what motivates people to engage in these kinds of settings to further promote integration and enable social mobility.

### **5.3 Article 3 – Intersectoral collaboration**

Bulling IS and Berg B. (2018) "It's our children!" Exploring intersectoral collaboration in family centres. *Child & Family Social Work* 23(4): 726-734.

Services provided to children and young people are often described as fragmented. To meet this challenge different forms of collaboration between sectors and services have been established and family centres are one of the models collaboration implemented in Norwegian municipalities to

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provide better holistic services for children and young people. In this article, we explore how professionals and managers working in family centres construct and practice intersectoral collaboration. Furthermore, we provide insights into the challenges and opportunities for developing interdisciplinary practices.

The data material used in the analysis consisted of both participant observation, focus groups and interviews. The findings show that both professionals and managers found it challenging to prioritize intersectoral work. Intersectoral work was constantly measured against “the core objectives”, these were the tasks that were defined by legislations and guidelines with specific reporting requirements and deadlines. Management structures and emphases had an impact on the capacity to develop new cross-sectoral practice. One of the main challenges was managers putting “the spotlight” on specific intersectoral initiatives resulting in other initiatives decaying in the shadows.

We discuss how intersectoral collaboration should be viewed as a collective learning process. Using the concept of expansive learning developed by Engeström (2001) we show how professionals belonging to different sectors can invest in collaboration while maintaining the perspectives and competences that are specific to their field of expertise. Furthermore, we argue that articulating an aim of generating intersectoral collaboration is vital to ensure the quality and sustainability of services. A flat management structure may hinder the capacity to implement a collective strategy for the development of the family centres. A lack of discussion on the scope for intersectoral activity compromises the potential of both preventive and health promotion initiatives. Such an approach might also have an impact on the family centre’s ability to view their activity holistically; an understanding that the family centres are situated, linked to other public services as well as the voluntary sector. Working on the aim and scope for intersectoral collaboration might establish greater interdependency across and between sectors and services and therefore providing a more dynamic form of collaboration and a better utilization of the competence within the family centres.

#### 5.4 Article 4 – Participant observation

Bulling IS. (in review) 'You don't look like a researcher' Negotiating roles in participant observation. *Qualitative research*.

The role of the participant observer is a central issue in the research methodology literature. Nevertheless, little is written about the relational aspect of developing roles in participant observation. In this article, I use situations from my fieldwork to reflect on the process of negotiating a role repertoire as a participant observer. The reflections rest on the idea that the roles, both those of researchers and informants, are jointly constructed and that they are under continuous negotiation and re-negotiation throughout the fieldwork.

Through analysing field notes and memos focusing on the interaction with informants, I found that as the study progressed I developed a role repertoire. The roles were dynamic, open for re-negotiation within a particular social interaction, but had a core-set of characteristics that made them distinct. Having established a role repertoire made it possible to move between different roles based on the level of information I was seeking or the nature of the interaction.

I found that the process of negotiation was dependent on my own and the informant's expectations, competencies and influenced by time and context. Both informants and I had informal and formal competencies that were demonstrated through our interaction. Which competencies that were held at bay and which were exhibited varied due to setting and who was present in the situation. Within the process of negotiation, we attempted to mobilize each other's hidden competencies. This meant that an interaction could start with one role that changed over the course of the interaction. The negotiations challenged initial expectations and provided me with the possibility of exploring other aspects of informant practices. One example of this was that some informants became co-constructors in the analysis of data. They engaged in meta-discussions about preliminary analysis and ideas that evolved over the course of the fieldwork, and provided me with new ideas and critical perspectives, validation of my interpretation, guiding the next phase of analysis.

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I argue that it is useful as a researcher to have a set of complimentary roles when doing participant observation. The roles are context sensitive and therefore have to be developed within the particular study the researcher is undertaking. This process requires the researcher to be open, to risk exposure and be reflective about his or her own roles. Acknowledging that fieldwork is relational requires researcher to be curious about both their roles and those of their informants. Through engaging in the process of negotiating a role repertoire, the researcher can access a broad variation of voices and practices and generate far richer and more accurate data.

**Article 1 - Low threshold services**

Bulling IS. (2017) Stepping through the door - exploring low-threshold services in Norwegian family centres. *Child & Family Social Work* 22(3): 1264-1273.



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

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**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 emphasize 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 marginalized 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 (Muckenhuber *et al.* 2011; Braine 2014; Rosenkranz *et al.* 2016). These services have been found to mediate access to resources and healthcare services (McNeil & Small 2014; Kappel *et al.* 2016), 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 healthcare 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 organizing 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 presents 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 organized. 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 (Folkehelseoven, 2011; Helse- og omsorgstjenesteloven, 2011) manifested a reorientation of the public services, aiming to mobilize 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. 47 2008–2009; Meld. st. nr. 34 2012–2013; Meld. st. nr. 26 2014–2015). 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 healthcare services for people with substance addiction or mental health challenges (Åndanes *et al.* 2008; Edland-Gryt & Skatvedt 2013; Elstad 2014). 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 organizational structure and the type of services included in the centres (Gamst &

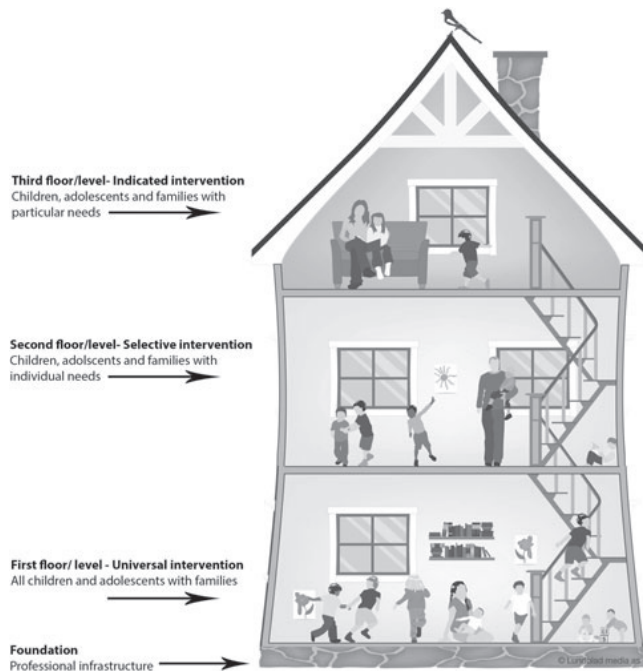
Martinussen 2012). LTSs working to improve children's mental health are found to often be connected to an interdisciplinary collaboration model (Norvoll *et al.* 2006). The family centres included in this study are inspired by an interdisciplinary model called the family's house.

### 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, S.-o. 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 shows that there were established 150 centres throughout the country (Gamst & Martinussen 2012). The services included in the family's houses were healthcare 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 organized, connected and placed within the model.

The model is illustrated by a three-floor building (Fig. 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 healthcare 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 The family's house model.



## 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 analyses and 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 were 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 10 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 (Table 1). The parents included in this study were using the LTSs. The services are open to all the inhabitants in the community. Because the services do 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

**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 provides 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 specializing in language and social skills; parents can attend the café, while the children are at kindergarten.

(Fangen 2011). The professionals were interviewed in eight focus groups in addition to 13 individual interviews, 52 professionals all together.

The process of analysing interchanged with data collecting throughout the study, and analytical ideas were 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 was refined through interviews with both professionals and parents when revisiting all three sites at the end of the study. The interviews were documented through audio recordings and notes. NVivo 11 qualitative data analysis software (Qualitative Solution and Research International 2015) was used to organize 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.

## 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 income can afford better housing in the rural areas. The challenge is often transportation, because 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 that they are being able to combine a visit to open kindergarten with consultations in the healthcare 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 healthcare 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). To 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 café. '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 income. 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 income. 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 emphasized 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 formalized 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.

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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 mobilize 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 because of 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 prioritize:

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 omsorgstjenesteloven, 2011; Helsedepartementet 2004; Helsedirektoratet 2010; WHO 2013), which emphasizes 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 characterized 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 were an important premise for participation and trust. Edland-Gryt & 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 involve both 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 marginalized 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 shows that the threshold of registration and the threshold of competence intervene. A threshold for registration can be a lack of 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 (Nutbeam 2008; Goth & Berg 2011). 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, renders interaction across social barriers possible and acknowledges the notion that the population approach to prevention work has high value for the society at large (Rose 1981; Mackenbach *et al.* 2013). 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 were 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 angles. 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 shows 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. Therefore, 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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## **Article 2 - Integration**

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## R

# En mangfoldig møteplass

## Åpen barnehage som integreringsarena

Ingunn Skjesol Bulling

### Sammendrag

Integrering er en uttalt målsetning i norsk innvandringspolitikk. Denne artikkelen ser på integrering på det relasjonelle nivået, og diskuterer hvordan Åpen barnehage kan fremme integreringsprosesser. De åpne barnehagene i denne studien er møteplasser for barn og deres omsorgspersoner. Artikkelen bygger på deltakende observasjon, i tillegg til intervju av både foreldre og ansatte i fem åpne barnehager. Tre kategorier presenteres for å synliggjøre hovedtrekk ved settingen som kan ha betydning for integrering: Mangfoldet i gruppa, fellesskap gjennom hverdagsaktivitet og dynamisk språkmiljø. Gjennom samhandling der både barn og voksne deltar dannes det et mulighetsrom for ulike integreringsprosesser. De utvikler språkkompetanse, blir kjent med ulike kulturer og tradisjoner, forhandler identitet og bygger nettverk. De åpne barnehagene framstår som møteplasser som oppleves som attraktive både for minoritets- og majoritetsbefolkningen.

### Abstract

Integration is high on the agenda of the Norwegian migration policies. This article explores integration on the relational level, and discusses how Open Kindergarten can promote integration processes. The open kindergartens in this study are meeting points for children and their caregivers. The article is based on participatory observation and interviews, with both parents and professionals, in five open kindergartens. In this article, I present three categories which highlight how the setting may promote integration processes. These are: the diversity of the group, community through everyday activities and an interactive language environment. Through their interactions, the children and adults together, create a setting that renders integration processes possible. They develop language competence, become acquainted with different cultures and traditions, negotiate identity and build social networks. The open kindergartens are seen as attractive meeting points for both the minority and the majority population.

### Innledning

Migrasjon er en utfordring, både for individet som flytter og for samfunnet som tar imot dem (Fandrem 2011). Det norske samfunnet er i endring. Siden midten av 1970-tallet har innvandring og globalisering i økende grad gjort Norge til et flerkulturelt, fleretnisk og flerreligiøst samfunn (Goth og Berg 2014). I

dag har 17 % av den norske befolkningen innvandrerbakgrunn eller er barn av innvandrerforeldre (SSB 2017b). Vi vet at innvandrere er en sårbar gruppe. Den voksne innvandrerbefolkningen rapporterer i større grad enn voksne født i Norge at de har dårlig helse, og spesielt i forhold til psykiske

plager (Dahl, Bergli og van der Wel 2014). Tall fra statistisk sentralbyrå viser at innvandrere har høyere arbeidsledighet enn resten av befolkningen (SSB 2017a). Barn med innvandrerbakgrunn er sterkt overrepresentert blant de som lever i husholdninger med vedvarende lavinntekt, og tendensen er økende (NOU 2011:14). De får i gjennomsnitt lavere karakterer enn dem som har norsk som morsmål (Bakken 2007). Barn med innvandrerbakgrunn er også i større grad representert i gruppen elever som får spesialundervisning (Markussen, Frøseth og Grøgaard 2009). Kunnskap om, og fokus på risikofaktorene for ulike innvandrergrupper er viktig. Samtidig er det viktig å sette fokus på de ressursene et økt mangfold kan bringe med seg. Det er en sterk overvekt av risikoperspektiv når innvandrere omtales i politiske dokumenter. Denne artikkelen fokuserer på ressursene, og hvordan Åpen barnehage kan fremme integreringsprosesser. I dette ligger det ikke en fornektelse av utfordringene, men en erkjennelse av at vi trenger å løfte ressursperspektivet i integreringsarbeidet.

*- Barn med innvandrerbakgrunn er også i større grad representert i gruppen elever som får spesialundervisning.*

Integrering har vært en sentral politisk føring på innvandringsfeltet over flere tiår, men det legges ulikt innhold i begrepet. Denne artikkelen tar utgangspunkt i et *relasjonelt integreringsbegrep*, der fokuset er på det som skjer i møtet mellom minoritet og majoritet (Berg og Lauritsen 2009). Dette perspektivet på integrering innebærer et gjensidig ansvar fra begge parter, som motsats til en forståelse der individet forventes å «integrere seg» inn i et etablert og uendret samfunn. Integreringsprosessene

skjer på ulike nivå, og prosessene har betydning for hverandre. Integrasjon forutsetter åpenhet og nytenkning både på individnivå, relasjonelt nivå og strukturelt nivå (Berg 2010: 54). Denne artikkelen utforsker det relasjonelle nivået. Fokuset er på det som skjer i møtene mellom deltakerne, og hvordan dette kan ha betydning for integreringsprosesser for barn og familier. I det analytiske arbeidet ble følgende teoretiske begrep nyttige for å se de empiriske funnene i denne studien i en større sammenheng: Tilhørighet, relasjoner og mangfold.

Integreringsprosesser handler om å oppleve tilhørighet på tvers av kulturelle grenser og samfunnsstrukturer. Å oppleve tilhørighet er sett som et grunnleggende behov (Malsow 1954; Baumeister, Leary og Steinberg 1995), som er avhengig av erfaring med å bli sett og verdsatt i møte med andre (Hagerty m.fl. 1992). Å etablere seg i et nytt land innebærer en form for reorientering når det gjelder egen posisjon, egne roller og opplevelsen av hvem man er (Berg og Lauritsen 2009). I denne prosessen må de som kommer til et nytt land finne en balanse mellom å ta vare på det de opplever som verdifullt fra opprinnelseslandet og kombinere dette med det som kreves, forventes og gis av muligheter i det nye vertslandet (Berg 2010: 337). Dette kan forstås som en forhandling der målet er tilhørighet. For mange er det viktig å holde på opplevelsen av tilhørighet både til opprinnelseslandet og til sitt nye hjemland. De minste barna som er med i denne studien lever sine sosiale liv tett knyttet til sine nærpå personer. Hvilke arenaer de er på og hvem de møter defineres av de voksnes valg. For deres integreringsprosesser vil det være viktig å få muligheten til å begynne å forhandle identitet, tilhørighet og sosial tilknytning (Kalkman 2017).

For å etablere tilhørighet til et samfunn er både nære relasjoner og mer perifere kontakter viktige (Semb, Borg og Ness 2016: 205). Granovetter (1973) beskriver styrken i de svake koblingene mellom aktører fra forskjellige nettverk. Han viste at de svakere koblingene ga tilgang til impulser som ikke var tilgjengelig fra de personene som inngikk i personens nærmeste nettverk. «Weak ties, often denounced as generative of alienation are here seen as indispensable to individuals opportunities and to their integration into communities; strong ties, breeding local cohesion, lead to overall fragmentation” (Granovetter 1973: 1378).

*- De åpne barnehagene skiller seg fra de ordinære med at barn og voksne deltar sammen.*

Granovetter argumenterte for at disse svake koblingene ga muligheten til at ulike nettverk knyttet seg sammen, og at dette kunne føre til mindre fragmenterte samfunn. Gjennom en studie av førstegenerasjonsinnvandrere i Norge har Valenta (2008) vist betydningen av de svake koblingene for nyankomne innvandreres rekonstruksjon av en positiv identitet. Han fant at deres bekjentskap med nordmenn hadde betydning for opplevelsen av å bli akseptert, og for å se seg selv som inkludert og respektert i det sosiale miljøet (Valenta 2008: 223).

Et annet gjennomgående begrep i denne artikkelen er mangfold. Mangfold brukes ofte for å beskrive noe som flerkulturelt. Fandrem (2011) beskriver mangfold som en normaltilstand. Hun vektlegger at mennesker er forskjellige, og at vi derfor må møte hvert menneske med å ta hensyn til det unike hver og en har med seg. Her brukes det for å synliggjøre at de som deltar

i Åpen barnehage er ulike, både når det gjelder etnisitet, kjønn og sosiokulturell status. Mangfoldet ses som noe positivt (Berg 2010), det representerer en ressurs. I dette arbeidet har jeg valgt å benevne dem som har migrert til Norge som mennesker med innvandrerbakgrunn.

