Limited access to family-based addiction prevention services for socio-economically deprived families in Switzerland: a grounded theory study

Andreas Pfister (andreas.pfister@hslu.ch)
Lucerne University of Applied Sciences and Arts https://orcid.org/0000-0002-9242-8260
Nikola Koschmieder
Hochschule Luzern
Sabrina Wyss
Hochschule Luzern

Research

Keywords: Family-based, Substance abuse, Addiction, Prevention, Health promotion, Access to services, Identification of candidacy, Low SES, Deprived families, Hard-to-reach

Posted Date: June 25th, 2020

DOI: https://doi.org/10.21203/rs.3.rs-36684/v1

Version of Record: A version of this preprint was published on October 28th, 2020. See the published version at https://doi.org/10.1186/s12939-020-01305-1.

Abstract

Background: Families living in poor socio-economic circumstances, already confronted with social and health inequalities, are often not reached by family-based addiction prevention services. Besides quantitative models and health literacy approaches, qualitative research is lacking that could shed light on the exact circumstances and processes that lead to hindered addiction prevention service uptake by these families. Drawing on the concept of candidacy, we therefore reconstructed how socio-economically deprived parents and their (pre)adolescent children in the German-speaking part of Switzerland (non-)identified their candidacy for family-based addiction prevention services.

Methods: Following grounded theory, we collected and analysed data in an iterative-cyclical manner using theoretical sampling and theoretical coding techniques. Sixteen families with children aged 10–14 years were interviewed in depth (parent/s and child separately). All but one family lived below the at-risk-of-poverty threshold.

Results: Socio-economically deprived families' modes of recognizing and handling problems in everyday life were found to be core phenomena that structure the process towards (non)identification of candidacy for family-based addiction prevention services. Four modes anchored within socio-demographic resources were found: Families with mode A perceived their current life situation as existentially-threatening and focused daily coping on the main pressing problem. Others (mode B) perceived prevalent multiple problems as normal (now); problems were normalized, often not recognized as such. In mode C families, problems were pragmatically recognized at a low threshold and pragmatically dealt with, mostly within the family. In mode D families, problems were constantly produced and dealt with early by the worried and anxious parents monitoring their child. From modes D to A, vulnerability increased concerning non-identification of candidacy for family-based addiction prevention services. Further, thematic relevance of addiction prevention, past experience with offers, integration in systems of assistance, strategies to protect the family, and families' search for information influenced whether identification of candidacy took place.

Conclusions: Socio-economically deprived families differ in modes of problem construction and handling in everyday life; this differently opens up or closes routes to family-based addiction prevention. Addiction prevention practice should build on a bundle of diverse strategies for outreach to these families, stressing especially interventions on the structural and environmental level.

Background

Vulnerable populations most in need are often the least reached by health promotion and prevention services [1–5]. This is also the case when it comes to involving socio-economically deprived families with (pre)adolescent children in family-based substance abuse prevention programmes ([6], p. 8). Risk and protective factors in families [6–8], adolescence as a window of opportunity for shaping health behaviour [9], and effects of parental monitoring on adolescent's substance use behaviour [10–14] are well known.

Therefore, some preventive efforts are directed towards parents and families. They are named, for example, “family-based prevention programmes for alcohol use in young people” [15] or “family-based prevention of substance use disorders” [8], depending on whether the focus is on certain substances, tackling substance use disorders overall, or addressing non-substance related behavioural problems/addictions (e.g. excessive smartphone use). In the following, we use the term ‘family-based addiction prevention services’ (FAPS) to include both substance and non-substance use-related programmes.