### **Åpen barnehage - en del av familiens hus**

Åpen barnehage er et kommunalt lavterskeltilbud, en møteplass for barn og deres omsorgspersoner. De åpne barnehagene i denne studien er en del av tjenestene i Familiens hus, en familiesentermodell med samlokaliserte kommunale tjenester for barn, unge og deres familier. I 2012 hadde 132 norske kommuner valgt å etablere familiens hus eller lignende samarbeidsmodeller (Gamst og Martinussen 2012). Sentrene inneholder tjenester som helsestasjon, pedagogisk-psykologisk tjeneste, forebyggende barnevern, svangerskapsomsorg og fysio- og ergoterapi. Som en del av virksomheten tilbyr sentrene ulike lavterskeltilbud. En fjerdedel har tilbudet Åpen barnehage. Dette tilbudet har som mål å være en foreldrestøttende og nettverkskapende møteplass, som fremmer trivsel, utvikling og helse hos barn og foreldre (Adolfson, Martinussen og Thyraug 2011). De åpne barnehagene skiller seg fra de ordinære med at barn og voksne deltar sammen. Familiene kan komme og gå som det passer innenfor åpningstiden, og det er ingen krav om forhåndsavtale, søknad eller henvisning. De som bruker tilbudet representerer en stor variasjon både når det gjelder alder, kjønn, økonomi, utdanning, etnisitet og arbeidssituasjon. I tillegg til å være en åpen møteplass benyttes de åpne barnehagene som arenaer for mer målrettede tiltak, og i enkeltsaker kan de ansatte samarbeide med tjenester som barnevern eller fysioterapitjenesten.

Virksomheten i de ulike åpne barnehagene er tilpasset den konteksten de tilhører, men felles for dem er at de ansatte beskriver at de jobber for barna gjennom å støtte foreldrene i deres omsorgsrolle. De åpne barnehagene i denne studien er bemannet med en til to ansatte i åpningstiden. De samarbeider med de andre tjenestene i familiesentrene, og kan bistå foreldrene i å ta kontakt med ulike tjenester ved behov. Ett av sentrene har organisert det slik at tilbudet besøkes av representanter fra de ulike tjenestene på faste dager. Aktivitetene i de åpne barnehagene varierer også fra sted til sted, men de ligner ordinære barnehager med frilek, sangstund, lese-krok, utetid og måltider.

De åpne barnehagene representerer et lite utforsket felt. En rapport som fokuserte på organiseringen av virksomheten i de åpne barnehagene fant at det var stor variasjon mellom barnehagene i forhold til om man legger hovedvekten på læring, opplevelser og formidling, på inkludering og forebyggende helse- og familievern, eller på integrering av minotetspråklige (Haugset 2014). Det er ikke funnet studier som har sett spesifikt på integreringsprosesser i Åpen barnehage. En rapport fra 1998 viste at det ikke var så mye kontakt på tvers av kulturer som de ansatte forventet (Tingstad og Kvamstad). De studiene som har sett på brukerperspektivet har funnet at brukerne var godt fornøyd med tilbudet, og at de opplevde at Åpen barnehage bidro til etablering av nye relasjoner og stimulerte til styrkede nettverk (Vedeler 2011; Haugland, Rønning og Lenschow 2006). Kontakten med de ansatte er også trukket fram som viktig, og de opplevde at terskelen for å stille spørsmål var lav (Bulling 2016; Haugland, Rønning og Lenschow 2006). En undersøkelse i åpne barnehager i Sverige fant at gruppen familier som brukte tilbudet representerte

en variasjon når det gjaldt sosioøkonomiske faktorer som lignet den i befolkningen forøvrig, og at de åpne barnehagene fungerte som en møteplass der foreldrene ikke opplevde noe krav om å prestere (Bing og Abrahamsson 2011). Disse studiene er gjort over en periode på 19 år. Mye har endret seg i forhold til hvilke tilbud som er tilgjengelig for familier med små barn i løpet av denne tiden. Som tidligere påpekt har også migrasjon endret sammensetningen i den norske befolkningen i samme periode. Målet med denne artikkelen er å bidra til kunnskap om integreringsprosesser for familier med små barn, og diskuterer følgende spørsmål: Hvordan kan Åpen barnehage fremme integreringsprosesser?

## Metode

Artikkelen er skrevet med utgangspunkt i prosjektet «Familiens hus som arena for helsefremming», som har til hensikt å utforske hvordan denne formen for tjenestetying kan bidra til å løfte ressursperspektivet i møte med barn og familier. Studien er inspirert av *Grounded theory* som en konstruktivistisk tilnærming (Charmaz 2014). Denne tilnærmingen ser forskerens forforståelse som et utgangspunkt for å utforske feltet, og kunnskapen den utvikler som kontekststøttet og samskapt av forskeren og deltakerne.

Datamaterialet er generert gjennom et feltarbeid i tre familiesenter med åpne barnehager. Sentrene er lokalisert i to kommuner og en av hovedstadens bydeler, og valgt ut for å representere en variasjon i demografi, både i forhold til befolkningstetthet og etnisitet. Datamaterialet som danner grunnlaget for analysene i denne artikkelen er feltnotater fra deltakende observasjon i de åpne barnehagene, i tillegg til intervju med foreldre som benytter tilbudet

og ansatte. Ett av sentrene hadde Åpen barnehage på tre ulike steder, så utvalget består derfor av fem åpne barnehager.

Datagenereringen ble gjennomført i to faser. Første fase besto av et besøk på hvert senter i 8–10 arbeidsdager. Hovedvekten var på deltakende observasjon der de åpne barnehagene ble en viktig setting. I tillegg gjennomførte jeg intervju med seks pedagoger som hadde hele eller deler av sin stilling tilknyttet Åpen barnehage. Fire jobbet i samme senter og ble intervjuet i en fokusgruppe, de to andre ble intervjuet individuelt. Lydfiler fra intervjuene og feltnotatene fra observasjonene utgjorde datamaterialet fra første fase. Analyseprosessen startet fra første møte med feltet. Gjennom hele første fase skrev jeg analytiske notat (memo) (Charmaz 2014), der spørsmål og små analytiske ideer gradvis tok form. Det var i disse notatene jeg begynte å se at materialet inneholdt interessante elementer om integreringsprosesser, foreldreroller og utenforskap. Disse begrepene gav utgangspunktet for de første kodene: Tilhørighet, språk og vennskap. Materialet ble kodet, og etter hvert ble handlingene knyttet til disse begrepene interessante. «Å dele leker» og «å by på mat», og «å hente kaffe», «å gi plass på lekematta» osv. De samme kodene ble brukt for å utforske både intervjuene og observasjonene.

*- Mennene med kaffekoppene var i Åpen barnehage i flere timer denne dagen.*

Intervju og deltakende observasjon ble benyttet i fase to for å utdype og konkretisere de foreløpige analysene. Det ble gjort et teoretisk utvalg (Charmaz 2014). 14 foreldre ble intervjuet, i tillegg til at fire av de ansatte ble intervjuet igjen. Det ble avtalt en dag i hver av de tre sentrene for å gjøre for-

eldreintervju. Foreldrene ble forespurt av de ansatte. Inklusjonskriteriet var variasjon på kjønn, etnisitet, og alder. Det var ikke nødvendig med tolk i intervjusettingen, det var tilstrekkelig å justere på tempo og stille oppfølgingsspørsmål for å avklare at innholdet i ytringen ble forstått riktig. Kombineringen av deltakende observasjon og intervju sikret et mangfold av stemmer i datamaterialet (Fangen 2011). Å skriftliggjøre analytiske tanker gjennom notatene var viktig i andre fase, og i tiden etter at datagenereringen var avsluttet. Notatene inneholdt utdypinger av kodene, og tankekart som viste koblingen mellom datakilder, koder og det som etter hvert ble kategoriene som presenteres her. Jeg brukte dataprogramvaren Nvivo 11 (Qualitative Solution and Research International 2015) til å organisere notater og lydfiler og til transkripsjon og analyser. Studien er godkjent av personvernombudet for forskning (NSD), og finansiert av Nord universitet.

## Empiri og analyse

Feltarbeidet i de tre familiesentrene ga et rikt materiale. Gjennom analyseprosessen ble jeg opptatt av det som fremmer integreringsprosesser i de åpne barnehagene. Jeg har valgt å presentere empirien i tre kategorier for å synliggjøre hovedtrekk ved settingen som kan ha betydning for deltakernes integreringsprosesser. Kategoriene består av utdrag fra observasjoner og samtaler med foreldre og ansatte.

- Mangfoldet i gruppa
- Fellesskap gjennom hverdagsaktivitet
- Dynamisk språkmiljø

### Mangfoldet i gruppa

Jeg sitter på gulvet i et rom fylt til randen av mennesker. Voksne og små barn. Jeg



lukker øynene og hører et mylder av stemmer, noen snakker somali, en snakker tysk med datteren sin, to damer snakker fransk i et hjørne, det er flere språk jeg ikke kjenner igjen, mange snakker norsk. Noen med sterk aksent. Jeg åpner øynene og tar inn resten av bildet. Inn gjennom døren kommer en mann med nystrøket skjorte og press i dressbuksa, i hendene har han to kopper kaffe. Han går forsiktig rundt lekende barn og foreldre som sitter på gulvet, med retning mot en ledig stol nesten i hjørnet av rommet. På gulvet foran stolen sitter en mann, kledd i hettegenser. Ermene er trukket opp til albuen, og avdekker armer der hver centimeter er fylt med tatoveringer. «Jeg regnet med at du også ville ha en kaffe» sier mannen med nystrøket skjorte og gir den ene koppen til mannen på gulvet. Stadig kommer det nye mennesker inn i rommet. De som allerede har funnet seg en plass hilser og gjør plass mellom leker og mennesker. (Feltnotat)

I dette overfylte rommet var det alltid plass til flere. De som tittet inn fra gangen fikk raskt øyekontakt med noen som hadde vært der en stund. Det så ut til å trygge dem som kom. Noen var godt kjent i settingen, mens andre kom for første gang. Den ansatte var raskt på bena hvis det kom noen som ikke hadde vært her før og informerte om rutiner og muligheter. De som kom inn i rommet inntok ulike posisjoner. Noen tok raskt kontakt med andre, kjente eller ukjente. Andre inntok en mer tilbaketrukket rolle. Mennene med kaffekoppene var i Åpen barnehage i flere timer denne dagen. De befant seg hele tiden i nærheten av hverandre, og de sa ikke så mye. Likevel var det tydelig at de kjente hverandre godt. De viste meg et fenomen mange av de ansatte var opptatt av, og som

en av barnehagelærerne omtalte som «usannsynlige vennskap». Sosiale koblinger mellom mennesker de aldri ville tenkt på å sette sammen. Mangfoldet i gruppa ga mulighet for å bygge relasjoner utenfor de sosiale gruppene de tilhørte ellers. Ifølge Granovetter (1973) gir slike koblinger effekt både på individ og samfunnsnivå. Personene som kobler ulike nettverk sammen får nye muligheter gjennom tilgang til andre mennesker og nye impulser. På et samfunnsnivå kan det føre til bedre integrerte lokalsamfunn fordi ulike grupperinger knyttes sammen.

En av barnehagelærerne som ble intervjuet sa: «Ingen dager er like her, du vet aldri hvem som utgjør gruppa i dag.» Mange av foreldrene er opptatt av at mangfoldet i gruppa er verdifullt i seg selv. Det gir mulighet for at alle som kommer kan finne noen å snakke med, noen de trives sammen med. De er også opptatt av at mangfoldet gir barna deres viktige erfaringer, og gjennom deltakelsen i dette miljøet håper de at de blir vant til at mennesker er forskjellige. En mor beskrev integrering som et fellesansvar hun ønsket å ta aktivt del i: «Jeg synes det er kjempeviktig for ungene mine også, altså vi lever i et samfunn der vi mer og mer blir nødt til å integrere oss, alle sammen, ikke bare de som kommer, men vi må også det, og det synes jeg er kjempeviktig.» (Intervju med mor)

Mange av foreldrene, både med innvandrerbakgrunn og de som er født i Norge, opplever at de har et ansvar for å bidra til at mangfoldet i samfunnet blir oppfattet som en normaltilstand (Fandrem 2011), og at de kan gjøre noe aktivt gjennom å gi barna sine erfaringer med mangfold. Erfaringene barna får fra det sosiale samværet med andre jevnaldrende kan sees som en start på å forhandle deres forståelse av hvem de er i forhold til andre (Kalkman 2017). Noen

av barna var mer tilbaketrukkne, men mange tok kontakt med de andre barna i gruppa. Flere av foreldrene fortalte at barna deres tok mer kontakt med ukjente barn på lekeplassen hjemme etter at de begynte å gå i Åpen barnehage. En far fra Tyrkia snakket om at barna knyttet gruppa sammen:

Jeg liker fellesskapet, det setter jeg pris på, både voksne og ikke minst for de små. Det positive er smittsomt og det går videre, det går begge veier, det skapes fellesskap. Det blir ikke noe parallellsamfunn her, selv om det er mange etniske grupper her. Selv om noen kanskje prater mer med hverandre, så blir de dratt med inn i fellesskapet, på grunn av barna.

Han har sett noe sentralt. De voksne som helst kommuniserer med noen de kjenner fra før blir utfordret på dette av barna. Når det gjelder de minste barna er dette særlig tydelig på lekemattene. Den direkte kommunikasjonsformen til de minste barna krever en form for respons fra de voksne.

To mødre sitter side ved side i gulvet. De er helt stille, ser ut i rommet. Av og til smiler de til barna sine. En gutt og en jente sitter på gulvet. Gutten drar seg framover på magen. Speider etter de fargerike lekene som ligger akkurat utenfor rekkevidde. Moren til gutten løfter han tilbake slik at han er innenfor rekkevidde flere ganger, så skifter han retning. Drar seg raskt opp på kneet til den andre kvinnen. Hun ser ham rett inn i øynene og sier: «Hei! Hva heter du vennen?» Så er praten i gang, permisjonsordninger, motorikk, salg på H&M. I løpet av den neste timen har kvinnene vært igjennom et vell av tema. (Feltnotat)

Guttens forflytning i rommet åpner for en samtale som ikke var tilgjengelig bare sekkunder før. De to kvinnene som satt på gulvet og så ut i rommet hadde ved første øyekast få likhetstrekk. Den ene kommer fra Ukraina, den andre fra Vestlandet. Begge er nye i byen og mammarollen, det er nok. Når døren først var åpnet, hadde de mye å snakke om. De trengte ikke hjelp til å finne gode tema for samtalen fra en gruppeleder. De trengte bare et startpunkt. Jeg har sett denne situasjonen mange ganger, i ulike former. I de små kommunikasjons-situasjonene oppstår kontaktpunkter, på tvers av tidligere etablerte relasjoner. I dynamikken mellom barnas kroppslige og verbale kommunikasjon og de voksnes følelsesmessige inntoning og bekreftelse (Stern og Randers-Pehrson 2003), oppstår det kontaktpunkter på tvers av tidligere etablerte relasjoner. Mattene er barnas domene. I et åpent rom med mange deltakere vil de aller fleste av dem på ulike måter komme i kontakt med andre voksne de ikke kjenner fra før. Og gjennom utforskningen av rommet, menneskene og lekene trekker de med seg de voksne inn i samhandling med hverandre. Flere studier viser at innvandrersfamilier får kontakt med nordmenn gjennom barnas venner og aktiviteter (Berg og Lauritsen 2009; Johannesen og Appoh 2016). Samhandlingen i Åpen barnehage viser at barna fungerer som kontaktskapere allerede når de er noen måneder gamle. Barnas direkte kommunikasjonsform og kompromissløse tilstedeværelse åpner dører for samtaler og relasjonsbygging mellom mennesker som ikke ville tatt kontakt på andre arenaer. Mangelen på «rømningsveier» på mattene kan selvfølgelig også oppleves som vanskelig for noen foreldre, og det er viktig å være bevisst på at denne arenaen ikke fungerer like godt for alle. Likevel er det mange som både viser og forteller at det er

lettere å samhandle på mattene i Åpen barnehage enn på andre arenaer. «Kafeer er ikke tilrettelagt for barn, her har vi det bra begge to» (Feltnotat).

#### Fellesskap gjennom hverdagsaktivitet

Dagene i de åpne barnehagene var i stor grad fylt med hverdagsaktiviteter for familier med små barn, som frilek, lesing og måltider. Barna og de voksne har med seg sine vaner, utfordringer og mestringsområder inn i disse aktivitetene. Det innebar at de hadde noen etablerte strategier de kunne velge å benytte. Samtidig brakte situasjonene ofte også med seg de utfordringene familiene opplevde hjemme. «Putt brødskiva i munnen, den skal ikke ligge på bordet!» En mor ser oppgitt på datteren som har lagt alle de små brødskivebitene utover bordet. Det er ingen igjen på fatet. Datteren ser spørrende opp på mor, ser ned på bitene med brød igjen, tar opp en av bitene og presser den inn i øret.» (Feltnotat)

*- De voksne i hans barndom hadde ikke en foreldrerolle han ønsket å bringe videre.*

I disse daglige gjøremålene er ingen automatisk bedre rigget enn noen andre for å mestre situasjonen. Det hjelper lite med en akademisk grad mot leverpostei i øret. Barna utforsker, forstår og tester verden, grenser og rammer på sin måte. Foreldrene prøver å veilede dem. Å være sammen med andre foreldre som hadde lignende utfordringer som dem selv, så ut til å knytte dem sammen i et fellesskap. Egne erfaringer med hverdagsliv og foreldreskap bekreftes eller suppleres gjennom å settes i sammenheng med andres, noe som ifølge Hagerty m.fl. (1992) kan bidra til å utvikle en opplevelse av tilhørighet. Gruppen tok ansvar

for de situasjonene som oppsto gjennom å støtte barnet og den voksne i situasjonen. Det kunne innebære å gi råd, dele av egne erfaringer, å le sammen med dem, eller å gi barnet og den voksne rom til å ta tak i situasjonen uforstyrret.

Hverdagsaktivitetene ga også mulighet for å utforske ulikhetene i kultur i gruppa. Et eksempel på det var at mange av de voksne sang i leken med barna. Når sangen var på andre språk enn norsk fulgte ofte samtaler mellom de voksne om innhold, språk og nasjonalitet. Et annet eksempel som ga rike muligheter til kulturutveksling var måltidene.

Kjøkkenet er fullt. Rundt bordet sitter barn og voksne tett i tett. Her spiser de når det passer dem. Kjøkkenet har vannkoker, mikrobølgeovn, kjøleskap, kopper, skåler og bestikk. Alle har med egen mat. Utvalget av mat på bordet representerer en stor variasjon. En norsk kvinne ser interessert på maten i boksen som tilhører jenta med mørke krøller på 1 ½ år ved siden av. Den har bønner, hvit fisk og erter. Jenta plukker mat fra boksen med fingrene og spiser ivrig. «Hvordan har du fått henne til å spise det?» Hennes egen datter er litt yngre, sitter og spiser brødskive i terninger med leverpostei. Inni mellom tar hun etter posen med fruktmos. «Spise det?» Spør moren til jenta med de mørke krøllene. «Bør hun ikke spise det? Det er rester fra middagen i går, hun er så glad i erter!» (Feltnotat)

Det som nok var ment som et kompliment fra den norske kvinnen, gjorde den andre moren usikker. Mange av foreldrene med innvandrerbakgrunn er opptatt av å ikke gjøre noe feil. De fleste barn av norske foreldre hadde med matpakke med brød, de

minste barna fikk ofte grøt. I tillegg hadde de litt frukt, gjerne ferdigkjøpt som mos. Det framsto som en tydelig kontrast til de andre «matpakkene» på bordet. Små måltid som bar med seg andre kulturer og vaner. De var fargerike, luktet annerledes og ble tilberedt underveis i måltidet. Barna var nysgjerrige på hverandres mat, og fikk ofte smake av hverandre. De voksne snakket om oppskrifter, næringsinnhold, måltidssammensetning, hverdagsmat og festmat. Samtalene anerkjente kunnskap og kompetanse av uformell karakter. Hvordan maten ble tilberedt og spist, og hvordan ulike kulturer involverte barnet i måltidet og matlaging. Lindhart og Askeland (2016) finner også, gjennom en studie i en barnehage med stor andel minoritetsfamilier, at interessen for ulike matkulturer er stor i foreldregruppa. Det unike med denne settingen var at barna og de voksne spiste sammen i en gruppe. Det gav samtalen om mat og måltider en helt annen form enn den ville fått på et foreldremøte.

Måltidene var preget av at både voksne og barn søkte kontakt med hverandre. I tillegg skjedde det ofte noe uventet under måltidene. Noen veltet et glass og alt ble vått og klissete. Da måtte alle forholde seg til hverandre. De små hendelsene og kontaktforsøkene ble ofte til samtaler om hverdagsliv. Barna var til stede i samtalene, de avbrøt, bekreftet, ble utålmodige og uttrykte glede. Det ble skapt et fellesskap rundt bordet. Å ta del i dette fellesskapet var noe mange av foreldrene var opptatt av. De så det som viktig at barna opplevde tilhørighet i en større sammenheng.

Noen føler enda sterkere at de selv trenger fellesskapet de kan finne her. En annen far jeg snakket med beskrev en famling etter hvordan han skulle være forelder. Han flyktet fra hjemlandet som tenåring, og kom etter hvert til Norge og ble far mens

han bodde på et asylmottak. Han ventet fortsatt på oppholdstillatelse, men som han selv sa det: «Barna mine slutter ikke å vokse selv om saken min ligger på vent.» Nå var han far og måtte finne en måte å være det i den norske konteksten. De voksne i hans barndom hadde ikke en foreldrerolle han ønsket å bringe videre. Samtidig kjente han ingen andre måter å være far på. Han beskrev noe flere av de andre foreldrene snakket om, at de ønsket å finne en balanse mellom å ta vare på den kulturen de hadde med seg fra hjemlandet og det å passe inn i den norske konteksten. Dette er en utfordrende del av integreringsprosessen for mange av dem jeg møtte. For denne faren ble det å være i Åpen barnehage veldig viktig. «Jeg har fått se hvordan de [andre foreldre] leker med barna, hvordan de forklarer, trøster og hvordan de irettesetter. Da kan jeg lære av dem» (intervju med far). Her kunne han både lære gjennom å se hva de andre gjorde, og få muligheten til å snakke med andre om hvordan han så sin egen rolle, og barnas situasjon.

Hverdagsaktivitetene gir muligheter for både samtaler og nye erfaringer. I disse aktivitetene har alle ulike mestringsnivå. Egne referanserammer og ideer om barneoppdragelse kan bli utfordret av noen som løser samme utfordring på en helt annen måte. I disse situasjonene så jeg en maktforskyvning der foreldre som hadde høyt mestringsnivå på mange områder, åpent delte at de opplevde foreldrerollen som utfordrende. Det gjorde det mulig for andre som deltok å dele sine mestringsopplevelser på arenaer som ikke kommer så tydelig fram i samfunnet ellers. Jobb, størrelse på hus og hvilke ferieturer man har råd til vurderes som synlige bevis på suksess i mange sammenhenger. Ved bordene i Åpen barnehage verdsettes andre ting.

### Dynamisk språkmiljø

Deltakerne i gruppa representerer, i tillegg til mangfold på mange andre parameter, også et mangfold når det gjelder språk.

Den ansatte smårydder, går mellom hyllene og bordet, en liten tur ut på kjøkkenet for å hente flere kopper. Det er lyd fra heissjakten og kort tid etter står en mor med en vogn i gangen. «Hei! Har du gått hit? Eller ble det buss i dag? Det er jo egentlig fint vær, vi tar vel en tur ut etter hvert.» «Neida – jeg tar bussen hjem. Det er nedoverbakke hit, det går fint, men det blir litt tungt å gå opp alle bakkene tilbake.» De snakker fort på dialekt, den ansatte fortsetter å rydde, mor pakker barnet ut av vogna. I løpet av kort tid kommer flere barn ifølge med sine foreldre. Den ansatte skiller på hvem som kommer. Hun hilser på alle både barn og voksne, men stopper med ryddingen når det kommer noen som ikke er stødige i norsk. Setningene blir korte, tempoet går ned, hun går over til riksmål. «Hvordan står det til?» «Bra?» svarer kvinnen og ler; hun ser nøye på den ansatte og gjentar i stakkato: «Sier man det? Hvordan står det til?» Latter blant de andre voksne i rommet. «Ja hva sier vi egentlig?» sier den ansatte og henvender seg til de andre. Ulike forslag kommer på løpende bånd. Uttrykkene testes ut blant foreldrene som har lite norsk kompetanse. (Feltnotat)

Her ble det å ønske deltakerne velkommen, benyttet til språktrening. Det var kvinnen som søkte mer kunnskap, hun var ivrig etter å lære, og etter å forstå. Jeg har hørt mange slike samtaler, de var ofte fylt med latter. Å lære et nytt språk innebærer langt mer enn å lære ord og setninger. I denne settingen var det rom for å stille spørsmål om hva

ulike utsagn egentlig betyr. Det er de andre foreldrene som svarer, og spørsmål de ikke klarte å svare på ble sendt videre i rommet. Ofte ble et tredje språk benyttet for å forstå ord eller setninger. Hvis noen kunne litt spansk, tysk eller gresk ble det benyttet som en måte å klargjøre innholdet i uttrykket. De tolket ikke, de oversatte ikke direkte, de forklarte begrepene med de midlene de hadde tilgjengelig.

I tillegg til språktrening i de situasjonene som oppstår benyttes leken aktivt til begrepsinnlæring. Sangstunden har mange sanger med bevegelser, som viser hva de synger om. Noen av barnehagene sendte med tekst til sangene de benyttet hjemme, og de voksne noterte «gloser» i margin for å huske betydningen til de kom hjem. Barn som hadde lite erfaring med norsk ble ofte invitert til å komme opp i sofaen sammen med en av de ansatte for å lese. De ansatte var også bevisste på å benevne ting og handlinger i leken med disse barna.

Det dynamiske språkmiljøet gjorde det mulig å etablere tilhørighet også for de som hadde begrensede norskkunnskaper. Gjennom å støtte språkutviklingen både til barn og voksne formet de ansatte en praksis som ble videreutviklet av de andre foreldrene som deltok. Ingen ble korrigerert uten at de selv ba om det. Alle gikk inn for å forstå og for å bistå hverandre i kommunikasjon. Foreldre som valgte å snakke et annet språk med sine barn ble støttet på det. Dette samsvarer med kunnskap om at de fleste barn kan bli flerspråklige om de får mulighet til å bli kjent med flere språk tidlig. Det kan også ha betydning for kontakt med andre familiemedlemmer (Cummins 2000; Aukrust 2006; Bakken 2007). Samtidig la de til rette for at de voksne skulle få erfaring med norsk. Gjennom å styrke de voksnes språkkompetanse ble de gitt en mulighet til en mer aktiv posisjon i oppfølging av egne

barns videre læringsprosesser. På den måten ble språkutvikling et felles prosjekt for barna og de voksne sammen. Dette kan minne om andre tiltak som familielæringsprosjekter, der grunntanken er å styrke familien som en helhet for å gi både barna og de voksne gode forutsetninger for videre utvikling (Hauge og Aamodt 2008).

Selv om flere av deltakerne ikke snakket norsk sto det sjelden i veien for kommunikasjon. At kommunikasjonen på kryss og tvers av språk gikk så uanstrengt kan ha en sammenheng med hvilken posisjon de ansatte tok i samhandlingen. Når de satte seg ned på gulvet og lekte samtidig som de snakket med foreldrene, ble avstanden mellom dem mindre. Latter var et sentralt virkemiddel i samhandlingen, selv om temaene kunne være alvorlige: kreftdiagnoser, krig, alvorlige funksjonsnedsettelse, skilsmisser, fattigdom og depresjoner. En som ikke har sittet på en av disse lekemattene ville aldri trodd at samtalerne hørte til der blant leketog og rangler. Men det gjør de, og kanskje har mangfoldet i tema og den ufarlige stemningen også betydning for at de med lite norsk kompetanse våger seg ut i samtalen.

Flere av foreldrene var opptatt av at barna fikk erfaring med et rikt språkmiljø ved å delta i Åpen barnehage. En far som har innvandret fra Tyskland sa det slik: «Det er jo veldig blandet, det er mange barn her med både to og trespråklige foreldre. Og det er litt kult, selv om jeg har assimilert meg ganske langt, og snakker norsk så godt jeg kan.» (Intervju med far)

Han har tatt et valg på å snakke norsk med datteren, det er hverdagsspråket hans. Likevel synes han det er viktig at hun får være en del av et fellesskap der det er et mangfold i språk og kultur. Jeg ser dette som en del av hans reorientering av egen identitet, i tillegg til at det handler om hvordan han tenker om datterens plass i det

norske samfunnet. Han ønsker at deres felles språk skal være norsk. Samtidig er det viktig for ham at barnet hans tidlig blir vant til å være i et mangfoldig språkmiljø. Foreldrene har svært ulike utgangspunkt for å ha mulighet til å tilegne seg norskkompetanse.

Ved et bord sitter en kvinne fra Somalia alene, helt stille og blar i barneboken 1000 ord og bilder». Boka har bilder som viser aktiviteter og ting, hvert bilde har et ord både på norsk og engelsk. Hun blar i boka, og ser opp hver gang en av de ansatte passerer forbi. «Når vi har tid bruker vi å øve på norsk sammen med henne» sier en av de ansatte til meg. Det er utetid, og alle kler på seg selv og barna, og forsvinner ut. Kvinnen med boka blir sittende. «Vil du heller lese?» «Ja, han [sønnen] sover. Greit?» «Jada, det er greit, vi er rett her ute». Jeg setter meg ned sammen med kvinnen. Vi småprater mens vi blar sammen i boka, hun peker på bildene og uttaler ordene som står der. Ser spørrende på meg. Jeg bekrefter, justerer og bruker ordene i setninger. Hun forteller at hun har vært i Norge i litt over ett år. Sønnen hennes er snart 1 ½ og skal begynne i vanlig barnehage om noen måneder. Jeg spør om hun har tenkt på å begynne på norsk-kurs? Hun rister på hodet. Nei jeg er gravid igjen, og legger en hånd på magen sin. «Om ett år – kanskje.» (Feltnotat)

De åpne barnehagene tilbyr et språkmiljø for kvinner med begrensede språkferdigheter i norsk som ikke har tilgang på dette andre steder. De fleste språkkurs i norsk er organisert på en måte som gjør at en gruppe kvinner faller utenfor norskopplæringen, fordi de har ansvaret for barn under skolealder på dagtid. De samme kvinnene

har heller ikke tilgang på andre arenaer der de kan få språktrening i norsk. Åpen barnehage blir en arena der disse kvinnene kan komme og bruke språket i hverdagsituasjoner som påkledning, lek, matlaging og på turer. Utfordringen ligger i manglede kapasitet til å møte dem som trenger mer oppfølging. Det finnes noen få spesialtilpassede tilbud, men de fleste stedene mangler dette.

### En mangfoldig møteplass

De åpne barnehagene jeg har besøkt har ikke integrering av innvandrere som uttalt målsetning. De har fokus på foreldrerolle, relasjoner, utvikling og samspill. Kanskje er dette hovedstyrken for denne arenaens evne til å fremme integreringsprosesser, fordi fokuset på foreldrerollen som noe allment favner både minoritets- og majoritetsbefolkningen. Et paradoks innenfor integreringsarbeidet er at tiltakene rettet mot integrering har en tendens til å bli segregerte tilbud for den gruppen som står «utenfor». Der representerer de åpne barnehagene i denne studien noe annet. Gjennom å ønske alle foreldre velkommen, tar de høyde for at alle foreldre har utfordringer og bekymringer, det er nivået som er ulikt (Daro, 2016). Deltakerne er like forskjellige som samfunnet de er en del av. Mangfold i foreldreskap og omsorgsroller så ut til å gi deltakerne trygghet i å kunne utøve foreldreskap på sin måte. Miljøet gav tilgang til rollemodeller og frihet for hver familie til å ta sine egne valg. Graden av tilknytning både til arenaen og menneskene som deltar var ulik, og det var noe av det deltakerne verdsatte. Veien ble til mens deltakerne gikk den, sammen. Det innebar at de gikk ulike ruter, men i dette rutenettet ble mennesker koblet sammen. Gjennom å delta i fellesskapet knyttet de kontakter, både nære og mer perifere relasjoner som kan få betyd-

ning for deres opplevelse av å bli akseptert og inkludert i samfunnet (Valenta 2008).

Foreldrene med innvandrerbakgrunn har ulike tanker rundt sin egen etniske identitet. Noen av dem ønsket å opprettholde en sterk kobling til hjemlandet, andre beskrev et ønske om å bli norsk. De har også ulike tanker om hvordan dette ville bli for barna deres. Dette samsvarer med det vi ser i andre studier (Berg og Lauritsen 2009; Fangen 2008). Samtidig søkte foreldrene jeg har møtt en felles identitet, å være *foreldre i Norge*. Flere av dem brukte Åpen barnehage som en setting for å forhandle en foreldrerolle de kunne stå i, i familieliv og i møte med samfunnet. Kanskje kan samhandlingen som skjer i møtene mellom barn og voksne med ulik bakgrunn forstås som det Gullestad beskrev som kulturmøter (Gullestad 2002: 78) – der identitet ikke forstås som noe rigid, men i stadig forhandling, omforming og endring. Og at vi gjennom slike møter kan se felleserfaringen med det å være norsk som en fleksibel identitet. Det kan gi rom for å være både like og ulike avhengig av tid, sted og sammenheng. En slik fleksibilitet, vil kunne gi større mulighet for å oppleve tilhørighet for barn og familier. Fordi det er akkurat det familiene jeg har møtt gjennom denne studien er, både like og ulike.

Mange mennesker er innom de åpne barnehagene i løpet av et år. Noen er der bare noen få ganger, andre er gjengangere over år. På denne måten vil mange i et lokalsamfunn ha med seg erfaringer og relasjoner fra denne arenaen, og en kan tenke seg at de erfaringene også vil få betydning når de treffer mangfold på andre arenaer, på idrettsplassen, på skolen og på lekeplassen. Åpne møteplasser kan være en måte å bygge lokalsamfunn, der ulike nettverk forenes som en motvekt til fragmenterte lokalmiljø (Eriksen 2011: 31).



Denne studien viser at åpne møteplasser som er attraktive for mange ulike mennesker kan bidra til en opplevelse av tilhørighet. I et integreringsperspektiv er det vesentlig å etablere møteplasser der minoritets- og majoritetsbefolkningen

møtes. Gjennom å utforske slike arenaer kan vi bygge forståelse for hva åpne møteplasser kan bidra med, og forstå mer av hva som er viktig for at ulike mennesker ser nytten av å delta på slike arenaer.

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**Article 3 – Intersectorial collaboration**

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# “It's our children!” Exploring intersectoral collaboration in family centres

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## Abstract

Services providing support for children and families are often described as fragmented and more concerned with the boundaries of their fields of responsibility than collaborating with other sectors. To meet the need for greater collaboration, there is increased impetus for establishing interdisciplinary services, such as family centres. This paper presents the results of a qualitative study based on in-depth interviews and participant observation in 3 Norwegian family centres. The findings provide insight into central challenges in developing new practices within the field of family support; we discuss how intersectoral collaboration is constructed in relation to the core objectives of the family centre, professional competence, and service stability. This study demonstrates that both managers and professionals struggle with prioritizing intersectoral work, which mainly focuses on prevention and health promotion, over and above their traditional sectoral responsibilities. It also illustrates the necessity of articulating intersectoral collaboration as an explicit aim and exploring its implications and examining how this contributes to family centres building supportive communities. Building integrated services is not the ultimate goal of this particular form of service provision but rather the first step towards building interconnected support systems for all children in the community.

## KEYWORDS

family centre, family support, integrated services, management structures

## 1 | INTRODUCTION

The increasing acceptance that the early years of life are crucial for a range of health and social outcomes across the life course (Irwin, Siddiqi, & Hertzman, 2007) has placed early child development and family support high on the political agenda globally. The development of young children is influenced by actions across a broad range of sectors, including health, nutrition, education, and labour (WHO, 2008). To be effective, services at all levels need to be better coordinated and to converge with families in a way that puts the child at the centre (Irwin et al., 2007). In spite of this, few countries have managed to implement the actions necessary to provide holistic early childhood development services (Daelmans et al., 2017).

The challenge of coordinating services is also apparent in the Norwegian context (Meld. St. 24, 2015–2016; Meld. st. nr. 26,

2014–2015). The services that provide support for children and families are fragmented, divided into different sectors that specialize in physical and mental health, education, social welfare or child welfare. Service providers' areas of expertise have developed over decades, resulting in a system in which the services are more concerned with policing the boundaries of their fields of responsibility than collaborating with services in other sectors (Willumsen & Ødegård, 2015). New public policies and legislation (Folkehelseplanen, 2011; Helse- og omsorgstjenesteloven, 2011; Meld. st. nr. 34, 2012–2013; Meld. st. nr. 26, 2014–2015) are challenging municipalities to break these patterns. Several Norwegian municipalities have chosen to organize family support services in family centres, co-locating services from different sectors. The co-location provides a multidisciplinary setting but does not necessarily provide integrated services or ensure interdisciplinary working. The aim of establishing the centres was to

provide holistic family support, through interdisciplinary collaboration across services and sectors requiring professionals and managers to rethink how they provide high-quality family support. Research on integrated services in Norway has primarily focused on two fields: integrated health care services (Grimsmo et al., 2016; Skråstad, 2014) and coordinated services for people with disabilities (Breimo, 2014; Eriksen, Andersen, & Askheim, 2006; Lundeby, 2008). Internationally, there is little research on how multiagency teams are changing their ways of working (Frost, Robinson, & Anning, 2005). Most studies describing the antecedents of interdisciplinary work have focused on practitioner's interactions and abilities and not on leadership (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005).

In this paper, we explore the practices and perspectives of professionals and service managers in three family centres. This study explores how intersectoral collaboration is constructed in the family centres and provides insights to the challenges and opportunities for developing new interdisciplinary practices within a particular organizational form for delivering family support.

### 1.1 | The family's house model

The family's house is the organizational form of the family centres included in this study. The family's houses are centres that provide interdisciplinary health and social services for children, adolescents, and their families living in a municipality. The first houses were established between 2002 and 2004 by the Norwegian Health Authorities as part of a pilot included in the national plan for advancing mental health care (Sosial- og helsedepartementet, 1998). The pilot was based on the Swedish family centre model and adapted to the Norwegian context (Thyrhaug, Vedeler, Martinussen, & Adolfsen, 2012). The pilot demonstrated that this model made more services available to families and that professionals experienced opportunities for greater flexibility and felt more professionally confident (Haugland, Rønning, & Lenschow, 2006). The health authorities recommended that the municipalities further explore the model, and a survey in 2012 found that nationally, 150 centres had been established (Gamst & Martinussen, 2012). The composition of the centres varied, including health care services for children, pregnancy care, child welfare services, pedagogical-psychological services and in a quarter of cases open kindergartens. Despite these differences, they all sought to provide an adequate level of support for families but in a holistic way (Adolfsen, Martinussen, Thyrhaug, & Vedeler, 2012), 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). In the latest family policy white paper, this model was described as a way to meet the need for coordinated and holistic family services (Meld. St. 24, 2015–2016). The term *Family's house* implies a tangible building but is also a metaphor for how the services are organized, connected, and situated.

Family centres are found in countries throughout the world, including Australia, New Zealand, the United States, Japan, France, Italy, Greece, Belgium, the Netherlands, England, Ireland, Sweden, Finland, and Norway (Bing, 2012; Busch, Van Stel, De Leeuw, Melhuish, & Schrijvers, 2013; Hoshi-Watanabe, Musatti, Rayna, &

Vandenbroeck, 2015; Tunstill, Hughes, & Aldgate, 2007; Warren-Adams, 2001). The centres are diverse in the forms of support they offer and their organization. Hoshi-Watanabe et al. (2015) explored family centres in four different countries and found diverse cultural and socio-political contexts and rationales for their creation but shared similar ways of functioning. Family centres are found to provide informal meeting places for parents with young children and professionals (Hoshi-Watanabe et al., 2015; Lindskov, 2010). Both professionals and parents participating in activities in family centres highlight the significance of focusing on families' resources and listening to how they understand their own situation. This approach influences both parents' ability to build trust in professionals and also to position the professionals as able to support families both directly and by connecting them to other services (Bulling, 2016; Leese, 2016). From a professional perspective, the centres lower the threshold for interdisciplinary collaboration (Busch et al., 2013) although the potential for collaboration is not always fulfilled. Research has also shown that establishing a centre does not ensure that professionals will adopt new practices. In her study of a Swedish family centre, Hjortjö (2006) concluded that the centre was not a unified organization and the professionals working in the centre were more concerned with their individual service rather than collaborating with professionals in other sectors. Leadership and management structures are to too little degree addressed in these studies, which lead us to include the service manager's perspectives in the analysis of the professional's interdisciplinary work for this paper.

## 2 | METHOD

The fieldwork took place in three Norwegian family centres and was approved by the Norwegian Social Science Data Services. The three sites one in a rural area, one in a small town, and one in a capital city district were chosen to maximize variation in the populations served. To ensure comparability, the centres invited to participate in this study met three inclusion criteria: (a) a minimum of three co-located services targeting children and families, (b) a formal setting for interdisciplinary collaboration, and (c) an open kindergarten. The fieldwork generated rich data including participant observation and interviews with both users and staff. For the purposes of this article however, we present the analysis of how the professionals and managers practice and understand interdisciplinary work across services and sectors and therefore have excluded data from interviews with the parents.

Inspired by grounded theory as a constructivist approach (Charmaz, 2014), analysis and data-generating interchanged throughout the study. The first author had access to the family centres and participated in their various activities, consultations, and meetings together with both professionals and families. The fieldwork was conducted in two stages. The first stage involved visiting each of the centres for eight to 10 working days, generating data through participatory observation and interviews to represent a wide variety of voices including service managers, professionals, caregivers, and children (Fangen, 2011). The second stage was a revisit to the three centres aiming to explicate the categories from the initial analysis, using theoretical sampling to decide whom to interview, which meetings to attend and what activities to observe (Charmaz, 2014). In addition to informal conversations and participatory observations, both service

managers and professionals from the services were interviewed during the first visit to each centre. Twenty individual interviews were conducted, 12 professionals and eight managers; in addition, nine focus group interviews took place, six with professionals and three with managers. This included all the service managers in the three centres. The sampling of professionals for the interviews were based on the participatory observation, aiming to provide a variation in experiences of interdisciplinary work, professions, and the services they worked in. The observations and interviews were documented using digital notes and audio recordings.

Writing memos and discussions with the co-author, colleagues, and subsequently participants in the study drove the initial analytical process. The emerging ideas and structures were organized using mind maps and became the foundation for the emerging concepts and the initial coding of both field notes and interviews. The first stage of the analysis revealed the tension between the core objectives and interdisciplinary work, and an interest in exploring the differences between the perspectives of managers and professionals. These interests shaped subsequent fieldwork in the centres to elaborate and refine the concepts (Charmaz, 2014). On the revisits, data were gathered through participant observation and interviews in all three centres, both individual (with two service managers and one professional) and in five focus groups (five with professionals and one with a team of service managers) sampling the groups of professionals least represented in the first stage of field work, public health nurses and physiotherapists.

The material was organized using NVivo 11 qualitative data analysis software (Qualitative Solution and Research International, 2015). The program provided a structure that enabled a common analytical framework, searching for commonalities and differences in the material revealing issues prevalent in all three centres. The analysis identified three main issues: (a) how competence was managed in the centres, (b) the challenge of balancing interdisciplinary work and core service objectives, and (c) the spotlight effect, illustrating the impact of leadership on shaping interdisciplinary practice in the centres.

### 3 | FINDINGS

Here, we present how the managers and the professionals in the family centres understand and practice their work across sectors, aiming

to provide insights into their construction of intersectoral collaboration. We focus on three main issues: managing individual and collective competence, core objectives, and the spotlight effect.

#### 3.1 | Managing individual and collective competence

The family centres included different professionals such as public health nurses, physiotherapists, special education teachers, kindergarten teachers, and psychologists. Many of them held specific qualifications such as family therapy, nutrition, trauma, or specialization in parent training programs. Service managers and professionals were concerned with how these resources should be used in a way that not only worked across services and sectors but was also interdisciplinary.

The three centres in this study all included services that belonged to different sectors in the public service system, the health sector, education sector, and the child welfare sector (Table 1). Each sector has specific legislations, regulating their mandate and mandatory assignments. The services included in the centre differed, FC1 was the only one that did not include child welfare services, and FC2 included mental health services. Although all three centres in this study were defined as a part of the public services in the municipality, only one of them (FC3) was defined as a unit within the municipality's organizational map. Thus, this centre had a budget post and a director with the authority to make decisions on behalf of the centre as a whole. The director led a team of managers, each in charge of a service within the centre. The other two centres, FC1 and FC2, did not have a director and were led by teams of service managers. The teams had a flat structure and lead by consensus. These centres did not operate with a common budget. There was a significant difference between the centre with a director and the centres led by the service manager team when it came to the flexibility of the use of the centres resources. The director of FC3 held monthly meetings with the service managers focusing on their assignments in relation to economics and available competence, establishing common accountability and where necessary redistributing resources within the centre.

In the two centres without a director, the resources in the centres were perceived to be the individual responsibility of the relevant service managers. However, this was an area several of the service managers felt that they fell short. One of them explained, "I do not think we have fulfilled

**TABLE 1** Management structures in the family centres

			Health sector	Education sector	Child welfare sector
Family centre 1 (FC1)	Team of service managers	Children and family* Psychological pedagogical services Child welfare services	X	X	X
Family centre 2 (FC2)	Team of service managers	Health care services for children Psychological pedagogy services Child welfare services Mental health	X	X	X
Family centre 3 (FC3)	Director	Team of service managers	X	X	
		Health care services for children Special pedagogical help Physiotherapy and occupational therapy Family projects**	X	X	

Note. St.dev = standard deviation.

\*The service consists of health care services for children and psychological pedagogy services.

\*\*Focuses on integration and Norwegian language training.



the expectations of leadership held by our employees. I especially think about our inability to utilise the competence and commitment we have around us" (Manager FC2). For these centres, some service managers felt that the capacity to take a holistic perspective about the centre's collective competence was undermined by the way the centres were organized.

Competence was understood in different ways by the service managers. Some talked about competence as a skill held by an individual primarily gained through formal education or training. The managers who talked about competence in this way did not favour interdisciplinary teams as a way of delivering services but rather so referral to other areas as the way to provide services. "Why do we need a [interdisciplinary] team, if we know where the door [to the other services] is?" (Manager FC2). These managers were concerned that collaboration, which was time-consuming, undermined the delivery of services. Instead, they wanted their employees to collaborate across sectors only when it was useful and efficient and typically using referral rather than through interdisciplinary working. The manager team in FC1 described the centres mainly as "a setting to distribute information and develop common routines" (Manager FC1) rather than a setting to engender interdisciplinary working. Other managers talked about competence mainly as something the professionals developed over time through interaction with each other. They saw interdisciplinary work across services as an opportunity to build a collective competence that amounted to more than the aggregate of individual competences. "They need time, working like this [in an interdisciplinary team] is almost an education in interdisciplinary work, they have developed a way to work with families that feeds back to the other services in the centre" (Manager FC1). These two different ways of viewing competence were also apparent in how they planned competence development; some argued to prioritize individual qualifications, whereas others argued to focus on competence development as a collective process.

The team of service managers in FC2 spent a lot of time debating how to prioritize the further development of the centre's activity. They often referred to the professionals as "yours" or "mine," signalling which service and sector they belonged to. One example of this was a physiologist that used to be defined as a common resource in the centre, but was now "pulled back" and placed in a regular position within the ordinary service. "I am responsible for her, she is under my jurisdiction, so I had to be sure I could justify how we used her" (Service Manager FC2). The other service managers disagreed with this decision but had no way of stopping it happening. These ongoing discussions were seen as valuable by the service managers as they provided them with insights into the other services in the centre. Even though the discussions were seen as valuable, one service manager stated on several occasions that she thought the centre would have been better off if there had been a director. Because none of the service managers held the authority to make a decision on behalf of the centre as a whole, it was difficult to find resources for interdisciplinary collaboration and development of common holistic practice across services. The tension between the different views on interdisciplinary collaboration resulted in interesting discussions, but because they needed consensus to decide a way forward, they often chose to do more of what they were already doing.

The intersectorial work in the centres was described by many professionals as "a balancing trick" that involved trying to find a way to be

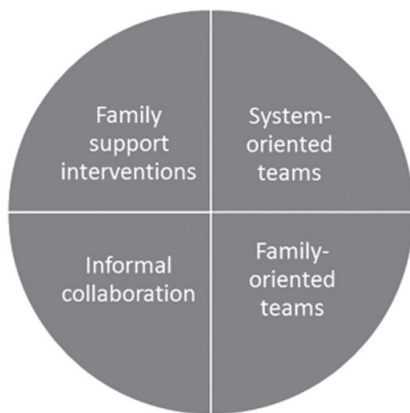
both confident in their own competence and open to the perspectives of other professionals. The professionals with experience of working in teams saw teamwork as an opportunity to broaden their experience. Working together over time, the professionals developed a common competence, a foundation for their work with the families. Even though they saw this common foundation as a strength, they were apprehensive about becoming generalists; there was a fear of this constraining innovation. This was also a concern expressed by some of the service managers. Diversity was seen as key resource; if everyone brought the same perspectives to discussions, then the collaboration lost momentum. Some of the professionals who had been working in the system for many years held a broad competence that reflected far more than their formal education. However, they were very attentive to being overconfident and working beyond their area. "I have to remember I am here with my special education hat on; that is the area I am supposed to take care of" (Professional FC3).

### 3.2 | The core objectives

The professionals and the service managers seemed to divide the work in the centres into two types of tasks, intersectorial collaboration and what they described as *the core objectives*. They saw intersectorial collaboration as crucial for developing a high-quality family support service. At the same time, this part of their work was under constant pressure of being squeezed out. One of the professionals working in the children's health care service said, "We have no choice; we have to do our real tasks first. They are statutory, not optional" (Professional FC1).

The service managers in all three centres found balancing the core objectives and the intersectorial collaboration challenging. Both service managers and professionals described prioritizing core objectives, the part of their work that was defined by legislation and guidelines with specific reporting requirements and deadlines. If they did not fulfil these requirements, they were considered to be in breach of their duty. Health promotion work across sectors were also a part of their mandates defined by national policy. Still, there were no regulations or guidelines that defined how these policies should be implemented in practice, and there was no system to evaluate if the municipalities met these requirements. Exploring the intersectorial collaboration, we found four main types of collaboration (Figure 1): family support interventions, system-oriented teams, family-oriented teams, and informal collaboration. The four types were present but differently stressed and developed in all three family centres.

FC1 had an intersectorial team that worked with families with preschool children to help them find ways to tackle their challenges before their issues grew too large. The team, which had been functioning for a decade, had stable resources and was well known in the municipality. In addition to this, the service managers now wanted to establish family support interventions that were not related to a specific target group but could be used by the different services in the centre. Even though the service managers agreed that this was a good idea and had undertaken extensive discussions it had not yet been implemented. The imbalance in the level of regulation between the core objectives and the intersectorial work seemed to make it difficult for the services managers to make decisions favouring the latter



**FIGURE 1** Four types of intersectorial collaboration practiced in the family centres

approach. In addition, several of the professionals lacked motivation to alter their own practice.

Another example of this challenge was apparent in a discussion between two service managers in FC2 who wanted to initiate a universal intervention in the public schools to promote children's mental health. The intervention would require efforts from professionals in the two sectors and schoolteachers throughout the municipality. The two service managers both saw this intervention as relevant to their mandates, but it would require moving resources. One of them was very enthusiastic about the idea, whereas the other one was more reserved. It was mainly the timeline that they did not agree upon, as one wanted to start right away but the other did not see how that would be possible.

Collaboration across sectors was understood, by many of the professionals, as something that came on top of their existing workload. The professionals were torn between fulfilling the legally required tasks described in strict guidelines and the less distinct areas described in their mandates. A public health nurse described how they were striving to meet conflicting expectations:

*We go a bit outside of our mandate—well, not our mandate, but the guidelines. We are starting these guidance groups, and we believe that to be a strength for the parents. However, they are constantly adding more tasks to our “not optional” list. It does not add up.*  
(Professional FC2)

Several of the professionals perceived the guidelines as a job description rather than viewing their work to a broader mandate. Several of the service managers talked about the need for a different perspective. Inspiring the title of this article, one service manager said her dream was that all the services working with children and their families would join forces and take shared responsibility for all children, rather than focusing on individual cases. “We need to think about all the children in our municipality. It's our children. We need to see everything in relation to them” (Service Manager FC1). A service manager in FC3 argued that now was the time to reinterpret the mandates.

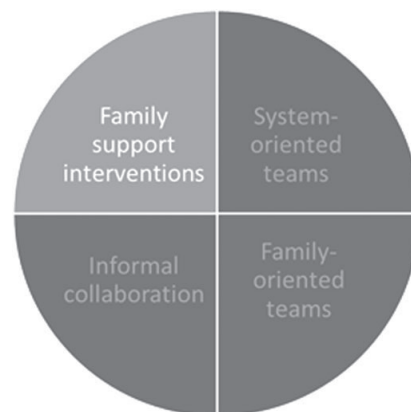
*We need to use our position to look at our assignments, redefine them, how we think about them, and how we distribute them. What we should do in a centre like this is to look at how we can solve the tasks together.*  
(Service Manager FC3)

Some of the professionals defined intersectorial collaboration as a vital part of their job and a primary motivation for working in the centre. They saw the short communication lines between the different services as an opportunity to provide support for the families at an early stage, thereby preventing escalation. “I think we can replace some of the individual work, where we often meet one child and a parent, with group sessions. I even think it might be better in some cases” (Professional FC2). Even though they saw this as an important part of their work, they often felt that their efforts in this area were not valued as much as the core tasks.

*If someone, for example, takes a leave of absence, we become short-staffed. Then the cut is always taken from the resources assigned to the interdisciplinary prevention work. It could have been the other way around.* (Professional FC1)

### 3.3 | The spotlight effect

Both managers and professionals were concerned with the challenge of keeping momentum for their intersectorial collaboration. Simply establishing routines, teams, and interventions was insufficient, as such structures could easily erode over time. Exploring the collaboration across sectors within the centres, we found a spotlight effect (Figure 2). This effect was created by service managers focusing on one specific type of collaboration by initiating projects, arranging seminars or allocating new resources. The spotlight focuses attention on a particular issue or area thereby encouraging intersectorial working, where the professionals work together to solve an issue or develop a service. At the centre of the collaboration was the families' perspectives. The professionals were constantly considering how their own



**FIGURE 2** The spotlight effect [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

competence could be a resource as part of holistic approach rather than asserting single competing sectoral perspectives. "This is what makes my job interesting, to be allowed to contribute with my ideas, and to see them develop" (Professional FC1). The structure of the centres, where services from different sectors were brought together to support families, provided the professionals with a frame that made sense to them.

The service managers seemed to be able to create change by agreeing an area to light up. In one of the centres, the team of service managers devoted significant resources to develop parent training programs. Teams consisting of professionals from different sectors in the centre were brought together in pairs to lead the programs making it possible for the centre to offer a wide range of interventions supporting parents in the municipality. The service manager of the child welfare services in the centre explained,

*I am proud of the development of the different family support actions we have managed to establish together. I am convinced that we could not have done this alone, especially when it comes to the efforts directed towards parents. This has been made possible by collectively prioritising competence development, both by selecting the same programs and implementing them together.*  
(Manager FC2)

The challenge lay in what happened outside spotlight. When the service managers steered the light to one type of intersectorial collaboration others were left in the dark. The opportunity cost of prioritizing family support interventions meant less focus on the overall system in the centre. This pattern was apparent in all three centres. When one type of intersectorial collaboration was highlighted, the other three types of collaboration became less functional, and established routines and practices eroded. One example was a family-oriented team that had not held a single meeting for 6 months; meetings were cancelled due to low participation and a lack of referred cases. When asked about the meetings, the professionals explained that although they were useful, they could not find the time or that they tended to conflict with other obligatory meetings. The service managers confirmed that they had not discussed the importance of these meetings for a long time.

It seemed to be easier to set the spotlight on formal settings for collaboration rather than informal collaborative efforts. Informal collaboration was considered an important part of interdisciplinary work, but the professionals varied in recognizing that co-location provided greater opportunities for this form of collaboration. The teams of service managers in all three centres emphasized that informal collaboration was vital for ensuring high-quality services. They attempted to bring the sectors closer together through arranging coffee meetings and organizing development programs although this had little impact on practice. Instead, informal collaboration was far more dependent on individual initiative.

Observing the professionals at work revealed significant individual differences in commitment to collaboration across sectors. Having interdisciplinary collaboration when defined as a part of one's job, such as belonging to an interdisciplinary team, seemed to promote

broader informal interdisciplinary collaboration. Formal collaboration provided professionals with a network of colleagues from other sectors and a common language across sectors. This enabled professionals to draw on informal contacts with other services and to communicate more precisely about families' challenges and possible solutions.

## 4 | DISCUSSION

The findings show the importance of both leadership and management structures in facilitating collaborative interdisciplinary practice when different services are co-located. Lacking a centre director and a common budget, it was challenging to achieve the potential of interdisciplinary working promised by co-locating family support services. The flat structured service manager teams became discussion groups rather than enacting a collective strategy. This managerial form relied on consensus to make changes, which was challenged by substantial differences in commitment to collaboration between the different services. The service managers were primarily accountable for the tasks defined for their sector, thus prioritizing these core objectives above interdisciplinary activity. If new proposals for interdisciplinary collaboration were not compatible with their interpretation of their sectoral mandate, they were inclined to refuse to participate. Without clear leadership professional's ability to take initiative in collaboration across sectors, both formal and informal was limited. This was contrasted with the approach in the team of sector managers led by a director, who held the authority to make decisions. In this team, all the participants were expected to contribute to the development of the centre, whether such activities fell within or beyond their sector. The result was that the sector managers felt accountable for the collective service delivery from the centre rather than clinging to their own sectoral responsibilities.

These conflicting perspectives in the flat structured team can be seen as an expression of the absence of an agreed conception of the centre's aim and the relevance of service integration. The importance of addressing such concerns is highlighted by Boston and Gill (2011) in considering accountability in working across organizational boundaries. They illustrate the different degrees of integration using a model defining a continuum from co-existence to full collaboration. The highest level of collaboration is defined by characteristics such as shared responsibility, shared practice, and having a common goal. They argue that a key design issue for work across organizational boundaries is intensity and that this has to be related to consideration of scope. They define scope as having seven dimensions: duration, focus, societal reach, vertical reach, horizontal reach, breadth, and orientation and purpose. Discussions about these factors in the centres were rare according to the professionals' accounts. In the *Family's House Model* (Adolfson et al., 2012), such discussions are considered essential to constructing the house's foundations, a necessary prerequisite for a sturdy house. If the purpose of the collaboration is to align activities to ensure that they do not conflict, this requires a lower level of intensity than simply developing new shared practices. The service included in the centres are from different sectors each of which is strictly regulated by legislation. There is a risk that such requirement

undermine the reflexivity about professional practice that creates opportunities for change.

Professionals working in interdisciplinary settings valued the multivoicedness of discussions. In line with the findings of a study of multidisciplinary teams working with children and families in the UK, professionals in our study seem to experience a culture that contained difference (Frost et al., 2005). Engeström (2001) highlights the need to negotiate a shared objective for a group's common activity while at the same time acknowledging particular activity systems related to the individual sectors. Through keeping the connection to their sector but transforming their objectives, an opportunity to develop new practices is created. Engeström frames development of new interdisciplinary practices as a collective learning process, using the term *expansive learning*.

*In expansive learning, learners learn something that is not yet there. In other words, the learners construct a new object and concept for their collective activity, and implement this new object and concept in practice. (Engeström, 2010)*

Establishing family centres represents a policy shift promoting more collaborative and shared practice and less emphasis on core objectives and require that the professionals take part in constructing a new object for their collective activity. Dedicated time together is essential for expansive learning and thus dependent on both service managers and professionals believing in the creative potential that lies in collaboration across sectors. In these processes, it is important that everyone is equally involved in the discussion (Frost et al., 2005), to define the object of the common activity and potential solutions (Engeström, 2001). Framing intersectorial collaboration as a learning process may establish an interdependency (D'Amour et al., 2005) that motivates participants to prioritize this aspect of their work.

In the spotlight, the collaboration across services being highlighted by the service managers, there seemed to be a consensus on both the scope and intensity of the activity. Highlighting the collaboration formalizes this type of work and defines who should contribute and to what extent. This seemed to redefine the responsibility for engaging in intersectorial collaboration from an individual to shared responsibility, thus moving the activity towards collaboration on the continuum of integration. The consensus in the spotlight contrasts with the dissent in the "shadows." If the service managers did not follow up the interdisciplinary collaboration across services, it became devalued as part of professionals practice, less important than the clearly defined core objectives. When service managers prioritize some sectors and activities, there are opportunity costs (Drummond, Schulpeter, Claxton, Stoddart, & Torrance, 2015), resulting in some aspects of the centres having less functional strategies for intersectorial collaboration. It is not plausible for all of a centre's activities to be spotlighted all the time. Still, it is important that the service managers know the consequences of focusing on one area and consider the implications of not only where but also when to move the spotlight.

The professionals that had collaborated in interdisciplinary teams for a long time described moving beyond coordinating their efforts

with colleagues to developing new shared practices. Although being confident that the new practice was valuable, professionals were apprehensive about balancing the development of a common competence and still preserving their distinct approaches. Keeping their professional affiliation to their services was important for retaining competence in their fields. Engeström's (2001) theory of inter-organizational learning, the third-generation activity theory, might contribute to the understanding such processes. He suggests that different activity systems, here understood as the sectors within the centres, can work together to develop a new practice without denying or changing the activity system or sector. In this theory, the contradictions in a group, here represented by the different perspectives on family support, are seen as the driving force behind the development of new practices.

## 5 | IMPLICATIONS FOR PRACTICE

This study provides insights into the construction of intersectorial collaboration in family centres and is relevant for municipalities considering establishing such organizations, actors working in family centres, and other practitioners and service managers involved in joint work across organizational and sectoral boundaries. The results of this study emphasize the necessity of articulating the aim of intersectorial collaboration and exploring its implications. In this paper, we suggest reframing intersectorial collaboration from a problem solving approach to a form of collective learning. In framing collaboration as a learning process where none of the participants has a monopoly on the answers redressing existing professional hierarchies. The process of negotiating shared objectives may construct a setting in which the participants are interdependent and diversity in competence is valued, thus making the setting equally useful for all participants and strengthening its resilience and durability.


There is also a need to address the leadership and management structures in family centres. The absence of a centre director may undermine the opportunity to develop innovative and holistic interdisciplinary practice.

This study shows that both service managers and professionals struggle with the dilemma of prioritizing intersectorial work above traditional activities, a pattern that compromises the potential of both preventative and health promotion activities. We suggest three questions that might be useful for structuring such activities in a new way: Which parts of a sector's mandate are best delivered solely with resources from that sector? Which mandates can benefit from developing shared practice and pooled competencies and resources? Which challenges are not addressed through attention to core tasks? Answering these questions requires viewing services in a holistic context in which the centre is situated, involving other public services as well as the voluntary sector in taking part in a shared responsibility for all children (Daro, 2016). Thus, building integrated services within the centre walls is not the goal. It is the first step towards building interconnected support systems for all the children in the community, where the adults from a range of sectors and disciplines hold shared responsibility for creating a supportive environment for all children.

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**Article 4 – Participant observation**

Bulling IS. (in review) 'You don't look like a researcher' Negotiating roles in participant observation.  
*Qualitative research.*

This article is awaiting publication and is not included in NTNU Open





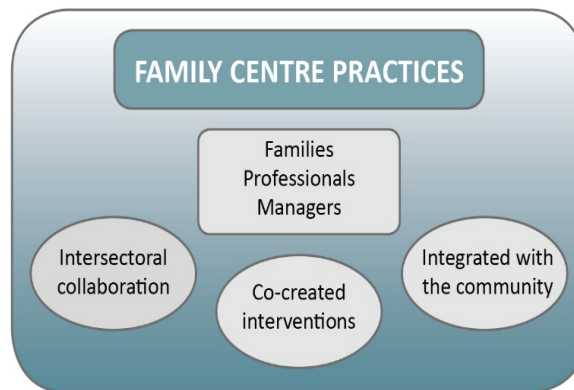


## 6 Creating accessibility in integrated family support

The present study adopted an exploratory design in which the empirical data led the analytical process. Using grounded theory, the analysis was driven by comparison across the dataset, refining ideas by both going back to the field to explore the practice and through comparing findings with theoretical ideas in the literature (Charmaz, 2014). In this chapter I present a conceptual model to illustrate how the practices in the centres are co-created and discuss the degree to which the centres are able to create accessible integrated family support services.

### 6.1 Family centre practices

In this section I present a conceptual model of practice (see Figure 1), drawing on evidence from all three family centres in this study. The model illustrates the potential of co-located integrated services to generate holistic family support that engages with the community.



*Figure 5. Family centre practices*

The family centre practices are co-constructed, by the actors; the families, the professionals and the managers. The model combines three practice categories that span organisational boundaries and aim to support families in their everyday lives. Elements from the categories were present in all

three family centres. However, there was variation, both internally and between the centres, in the extent to which they were practiced.

### 6.1.1 Intersectoral collaboration

The family centres include services from different sectors but aim to provide holistic family support. The collaborative practices in the family centres that were studied were both intersectoral and interdisciplinary. The degree of integration of the services in the centres varied, ranging from communication to collaboration on the continuum (See Article 3). There were different types of intersectoral collaboration (see Figure 2) related to different modes of interaction between the actors. In the following section, I present three types of formal intersectoral collaboration to illustrate the different modes of interaction, and how they facilitate and constrain an actor's ability to engage in collective learning processes and the development of new practice.

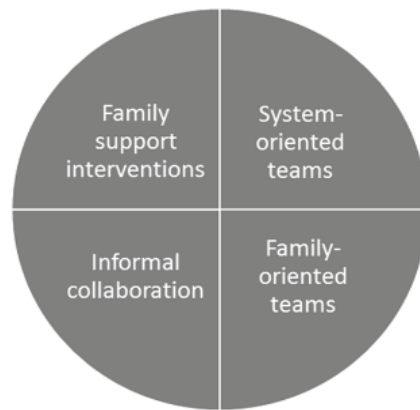


Figure 6.  
Intersectoral collaboration  
(Article 3)

#### Management teams

The system-oriented collaboration was concerned with coordinating the activities, planning competence-enhancing measures and the development of new practices. This work was primarily done by the teams of managers, and the organisational structure influenced the level of integration they were able to achieve (See Article 3). All three family centres were managed by intersectoral teams. The managers were accountable for delivering services to set targets from three different sectors of the public service system; children's welfare, education and

health. Two of the centres were led by a team of managers that adopted a flat management structure, while one had a designated director.

In the centres led by a flat structured management team, the targets were not the service delivery targets were not the managers common responsibility. Rather, each manager was accountable for fulfilling specific legislative requirements, reporting requirements, achieving deadlines and keeping within a specified budget for their part of the family centre. Deciding to implement a new initiative that involved resources from more than one of the service sectors required negotiating agreement with the other managers. However, managers could withdraw their staff members from a specific interdisciplinary team or intervention at any point without the approval of the other managers. The flat structured management teams became the setting for discussion and exchange of information, but they struggled to implement new practices.

The flat management structure hindered the development of integrated services. Even though parts of the activities in the family centres were organised across sectoral boundaries, the services were far from integrated but rather parts of a single joint organisation. The activity was trapped at a low level of integration (Boston and Gill, 2011) in the area between communication and coordination on the continuum. Managers explicit ambitions to establish common interventions that benefitted from the range of competencies in the family centres was not apparent in the decisions the management teams made, or rather did not make. The “hard factors” were not addressed and worked against the goal of developing integrated services (Boston and Gill, 2011). The family centres had adopted a flat management structure but did not address the implications of this organisational structure. The managers worked together in a formal structure but did not interact or negotiate to form what Wenger labels a joint enterprise (Wenger, 2010). A community of practice is not defined by formal structures, but through interaction in a group. For a team to become a community of practice it is necessary to move from a stated goal of integrated services to establish mutual accountability as an integral part of practice. Engeström (Engeström, 2001) highlights the necessity of negotiating a new object; a common focus that is not a replication of an aspect that is already established in one of the existing activity systems. Without engaging in these negotiations, the risk is that practices that are

already present are merely replicated with new labels, without utilizing the variety of competencies that become available by bringing sectors and professionals together in a family centre.

In the family centre that was organised with a director, as a unit in the organisational structure of the municipality, the interaction between the managers was different. Being a unit with a common budget and a designated director made the services included in the centre interdependent and promoted collaboration across sectors. The director held regular meetings about the family centre's economy, thus establishing an understanding that managing the resources was a common responsibility shared by all the service managers. This shows a higher level of accountability for a common goal (Boston and Gill, 2011) of providing integrated holistic services. In light of Wenger's (1998) concept of communities of practice, managers in this centre negotiated a joint enterprise. This led to a learning process based on engaging with the issues that the other managers struggled with; a process that changed their identity as managers. Both managers and professionals in this family centre were more inclined to say that they worked in the family centre, rather than in a specific service. This shows that they had adopted a collective identity rather than asserting an individual professional identity. When the interaction within the management team was based on interdependence and shared accountability this was more inclined to facilitate development of new practices across the services throughout the family centre.

### **Parent training program teams**

Collaboration in the family support interventions (see Figure 3) were often both interdisciplinary and intersectoral, as professionals from different services within the centre worked together to deliver a program or activity. One example of this was teams delivering parent training programs (Article 3). The teams operated on the highest level of integration, as they shared their resources and the responsibility for delivering the program (Boston and Gill, 2011).

To lead the programs, the professionals were required to undertake training. When all three sectors invested resources in training their staff for a specific program, keeping the programs running became a shared interest. The professionals that participated in the training developed a common

competence that helped bridge the gap between the different sectors. Professional jargon can hinder interdisciplinary collaboration and uphold boundaries between disciplines (Sørensen et al., 2012). Including the different professions in common training provided them with a setting where they could relate the content of the program to their specific fields of competence. Through the training they developed a common language that was applicable in other parts of their work, and this enabled more precise and efficient communication across sectors.

One of the family centres had several parent training programs and a significant proportion of their staff had undertaken training in one or more of the programs. Even though the professionals gained a common competence that was useful in other collaborative settings, the collaboration were often limited to the content of the program. This could be explained by the structure of these programs, where most of them follow manuals with detailed descriptions of topics and methods which limited the extent to which professionals could make adaptations to the local setting. Highly structured collaboration, might limit the creative potential that lies in collaboration. It might also be that the common training that adopts a very structured approach obscures some of the differences that drive collective creative learning processes. (Yasuoka, 2015) suggests that by working on a shared project, professionals from different disciplines create a common jargon that is functional for the task at hand. However, this does not mean that they understand the task in the same way; they still maintain their social world and understand the situations from their cultural context. He sees the interaction between professionals from different disciplines as inter-cultural collaboration, and ignoring this, the cultural variation is often a reason why interdisciplinary collaboration does not work. In the intersection of diverse knowledge lies the potential for creativity and innovation, however to generate this potential the goal of the collaboration cannot be to align the participants, but rather, the cultural differences should be seen as a resource and a potential driving force in innovation.

Maintaining the programs was a challenge in the family centres as usually only a few staff were trained to deliver certain programs. The consequence of one or two staff members leaving or being off sick was that an intervention could disappear. Evidence-based programs are time-consuming to

implement because the training and the competence needs to be maintained over time. Most of these programs had a structure for receiving supervision from an expert and provided settings where professionals could discuss their experience. Where a group of colleagues work in the same program in a local setting usually ensured that an intervention was sustainable and improved professionals assessments of their work situation (Patras and Klest, 2016). When there were more than two professionals working in program delivery teams it became easier to approach management to negotiate to overcome problems in program delivery (Patras and Klest, 2016). When the teams were intersectoral, this might lead to issues being lifted to the intersectoral management group earlier than when a program was 'owned' by one service. As the activity in the family centres increased, the task of coordinating the different initiatives became more challenging. Often teams did their own scheduling outside the family centre's timetable. Even though the programs were run jointly, with shared resources and shared responsibility, these initiatives were not necessarily well integrated in the family centre. A lack of information about program plans and content resulted in unequal access for families (Article 1). Access was dependent on an individual professional's knowledge of the programs. If the professionals did not know about a course, the parents they supported could not be advised to participate. Which parents received information about the different offers was not systematic and typically dependent on which professional they were in contact with. This demonstrates that a specific initiative within a family centre can have a high level of collaboration both across sectors and disciplines, without this necessarily ensuring that the services in the family centre are well integrated. It appeared there was a risk that focusing on specific activities distracted from the challenge of building an integrated family support service that promoted collective learning and the development of new practice.

### **Family centred teams**

In the family oriented teams professionals worked with families to find a way forward in challenging situations. The teams sought to map the situation and intervene before issues grew large. The teams were interdisciplinary; the professionals represented different parts of the public sector, and often collaborated with services outside the family centre. One of the teams had developed a practice



with a low threshold to making contact, a strong focus on families assets and a culture of interdisciplinary collaboration that enabled the team to support the families through a wide array of issues. The team was composed of professionals working in different parts of the family centre, representing diverse professions, services and sectors. The practice in this team was different from the way they worked in their respective sectors (Article 3). This was related to both the way they interacted with families and how they collaborated with other professionals within the team.

In this team families took an active role in mapping issues, analysing the situation, deciding on a way forward and putting a plan into action (Article 1). Working with the families as active partners makes it more likely that they will follow the initiatives that are planned (Daro et al., 2007). The team acknowledged the families as experts in their own lives and negotiated a way forward that was adapted to their capacity and available resources. To ensure that the parents received support while keeping their autonomy, required a reorientation of the professional role; from expert to collaborator. Working this way can be seen as challenging by professionals as it may be seen as undermining their professional competence (Hanna and Rodger, 2002). The family oriented teams developed practices that embraced a wide array of competences drawing on the competence and experience held by the families. Acknowledging family competence required professionals to share the power of being the experts with the parents. In return they gained trust and their advice was more likely to be followed.

As important as assessing barriers for accessing services, is assessing the applicability of the advice or intervention to the families everyday lives. The non-judgemental attitude of the professionals created trust (Edland-Gryt and Skatvedt, 2013), which made it easier for parents to be honest about how they experienced the changes and what they thought should be done differently. Through collaborating with the families, rather than providing advice on how they should parent, the team often created strategies that combined the efforts and resources from the professionals and the families. This made it possible to create holistic initiatives at an early stage; the strategies chosen were seen as realistic and viable by both parties and often the issues became less problematic after a relatively short time.

## EXPLORING FAMILY CENTRES

The professionals described the interdisciplinary collaboration within the teams as a balancing trick (Article 3) that aimed to combine being open to other professionals' perspectives while keeping the distinctive character of their own discipline intact. If they lost the diversity in the group by becoming too alike, they would lose some of the dynamic that made broad and creative discussions possible. They did not strive to become alike, rather they aimed for a culture where they could contain the differences, and allow professionals to change their practice to differing extents and on different levels (Frost et al., 2005). A significant part of their collaborative practice was to allow for different perspectives and ideas in the exploration of an issue. However, at some point they had to agree to a collective course of action that pooled their competence to secure the quality of a chosen intervention. This way of working allowed them to keep their professional identity and at the same time take part in creating new ways of supporting families. This can be seen as a process of expansive learning, where they maintained their affiliation to their primary activity system (Engeström, 2001).

To establish a culture for containing the differences in the team and yet allow for creative collective learning processes in the intersection between different areas of knowledge, the teams needed continuity. The formalised frames for collaboration was important. Having the teamwork as a defined part of their work description raised the status of intersectoral work, which was continuously under pressure from the core objectives (Article 3). This also meant that the same team members came to meetings and followed sets of parents as opposed to having a structure where each services had a different representative that might change over time. The status of the work in these teams was defined by the managers, when they set the spotlight on the work by earmarking resources from all three sectors (Article 3). Without the managers focus on this as a vital part of the family centres activity, the teams would quickly erode leading to low participation, a lack of referred cases and cancellation of scheduled meetings.

### **Informal collaboration**

Co-locating services from different sectors does not ensure integration, the services can exist side by side with little or any contact between them (Barsanti and Bonciani, 2019; Scheele and Vrangbæk, 2016). However, in the family centres in this study I found that the shared spaces prompted informal collaboration between professionals in different services (Article 1). Sharing a lunchroom or meeting for morning coffee created opportunities for informal discussions about the family centres as a whole and specific challenges and particularly difficult cases. The professionals that did the observation or got a request from a family asked permission to consult colleagues (Article 1). These conversations often led to collaboration across sectors and enabled the professionals to act early on issues that the families were concerned with. The issues discussed ranged from worries about a child's persistent skin rash, to a mother with suspected postpartum depression. Often, the discussions led to responding to the family the same day with an idea of how to move forward. This could be something the parents could do at home or a plan to follow up the issue from the family centres.

With more complex issues, professionals would ask their colleagues to join a consultation or come visit the open kindergarden so that they could meet the family. This often resulted in an appointment in the near future with the professional with the specific competence on the issue, for instance a psychologist or a physiotherapist. These informal collaborative practices were dependent on the professional's flexibility (Bronstein, 2003), and willing to make requests that did not follow established routines. Informal collaborations were often initiated by individuals that were highly motivated to pursue interdisciplinary working (Article 3). They were dependent on finding allies in other parts of the family centre to generate flexible solutions. Experience with intersectoral/interdisciplinary work influenced the level of informal collaboration professionals took part in (Article 3). When the professionals collaborated with other parts of the service system as a formal part of their work, they were more likely to make contact across sectoral boundaries outside formal settings. Engaging in formal collaborations provided professionals with insights in to the competence

and practices in other services (Articles 1 and 3). Knowledge about other parts of the family centre, combined with experience of joint working promoted contact across service and sector boundaries.

The flexible informal collaboration across sectors represents an important way to ensure accessibility to the right level of support for parents. However, several professionals postponed making contact with other services, either because they were worried that the issue they were concerned with was not severe enough for the other service to act on, or that resources would not be available. Instead of allowing the professionals with specific competence to assess what they could contribute barriers were created based on predefining the outcome of making contact. This is an example of the efficiency threshold; professionals stopped making an informal request because assumptions about available resources in another service, rather than on the needs of the family (Jacobsen et al., 1982). If informal collaboration is an individual responsibility it becomes fragile. Low levels of informal collaboration in the family centres weakened the potential that lies in co-location of services.

### **6.1.2 Co-created interventions**

The family centres aim to offer easily accessed services to support and strengthen parents in their role as caregivers (Adolfson et al., 2012: 18). Norway has a longstanding tradition offering universal health care services to all children. While health care centres initiate maternity groups including group consultations their services primarily meet with one child at the time. The open meeting places represent a different approach to supporting families, facilitating both access to professional advice and kin support. In the following section I describe the distinct character of these interventions and illustrate how parents and professionals negotiate their roles through collective learning processes.

#### **Universal services and thresholds**

Including children's health care services within the family centres ensures contact with almost all families in the local community. The health care services are universal and offer a program that

consists of individual and group consultations following all children from birth to the age of five<sup>1</sup>. The aim of the program is to support parents and children, promote children's physical, mental and social development, prevent neglect and abuse as well as detect developmental anomalies at an early stage. The parents in this study described health care service as a place where they could ask questions about things they were worried from staff they trusted and thought were competent (Article 1). However, several of the parents stated that they had not raised the issues they were concerned with when last visiting the health care service, due to limited consultation time. The public nurses working in the health care service were also concerned with rigid guidelines. The time with the families were to a large extent predefined, thus there was little scope to adapt the sessions to the diverse needs of families. Frost and Dolan (2012) emphasise the need for reflective practice when working with standardized programs while acknowledging the benefits and challenges associated with such interventions. The universal services provided through the health care service creates a contact point between the public services and almost all families. However, if some of the families do not feel they can raise the issues they are concerned with due to limited capacity, they may not get access to the support they need. Therefore high participation rates in standardized programs might obscure barriers to accessing the right level of support for some families. This suggests that even though families are in contact with the service system the registration threshold is still present (Jacobsen et al., 1982).

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<sup>1</sup> The children's health care service is regulated through legislations and guidelines recommending the service to offer a standardized program that includes 14 consultations including one home visit (The Norwegian Directorate of Health, 2017)

## EXPLORING FAMILY CENTRES

The rigidity in the standardised program contrasts with practice in another part of the family centres: the open meeting places. The open meeting places did not have guidelines that defined the activity or targets that had to be met but instead were perceived as dynamic mechanism to respond to the needs of the involved families (Article 1). The open meeting places were seen as low threshold services by both professionals and families and while there were still some barriers present, the setting was perceived as accessible (Article 1). An important characteristic of this mechanism was the low level of bureaucracy. There was no mapping of the families' situations prior to attending the meeting places and no referrals or registration was required to gain access.

Traditional services provide interventions to prevent disease or loss of health or to address a problem that is already present. The open meeting places by contrast adopted a broad health promotion approach that aimed to contribute to building supportive environments for children to grow up in (Barry, 2001; Barry and Jenkins, 2007). The focus of this approach is on the assets and capabilities families bring with them and adopts an approach that brings families together without requiring them to define a purpose or aim for their participation. The lack of requirement to formulate an issue and being allowed to come to the open meeting place without defining specific outcomes opens the setting to a diverse group of families. Participating families in this study represented all parts of the community and this was seen as an asset, both by the professionals and the parents (Article 1). All children were assumed to benefit from collective investments and children were not singled out for concern based on a belief that only poor parents required help (Daro, 2016b). This is not an intervention targeted at high risk families and the broad representation of families using it, marks out the open meeting place as a universal intervention. Even though every family does not make use of the open meeting place, all families are equally welcome.

The meeting place was a setting that brought families together and kin support was an essential part of this practice. Facilitating contact between parents was an important part of the professional's work. At the same time, they gave advice and counselling on topics that parents identified. To ensure access to support on a wide array of topics the meeting place was visited by professionals from other parts of the family centre. Most parents found this service useful as it meant they did not

have to make an appointment in order to address issues that concerned them. The parents got direct access to people with expertise on the issues they were struggling with and the informal tone of the conversations and the context made it easier for them to ask questions related to their situation. This approach to the service lowered the registration threshold (Jacobsen et al., 1982).

The professionals who attended the meeting place sometimes gave a short talk on a topic permitting parents that did not feel like making contact directly could be passive recipients of information. Questions raised by one family were often relevant for other participants. Being together in a group lowered the competence threshold (Jacobsen et al., 1982) as it did not require parents to formulate questions individually in order to access information. Some parents needed more support than could be provided within the setting of the open meeting place. For these parents' professionals gave advice on where to go or who to contact in the other services in the family centre. The parents often established a special relationship with one or more of the professionals working in the meeting place and therefore allowing themselves to be guided through the system this way felt safe. For the families that needed more extensive support than could be given from one service alone they felt it easier to accept the referrals when it was presented by the professional they already had a relationship with (Article1). This approach framed the professionals as guides, leading parents to the parts of the service system that had the capacity to help them.

### **Community of professionals**

The professionals working in, and connected to, the meeting place participate in their own communities of practice. These communities are informal; the members communicate over cups of coffee in the kitchen and interact in hallways on their way to work tasks. However, the ideas that are developed through these conversations are brought to formal settings including staff meetings, interdisciplinary teams and manager meetings. The communities of practice are not the same as formal interdisciplinary teams, rather they are the product of informal alliances entered into by professionals that find low threshold settings interesting and want to develop practices in these settings.

## EXPLORING FAMILY CENTRES

The professional's role in the meeting place is different from the professional's role in traditional services. The work is more about facilitating interaction between families than answering questions or providing advice. This requires a different way of working, and professionals visiting from other services often find this practice challenging. When observing the professionals connected to the meeting place, it seemed like some were insiders and others outsiders; some knew the code and others did not. This might be explained by Wenger's concept of communities of practice. In communities of practice, the negotiation of what it means to be competent is a collective activity (Wenger, 1998). The participants engage in developing ways to solve issues, as well as considering how they think about issues and their practice. Those professionals that did not participate in the conversations about the setting, the parent's situation and the professional role did not act as professionals within the context of the meeting place. Their professional identity was dominantly shaped instead by a different context, for instance consultations in the children's health care service (Article 2). Such professionals become outsiders in the meeting place, as they belonged to a different community of practice and they enacted a different professional identity (Wenger, 2010).

Working in settings like the open kindergarden meant taking on a different role as a professional. Instead of working with one family at a time, there might be 6 parents around a table taking part in a conversation. It was a challenge to work with a group of families at the same time, and it was the families that set the agenda for the conversations. Professionals that did not share their knowledge about children's development, health and risks, felt they did not contribute. This meant that if one of the parents asked a question there were often a group of parents that heard the answer. Most of the time parents started talking and thereby set the topic for the conversation. This meant that the professionals could not prepare for the topics that would be discussed and instead had to use their existing knowledge and admit their shortcomings for topics they did not feel they could competently discuss or provide advice. Working in the open kindergarden required a flexibility and a feel for when to let the parents talk amongst themselves and when to take an active part in the conversation (Article 2).



Communities of practice are established, developed and driven by the engagement of the participants. However, how the managers tend to them is of importance. “Like gardens, they respond to attention that respect their nature” (Wenger and Snyder, 2000: 143). The communities of practice connected to the meeting place were affected by management priorities. When the spotlight (Article 3) was focused on the meeting place the communities grew and the opposite was also true. In the family centres where the meeting place was under constant risk of being shut down due to budget cuts the communities of practice shrunk. The professionals prioritized where they invested their energy. All three family centres had staff that were interested in contributing to developing new ways to support families. Moreover, they believed that there was significant potential in creating spaces where families could meet and interact with professionals in ways that was not predetermined by instruction books and manuals. However, when the meeting places were under constant danger of being closed, the communities of practice connected to these spaces lost members. In such contexts it was not prudent for professionals to invest their energy and instead sought the opportunity to make a difference somewhere else, where the spotlight was directed; a context where they were more likely to get the resources, they needed to put ideas into practice. In contrast the meeting places that were talked about as a vital part of the family centre by managers, had communities of practice with members working in various parts of the centres. The ideas developed in these communities of practice were often acknowledged by the managers, as well as other professionals in the family centre and it was these communities of practice that new members joined.

### **Community of parents**

Some of the families had several characteristics that within a deficit model could be defined as risk factors (Morgan and Ziglio, 2007): young single parents, low income, poor living conditions, mental health issues, unemployment or low Norwegian language skills. Professionals often struggle to build a relationship with families that fall into these categories (Daro, 2016a; Folkehelseinstituttet, 2016). Parent’s prior experience with the service system may undermine trust in the professionals and be one of the reasons why it is difficult to negotiate a position that can help (Edland-Gryt and Skatvedt,

2013). Making a formal request for support can be seen as risky by the parents who may be concerned at how the “system” will use their information. The open meeting places represented a totally different way of creating a space where parents could tell their stories and share their experiences. Talking with other parents over a cup of coffee while their children were playing on the floor provided a social setting that enabled many of the parents to talk about the joys and challenges of parenthood; it provided a holistic experience not explicitly focusing on the most difficult aspects of parenting. However, the conversations in the open meeting places were surprisingly revealing and honest. People from different parts of the community shared experiences and listened with interest to the stories that were shared. The conversations about parenting occurred in the middle of enacting parenting; the children shared the meeting space with the parents.

The group of parents can also be understood as a *community of practice* (Wenger, 1998; 2010). They engaged in negotiations about what it meant to be competent in the practice they shared; parenting. Wenger emphasises that participants in a community of practice are not necessarily in agreement. Rather, Wenger suggests, the tension between different ways of solving an issue drives the development of new practices and shapes the learning process. The parents coming to the meeting places practice parenting in different ways. Through participating in the setting, children and adults together, the practices of parenting changes from being parallel to becoming connected practices that are adjusted and changed in relation to each other. Participating in everyday activities shifts the dynamic of power in the group. The familiarity of the activities ensures that all the parents have some competence they can demonstrate. Even when aspects of parenting within the meeting space were challenging it was not always predictable who would cope best with the situation. For instance, parents with higher socio-economic status did not necessarily cope better with a child’s tantrum (Article 2). When faced with real situations parents started to discuss alternative strategies and acknowledge each other’s resources as well as identifying new approaches that none of them had thought of beforehand. The open meeting places were not a normative setting that sought to promote one right answer, rather the parents negotiated a set of different practices and ways to parent. This created the opportunity to change their parenting approach or to gain confidence that their existing practice was acceptable (Article 2).

### **Boundary communities**

According to Mørck (2006) different communities of practice overlap, and in the intersections boundary communities are created. The boundary communities connect two or more communities and hold the possibility for interacting and re-negotiating positions and practices (Mørck, 2006). In the space shared between two communities of practice the participants can negotiate their position from a different perspective than when standing alone. The membership in the community provides them with a sense of competence and established practice that is not dependent on them individually but rather on a collective sense of how things should be done. This does not mean that the practices are set, but on the contrary the collective experience frames an understanding and provides a starting point; a position from it is possible to negotiate and alter practice if it is appropriate.

Over kitchen tables and on play mats in the meeting places communities of parents and professionals overlapped. In the boundary communities the participants negotiated knowledge and positions. People that would not normally interact in other settings connected in the meeting places. In these boundary communities parenting practices were negotiated through a collaborative learning process (Wenger, 1998) where everyone brought relevant competence to the table. In the conversations experience was highly valued and both professionals and parents shared their own stories. Instead of positioning themselves as experts, the professionals exposed aspects of their own experience and revealed shortcomings and identified strong points.

If we understand both the group of parents and the set of professionals in the family centre as communities of practice then both communities are created around the participant's common competence and their commitment to negotiate what it means to be competent. By defining them as communities we can also describe where they have their boundaries and where the communities overlap. Through the conversations about everyday life, as parents and families, the two fields of competence overlapped. The actors shared a common interest in how parenting was practiced and in mapping alternative strategies to meet the challenges that were identified through conversations.

Professional competence and the competence produced by experience met in these boundary communities and provided the parents with the opportunity to renegotiate the ways they thought about parenting. In the boundary communities, cultural practices and different ways of practicing parenting were presented and negotiated in a way that enabled the participants to renegotiate marginalised positions (Mørck, 2006) and to create new ways of perceiving of themselves and each other.

### **6.1.3 Integrated with the community**

Bringing services together in family centres facilitates intersectoral collaboration by connecting services and professionals within the centre's walls. The risk is that the services included in the centres become concerned primarily with the activity within the centre walls and therefore make little effort to reach out to the community that provides the context of the family centre. In the following section I discuss the extent to which the family centres were active in contributing to creating a supportive environment for children in the local community.

#### **Importance of walls**

The family centres varied in the extent to which their staff had established an organisational identity (Alvesson, 2013). An organisational identity was apparent in the way they answered the phone, or described where they worked. Some staff saw their work as primarily limited to the main services they provided. They worked in the health care service or in the children's welfare service rather than the family centre. Others saw their work as a part of an integrated family support service and presented themselves as employees in the family centre. For these staff the family centre was composed of services from different parts of the service system and by bringing these together in on site required moving not only services and staff, but also moving "ideas, meanings and beliefs of a culture nature" (Alvesson, 2013: 1). When the family centres were first established there was a focus on their scope (Boston and Gill, 2011); what they intended to accomplish. Conversations about the scope of the family centre continued in the management teams and in some professional

communities of practice, however most staff members rarely discussed the aim of providing services through the family centre, or what set the organisation apart from other parts of the service system. Culture does, by Alvesson's (2013) account, guide how people in organisations think, feel, value and act even if it is not an issue that receives explicit attention. One of the main goals of the family centres was to provide holistic family support services. Without a shared culture or common goals for the activity in the family centres there was a risk that the different groups of professionals developed in a way that fragmented services rather than creating a holistic family support service.

This study shows that co-locating family support services facilitated intersectoral collaboration and the development of new practices. It also shows that there were still boundaries between services in the family centres and dissent among the staff as to how extensive the collaboration should be. This presents a barrier to developing flexible practices. According to Boston and Gill (2011) it is vital to define the *vertical* and *horizontal reach* of joint work. In the family centres some of the professionals were involved in interdisciplinary and intersectoral collaborations more frequently than their colleagues. The family centres did not have clear descriptions of how extensive the integration should be. It was unclear if the goal of the family centres was that all staff members should collaborate across services, or if having some professionals create bridges between different parts of the centre was sufficient. The lack of negotiation over the scope of the family centres made it unclear for the professionals what was expected of them in terms of collaboration. Boundaries not only define some things as outside but also specifies what is inside. The professionals that had experience from working in the intersectoral low threshold settings, like the family centred teams, were more inclined to describe themselves as working in the family centre rather than in specific services. They described collegial relationships with professionals across the centre. This can be seen as an aspect of an organisational identity; the low threshold staff felt they were part of a social group that consisted of all the staff at the family centre. The sense of being connected to a formal entity, associating oneself with a 'we' created commitment to taking an active role in the development of the organisation and its practices (Alvesson, 2013). Creating a vivid outline of the centre, building sturdy walls, could provide staff members with a sense of predictability and a frame work within which to build collaboration. Clear definitions of how extensive the integration of

services should be would make it clearer which boundaries should be weakened, and which should be strengthened.

### **Bridging the walls**

To create integrated services the family centres had to invest in developing practices that connected the professionals within the centres together. The challenge was to find the right balance between building a sturdy organisation with integrated services and supporting collaboration with actors outside the walls of the family centre. Thick walls can strengthen the services within the family centre creating interdependency and commitment, however if they become too thick they will be impenetrable, making the resources gathered inside less accessible to the actors on the outside. Both the managers and the professionals were concerned with the nature of the role the family centre should play in the local community (Article 3). Many staff wanted the family centre to take a more active role outside the centre's walls. Others seemed to see discussions about the family centre's role in the community as disturbing often justified on the basis of scarce resources.

One of the ways the family centres interacted with the community was through collaboration with local voluntary sector organisations. This form of external collaboration was organised in a number of ways. Some initiatives were run by voluntary organisations but took place using family centre facilities. By inviting volunteers to hold their activities inside the family centre, the centres contributed to broadening the range of activities for families with limited impact on their own budget. All the family centres in the study had excess capacity in their facilities, especially in the evenings and expanding the use of the facilities had low cost implications. Having a broader offer of activities meant that more families in the community could find activities they wanted to participate in. Sometimes the family centres established a collaboration that involved professional resources as well as access to the facilities.

One example of this type of activity was an evening drop in meeting place for people that needed help with their studies. The target group was pupils and students of all ages and many families with foreign backgrounds participated. The activity was run by volunteers in collaboration with a

professional from the centre that worked with different types of initiatives directed towards families with poor Norwegian language skills. Through the joint work the volunteers gained competence from the collaborating professional in how to support learning for the participants, in return the volunteers provided a form of sponsorship for the professional contributing to building trust between the families and the service system.

The evening study group recruited a different segment of the population than the language courses that were run during the day. In addition to being helped with their studies, this became a meeting place where the participants could practice language skills, get help to decipher the cultural codes of Norwegian society as well as receive guidance on how to navigate the welfare system. These collaborative practices were based on a recognition of the different competence the actors possessed. It was important for the actors to be allowed to keep their distinctive difference in the joint work. Unclear expectations often create barriers to collaboration between the voluntary sector and the public services (Solbjør et al., 2014). One of the barriers to expanding the collaboration was the difference in accountability between professionals that had the activities as part of their work and the volunteers. The volunteers were seen as unpredictable by some of the professionals who were worried that engaging in activities run by volunteers would result in a situation where the volunteers did not attend and the professionals were left to fulfil the responsibilities alone. In line with Solbjør et al.'s (2014) study the collaboration between the voluntary workers and the professionals was dependent on both formal and informal interaction. Having a formal agreement was vital, but as important, was the relationship that had been built as it had an impact on the commitment to the activity and the willingness of the actors to rely on one another.

Even though the family centres managed to provide support for families from all parts of society, there were families the centres did not reach. For this reason, several professionals wanted to work in other settings, like youth centres or sports clubs. They wanted to provide services and make connections where children and young people lived out their everyday lives, like schools. Outreach, providing services to parts of the population that did not otherwise access services, is an increasingly

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popular strategy (Grymonprez et al., 2017). A project run by the physiotherapists aimed to improve the quality of physical education for the youngest children in local schools. By providing workshops with teachers and children followed by supervision for the teachers, the competence of the physiotherapists could benefit all the children in the local community, rather than solely being directed towards the children at high risk who contacted the family centre. This represented a different way of providing services, rather than targeting at risk groups; professional competence was used to build capacity within the community. These kinds of collaborative practices aimed to build sustainable change in the community through working together and developing new practices as an integral part of the settings where people lived their lives. It was an approach that acknowledged the resources in the community and sought to add to these to create greater resilience. Such an approach is dependent on establishing a collaboration that is not forced, but builds on mutual respect, trust and a common understanding of the needs and benefits that working together to reach a common overall goal can achieve (Bloch et al., 2014).

Bridging the walls is about establishing practices that reach out to the community in which the family centre is situated to make its resources accessible to all the families in the community. Outreach initiatives hold, according to Grymonprez et al. (2017) the risk of becoming a way of managing access by defining who needs the services. The way services are provided may exclude parts of the population that need help. They argue, that these practices can be seen as compromising the essence of social work which seeks to enable the recipients to flourish (Grymonprez et al., 2017). There is a distinct difference between targeting risk groups and linking resources in the family centre to the community in a way that allows families to access support on their own terms. This study shows that many of the families that take part in the activities in the family centres would not have been included in a targeted intervention. However, both targeted and collaborative interventions that drew on the resources of the family centres contributed to supporting families in situations they found challenging (Articles 1 and 2). When professionals managed access, instead of establishing practices of accessibility (Grymonprez et al., 2017), they risked excluding people that brought valuable resources as well as excluding people in need of support from the service system. It is important to assess the broader societal meanings of these

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types of interventions to understand how, we can construct supportive structures that engage with the lived experience of families and communities and take in to account the opportunities for accessing community resources through collaboration (Grymonprez et al., 2017).

### **Co-creating a supportive environment for all children**

Many of the collaborative practices in the family centres included the families as active partners in providing family support. Even though there were examples in all three family centres of bridging to the local communities, this practice was the least widespread. The resistance against increasing outreach activity was, to a great extent, linked to resources. From the professional's perspective they did not have the capacity to add more work. Those professionals who sought collaboration recognised the challenge from a different angle. For these professionals, rather than framing their practice in terms of resources or additional work they talked about the possibility of making a bigger impact by redefining their practice.

Commonly it was small changes that moved a practice from being internal to engaging in building supportive environments outside the walls of the family centre. One example of this was a family centred team who wrote a monthly column in the local newspaper. The topics they covered were diverse from children's upbringing, divorce to managing grief or bullying. Through writing in the local paper the professionals hoped to contribute to reflection and conversations at workplaces and over kitchen tables across the community. They wanted to share their knowledge and experience, not to lecture people, but to motivate them to reflect on their role in children's lives, and how they could make a difference. Another example was an open kindergarden that used to take the children to the local beach to play walking along the river bank trail that was frequently used by the local community. During the walk, and at the beach, the professionals interacted with the people passing by, as well as the parents, many of whom stopped for a little while or sat down on benches and talked to the parents and children who were participating in the open kindergarden. Through this practice the professionals were making the local people aware of the family centres activities and linking people from different parts of the community together. This approach did not require more

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resources but instead generated new ones, because the open kindergarden was enlarged by the people joining in.

The broad approach to family support adopted by the family centres made them able to address many aspects of family life. However, I argue that there remains untapped potential in the local community where they are situated that requires more collaborative activities beyond the walls. Daro (2016b) considers universal services as essential in creating a supportive environment for all children. One of the main benefits is, by her account, that it builds on the notion that “all parents have issues and concerns and differ only in the extent of which they have the capacity to address these issues” (Daro, 2016b: 420). Another benefit of building universal services is that it demonstrates a collective responsibility towards taking care of all the children in our society. She makes the argument that we should all take shared responsibility for bringing up the children in our communities. “Raising children is a collective effort best accomplished when the obligation extends to all adults that touch a child’s life” (Daro, 2016b: 420). I find her perspectives on family support interesting, particularly when combined with the concept of *Supersetting* (Bloch et al., 2014).

The supersetting approach is a way of constructing health promotion interventions through bringing an array of stakeholders together to develop intervention-based initiatives for sustainable impact in communities. The approach is inspired by the Ottawa Charter that highlights that “health cannot be ensured by the health sector alone. Health promotion demands coordinated action by all concerned” (WHO, 1986: 2). By engaging the stakeholders from different parts of the community in co-constructing interventions, they show that it is possible to create an impact that is sustainable (Bloch et al., 2014). This way of working to improve people’s health is interesting, because it takes the complexity of health into account and emphasises that communities have valuable resources embedded in them that can be mobilized through social interaction while retaining local ownership. Creating integrated services within the centres is an important step to promote the health of children and their families. However, seeing how the professionals and families co-created family support practices in the family centres suggested the potential to broaden the scope of the

collaborative practices and bring them out in the settings where the children live their everyday lives.

## **6.2 Implications for practice**

The study shows that the family centre model has the potential to provide accessible integrated services for children and families, however, the level of integration and accessibility varied. Comparing the family centres located in different communities revealed aspects that need to be addressed when establishing and running family centres in order for them to maximise their impact.

### **Mapping thresholds**

Even though the services were perceived as accessible by both parents and professionals, there were still barriers present at all three family centres studied. The research demonstrates how mapping thresholds from more than one angle reveals a broader array of barriers. As important, the discussions in the groups of actors, professionals and parents together, inspired conversations that lead to initiatives that addressed several of the thresholds they were aware of. To fully understand the thresholds that stand in the way of participation, it is vital to get information from the families that do not attend the family centres. To ensure that all families have equal access to the services in the centre, mapping the thresholds that limit access to services should be an integrated part of running a family centre.

### **Open meeting places**

This study demonstrates the value of interventions that focus on resources and are aimed at a broad target group. The family centres have managed to establish meeting places where families from all parts of the community come together and acknowledge in the diversity of the group a variety of resources. The meeting places represented a flexible setting where the families received different forms of social and practical support. These settings connected people that would normally not interact, and facilitated integration processes. The challenge with the meeting places is to clarify

their value, as they are often the target of proposed budget cuts. In a society where being an outsider is an increasing challenge these settings can be part of the solution.

### **Defining aim and scope**

When the aims for organising the services in family centres are not clear, it becomes challenging to prioritise intersectoral collaboration over other ways of providing services. The consequence is the preservation of a fragmented service structure rather than the development of intersectoral practice. Discussions about the aims and scope for collaboration need to be initiated on a regular basis and include the staff and other stakeholders, rather than being reserved for the internal management team. The rationale behind any intersectoral activity should be communicated to management in the municipality and politicians, in order for it to be reflected in financial allocation. To create an integrated family support service, joint work needs to move from being an individual concern to becoming a collective responsibility and this requires clear expectations and framing of the collaborative work by management.

### **Management structures**

The management in the centres played a vital role in moving practice from coexisting to becoming integrated services with shared resources and responsibilities. The structures of management made a difference to the ability of professionals to develop new practice. Having a flat structured management team preserved the boundaries between the sectors rather than bridging them. The teams that became discussion groups were best able to coordinate the efforts of the family centre. This capacity was related to the responsibility of each manager to meet their respective sectors targets, deadlines and budgets. If the family centre aimed to build an integrated family support service, these challenges needs to be addressed. The findings in this study suggest that it is best to organise the centres as a unit, with a shared budget and a designated director with the authority to make decisions if there is disagreement between different services.

### **Collaboration with the local community**

Creating supportive environments for children and their families cannot be done solely within the walls of the family centre but instead requires collaboration with the community they are a part of. The collaboration should include a group of stakeholders: public services, voluntary organisations, the private sector and ordinary people living in the community. Public services are often understood as separate from the civic community and to create a sense of shared responsibility represents a change in the discourse. Change cannot be forced. Sustainable integration of health promoting actions at a community level requires a process where all parties see the benefits of the collaboration (Bloch et al., 2014). Because of the position the family centres have among a wide group of families they can take an active role in initiating a broad collaboration aiming to create an interconnected support system for all the children in the community.

### **6.3 Implications for policy**

For the family centres to reach their potential, there is a need to address how the centres are situated within the organisational and management structures of the municipalities. If the intention is to create an integrated family support system this should be reflected in overall policies, in budgets and strategic plans. It is vital that the practice in the family centres is linked to municipal public health policies as a part of an effort to address social inequalities in health (Folkehelseloven, 2011).

### **6.4 Further research**

This study documents the thresholds for participation from the perspective of the actors in the family centres; the professionals working in the family centres and the parents visiting the family centres. However, it does not include the voices of the families that did not attend the activities in the family centres. Studies that include these families could shed light on thresholds that are hidden. It might also help us understand need and opportunity for other ways of providing family support to supplement the work of the family centres.

In the family centres the parents and professionals co-create family support. It would be interesting to further explore how different stakeholders can work together to build resilience and support children and families in the community. Bloch et al. (2014) identify the supersetting approach that combines developing sustainable coordinated health promoting efforts with producing new knowledge through the application multiple research methods. Adopting this approach might offer a systematic way of mapping community resources and engaging the population in creative processes to make a difference to the lives of families and children.

It would also be interesting to use the findings from this study to explore the quantitative dataset generated by the SKO study (University of Tromsø, 2019). The project examined family centres using surveys to generate data, and includes variables on user satisfaction, collaboration, organisational structures and service quality. The SKO study has collected data from all over the country, including the three sites included in this project. Research that found ways of connecting the in-depth qualitative data from my study with quantitative data from the SKO study would help to better understand the different ways that family centres encouraged interdisciplinary working and the relationship to organisational structures and satisfaction.

### **6.5 Conclusions**

The family centres aimed to provide readily accessible family services and facilitated intersectoral collaboration. However, there was variation in the level of service integration and the extent to which activities in the centres were connected to the local communities. Centres with more clearly defined aims were better at intersectoral collaboration. Prioritizing intersectoral work was challenging for managers and professionals. It was unclear when or if such work should be prioritized over other assignments. Manager's prioritization made a significant difference to the capacity of professionals to develop new ways of providing services. This study identified that accessibility needs to be understood as more than how people come in the door. True accessibility is dependent on how families are met when they enter the family centres, how they are helped to access services and the right level of support is delivered. As important is the community outside the

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centre; if a family centre was integrated into its community this provided resilience and continues support for the families it served. The strength of the family centres was their ability to help families recognise and use their own resources, access community support and therefore need to provide only limited professional interventions. The open meeting places in the centres facilitated both access to professional advice and kin support, allowing the actors to renegotiate roles, and take part in collective learning processes. While there was evidence of community integration of family centres this was not fully developed. The full potential of family centres can only be realized if they become a central part of an interconnected support system for families and children as part of a collective effort to build supportive communities for all.

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## **Appendices**

Appendix 1: Letter of approval NSD

Appendix 2: Letter of information and declaration of consent, for parents

Appendix 3: Letter of approval for 6 months extension of project, NSD

## Appendix 1

### Norsk samfunnsvitenskapelig datatjeneste AS

NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Harald Hårfagres gate 29  
N-5007 Bergen  
Norway  
Tel: +47-55 58 21 17  
Fax: +47-55 58 96 50  
nsd@nsd.uib.no  
www.nsd.uib.no  
Org.nr. 985 321 884

Ingunn Skjesol Bulling  
Avdeling for helsefag Høgskolen i Nord-Trøndelag  
Serviceboks 2501  
7729 STEINKJER

Vår dato: 04.12.2014

Vår ref: 40736 / 3 / SSA

Deres dato:

Deres ref:

#### TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 13.11.2014. Meldingen gjelder prosjektet:

<i>40736</i>	<i>Familiens hus som arena for helsefremming</i>
<i>Behandlingsansvarlig</i>	<i>NTNU, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Ingunn Skjesol Bulling</i>

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.12.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Sondre S. Arnesen

Kontaktperson: Sondre S. Arnesen tlf: 55 58 33 48

Vedlegg: Prosjektvurdering

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

*Avdelingskontorer / District Offices:*

*OSLO:* NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. [nsd@uio.no](mailto:nsd@uio.no)

*TRONDHEIM:* NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. [kyrre.svarva@svt.ntnu.no](mailto:kyrre.svarva@svt.ntnu.no)

*TROMSØ:* NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. [nsdmaa@sv.uit.no](mailto:nsdmaa@sv.uit.no)



Utvalget informeres skriftlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet.

Personvernombudet legger til grunn at forsker etterfølger NTNU sine interne rutiner for datasikkerhet.

Forventet prosjektslutt er 31.12.2018. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:

- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette lydopptak

## Appendix 2



Til foreldre/ foresatte

14.03.2016

# Invitasjon til deltakelse i forskningsprosjektet «FAMILIENS HUS SOM HELSEFREMMEDE ARENA»

## BAKGRUNN OG FORMÅL

Gode tjenester for barn og unge er en prioritert oppgave i det norske samfunnet. For å oppnå dette har mange kommuner etablert Familie hus/ familiesenter. Et viktig siktemål med Familie hus/ familiesenter er at tjenester som angår barnefamilier skal være samlet på ett sted og være lett tilgjengelige for alle. Formålet med denne studien er å få mer kunnskap om hvordan fagpersoner samarbeider i Familiens hus og hvordan familiene opplever tjenestene de mottar.

Prosjektet vil bli gjennomført i tre familiens hus på ulike steder i Norge i løpet av 2015. Både ansatte og foreldre vil bli forespurt om å delta. I tillegg til intervjuene med foreldre, vil det bli gjennomført observasjoner ved tre ulike Familiens hus/ familiesenter og gruppeintervju med ansatte ved sentrene. Målsetningen med prosjektet som helhet, er å bidra med kunnskap om hvordan slike arbeidsformer får betydning for hvordan mottakere av tjenester og ansatte i tjenesteapparatet samhandler.

## ORGANISERING

Prosjektet finansieres av Nord universitet, avdeling for helsefag. Prosjektansvarlig er Ingunn Skjesol Bulling, stipendiat ved Institutt for sosialt arbeid og helsevitenskap. Hovedveileder er Berit Berg. Resultatene fra prosjektet vil anvendes i Bullings doktorgradsarbeid. Det er etablert et samarbeid med SKO- studien [www.uit.no/forskning/sko-studien](http://www.uit.no/forskning/sko-studien) – Samhandling og kvalitet i kommunale tjenester for barn, unge og deres familier ved Regionalt kunnskapssenter for barn og unge- RBKU Nord, ved UiT.

## HVA INNEBÆRER DELTAKELSE I STUDIEN?

Intervjuene vil foregå på Familiens hus, og de vil bli gjennomført av prosjektansvarlig. Intervjuene vil ha en varighet på 30 – 45 min. Fokus i samtalene vil være på hvordan du opplever tjenestetilbudet, hvordan du beskriver samhandlingen med ansatte ved sentret og hva du opplever som viktig i møtet med representanter fra Familiens hus. Samtalene vil bli tatt opp på lydfil.

## **HVA SKJER MED INFORMASJONEN OM DEG?**

All informasjon som du gir vil bli behandlet konfidensielt. Det er kun prosjektansvarlig som vil ha tilgang til lydfilene. Datamaterialet blir lagret på et passord beskyttet område, og det er kun prosjektansvarlig og veiledere som vil ha tilgang til lydfilene. Etter intervjuene vil lydfilenes innhold skrives ned og anonymiseres. Dette materialet danner grunnlaget for det som vil bli publisert fra prosjektet, og kun forskere knyttet til prosjektet vil ha tilgang på dette. All publisering fra prosjektet vil ha en form der det ikke vil være mulig å koble teksten til deg som person, dine barn eller din familie. Prosjektet avsluttes 01.01.2019, og da vil alle lydfilet knyttet til prosjektet bli slettet.

## **FRIVILLIG DELTAKELSE**

Det er frivillig å delta i studien. Det vil ikke få noen betydning for den oppfølgingen du får fra Familiens hus om du velger å delta i studien eller ikke. Du kan når som helst trekke deg fra studien uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli slettet.

Hvis du ønsker å delta i studien signerer du det vedlagte samtykkeskjema og leverer det på Familiens hus. Skjemaene vil sendes til Ingunn Skjesol Bulling, og de vil arkiveres i avlåst arkiv på universitetet. Informasjon om tidspunkt og sted for intervju vil komme fra ansatte på Familiens hus.

Dersom du har spørsmål til studien ta kontakt med prosjektansvarlig Ingunn Skjesol Bulling, på tlf.74212329 eller på epost til [ingunn.s.bulling@hint.no](mailto:ingunn.s.bulling@hint.no) eller hovedveileder Berit Berg tlf. 73592556 eller på epost til [berit.berg@svt.ntnu.no](mailto:berit.berg@svt.ntnu.no).

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Med vennlig hilsen

Ingunn Skjesol Bulling  
Stipendiat NTNU

Berit Berg  
Professor NTNU

Monica Martinussen  
Professor UiT

## Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og samtykker til å delta i studien «Familiens hus som arena for helsefremming»

Navn: \_\_\_\_\_

BRUK BLOKKBOKSTAVER

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(Dato, Signatur av prosjektdeltaker)



## Appendix 3

**Fra:** [Lasse.Raa@nsd.no](mailto:Lasse.Raa@nsd.no)  
**Til:** [Ingunn Skjesol Bulling](mailto:Ingunn.Skjesol.Bulling)  
**Emne:** 40736 Familiens hus som arena for helsefremming  
**Dato:** tirsdag 8. januar 2019 11:40:20

English text below

### BEKREFTELSE PÅ ENDRING

Vi viser til statusmelding mottatt: 08.01.2019.

Personvernombudet har nå registrert ny dato for prosjektslutt 01.08.2019.

Det legges til grunn at prosjektopplegget for øvrig er uendret.  
Ved ny prosjektslutt vil vi rette en ny statushenvendelse.

Hvis det blir aktuelt med ytterligere forlengelse, gjør vi oppmerksom på at utvalget vanligvis må informeres ved forlengelse på mer enn ett år utover det de tidligere har blitt informert om.

Ta gjerne kontakt dersom du har spørsmål.

Vennlig hilsen,  
Lasse André Raa - Tlf: 55 58 20 59  
[Lasse.Raa@nsd.no](mailto:Lasse.Raa@nsd.no)  
Personvernombudet for forskning,  
NSD – Norsk senter for forskningsdata AS  
Tlf. direkte: (+47) 55 58 21 17 (tast 1)

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### AFFIRMATION

Referring to status report received 08.01.2019.

The Data Protection Official has registered that the project period has been extended until 01.08.2019.

We presuppose that the project otherwise remains unchanged.

Please note that in case of further extensions, the data subjects should usually receive new information if the total extension exceeds a year beyond what they previously have received information about.

Do not hesitate to contact us if you have any questions.

Best regards,  
Lasse André Raa - Phone number: 55 58 20 59  
Lasse.Raa@nsd.no  
the Data Protection Official for Research,  
Norwegian Centre for Research Data  
Phone number (switchboard): (+47) 55 58 21 17 (enter 1)