The extent and form of FAPS can vary [8, 15, 16]. The services can be directed towards parents exclusively, whole families (children and parents), students and parents (school-based), or – beside parents and children – diverse parties, such as a wider population in a city quarter, sport clubs, etc. [16]. “[M]ost existing programs however target parents and do not include the adolescents” [8]. Many programmes do not focus exclusively on substance or excessive media use but also address and promote wider familial resources and competencies, such as parenting skills, parental monitoring, and life skills [8, 15]. The overall goals of FAPS on the universal and selective level are to prevent or delay the initiation of (substance) use, “…or to reduce the frequency or volume of use among children of participating parents” [15]. Indicated interventions intend to reduce already prevalent risky (use) patterns among children of participating parents.

That families living in poor socio-economic circumstances are not sufficiently reached by FAPS ([16], p. 6) is also a problem for equity in health in supposedly rich Switzerland. In 2018, 13.9% of the Swiss population was living below the at-risk-of-poverty threshold. Families, especially single-parent households and couples with two or more children, are particularly affected [17]. Not reaching these underprivileged families more at risk of social exclusion and future substance abuse by their children [13, 18–20] would further accentuate already existing social and health inequalities through health promotion and prevention activities. Universal policies and strategies are in demand that must be implemented at “…a level and intensity of action that is proportionate to need…” ([21], p. 6). Policies and interventions should address – and reach! – above all the most vulnerable population groups. But do we currently have enough, and sound scientific, knowledge to better understand barriers and facilitators towards the (non-)participation in FAPS by socio-economically deprived families?

Understanding access to and utilization of FAPS as health-related behaviour means that we must consult different models and theories explaining health behaviour and health services use [22–27]. These models identify and relate factors to each other that impact health behaviour and/or health services use. For instance, parents with low socio-economic status (socio-demographic factor), low self-efficacy (personal factor), and low social support in their municipality (social factor) in which there is a lack of financial resources (structural factor) will have disadvantages not only regarding their own but also their children’s health, and regarding access to and utilization of preventive offers. Access to and utilization of services is also determined by health literacy [28]. A social gradient has been identified in this line of research: Higher proportions of people with limited health literacy were found among persons with financial

deprivation who had low social status and low education ([29], p. 1053). This is also the case for Switzerland [30].

Along with these general models and health literacy research, the research on parental engagement in preventive parenting programmes is limited [6, 31–33]. Specifically for FAPS, Laging compiled the factors that influence willingness to participate in these programmes [6], differentiating between intra-family and programme organizational factors. Intra-family factors are cognitions (e.g. privacy concerns [34]), extent of family conflicts, parenting and communication styles, level of order and organization, and the influence of individual family members that are not willing to participate. Some studies found that families most likely to benefit from such programmes are less likely to participate [35–37]. On the programme organizational level, logistical barriers and pragmatic aspects (childcare, costs, transport, time, place, programme duration), gratuities for participants, involvement of schools and communities (active promotion), and programme coordination and support were identified as relevant for participation ([6], p. 10). But, due to the state of research, Laging cannot set the intra-family and programme organizational factors in relation to families with socio-economic deprivation. Up to now, we do not know how, exactly, limited access to FAPS comes about in these families. Existing models and health literacy approaches are mostly quantitative and rather static. Besides identifying relevant factors, they cannot shed light on the exact circumstances and processes that lead to families with socio-economic disadvantage being poorly reached by FAPS. Moreover, qualitative research methods are generally underrepresented in health services use research, also in exploring prevention and health promotion services [2], even though qualitative methods could be a very important add-on to existing research [38].

We posit that the concept of candidacy can aid a better understanding of (limited) access to and utilization of FAPS by socio-economically deprived groups. The concept of candidacy using qualitative-interpretative methodology emerged from a “critical interpretive synthesis” of the scientific literature and empirical studies on access to healthcare by vulnerable groups in the UK [1, 5]. The concept of candidacy draws on an interactionist and process-oriented perspective and sees access to services as influenced by simultaneously ongoing processes determined by users and health services. According to Dixon-Woods et al.:

“Candidacy describes how people's eligibility for healthcare is determined between

themselves and health services. (…) Health services are continually constituting and seeking to define the appropriate objects of medical attention and intervention, while at the same time people are engaged in constituting and defining what they understand to be the appropriate objects of medical attention and intervention. Access represents a dynamic interplay between these simultaneous, iterative and mutually reinforcing processes. By attending to how vulnerabilities arise in relation to candidacy, the phenomenon of access can be better understood, and more appropriate recommendations made for policy, practice and future research.” ([1], p. 1)

The concept of candidacy was further developed by Mackenzie et al. [39]. It has been considered useful to understand journeys of vulnerable groups not only through different kinds of health services [40–50] but also through public services in general [39]. The candidacy journey through health services consists of seven stages: identification of candidacy; navigation of services; permeability of services; appearing at services and asserting candidacy; adjudication by professionals; offers of, resistance to, services; operating conditions and local production of candidacy ([39], p. 809). The entrance gate to access services is the "process by which individuals come to view themselves as legitimate candidates for particular services." ([39], p. 809). Identification of candidacy thus plays a key role in facilitating or hindering access of (vulnerable) groups to services. Dixon-Woods et al. found that managing "health as a series of minor and major crises", potentially due to normalization of health problems within socio-economically deprived communities, affects identification of candidacy for health services negatively, especially for prevention services ([5], p. 103). Whether this is also the case for identification of candidacy for FAPS, and what other aspects and processes concerning candidacy would be relevant within socio-economically deprived families, cannot be determined based on existing research. Therefore, we posed the following research questions:

- How do socio-economically deprived parents and their (pre-)adolescent children become candidates (identify their candidacy) for FAPS in the German-speaking part of Switzerland?
- Based on what constellations and (life) circumstances do parents and children conclude (or not conclude) that information about addiction prevention, offers of help, and/or contacts to specialists (e.g. social workers) are relevant for them and worth considering?

Methods

Grounded theory following Strauss and Corbin [51] provides a well-proven set of qualitative-interpretative procedures for developing theory from data, especially in new and emerging research areas. We therefore concluded that grounded theory [51] and the concept of candidacy as a "sensitizing concept" [52] would fit our research purposes best. A completed COREQ checklist (consolidated criteria for reporting qualitative research) can be found in Additional file 1.

Data collection

From May 2017 to January 2020 we conducted and analysed 32 interviews with socio-economically deprived families in the German-speaking part of Switzerland. Following a theoretical sampling strategy [51], we alternated phases of data collection and analysis. This iterative procedure allowed us to be driven by concepts identified in and raised by empirical data and to move towards a saturated grounded theory.

Inclusion criteria and sampling procedures

To include all forms of families (e.g. single parents, two-parent families, same-sex couples with children, etc.), we defined 'family' as a social community consisting of at least one child and at least one adult, in

which the adult(s) has/have a caring role towards the child. Families were included in the study that:

- consisted of at least one child aged 10–14 years
- lived in the German-speaking part of Switzerland
- had less than 60% of the national median equivalized income (= at-risk-of-poverty threshold [53]) at their disposal

The ages 10 through 14 are formative years in developing health behaviours [9], particularly concerning first interest in and potential use of psychoactive substances [54–57]. For that reason, families with children aged 10–14 are often targeted by FAPS and were thus of key interest for our study.

The family's socio-economic status (SES) was determined by parents' income, education, and occupational status [58]. As recent research draws attention to the diversity of families with socio-economic deprivation [58, 59], using the at-risk-of-poverty threshold [53], we only defined family income as hard inclusion criteria concerning SES. In line with theoretical sampling, we included also families with inconsistencies in SES (for example, higher educational backgrounds) in order to get a fuller picture of socio-economically deprived families. Taking into account different walks of life and different backgrounds, for example in terms of family size and constellation, parents' and child's age, ethnicity, and gender, and based on concepts and questions that the analysis of previous data offered, the overall research team decided continuously what type of family to include next in the study. Drawing on grounded theory methodology, we hereby applied strategies in maximizing and minimizing contrasts [51].

Recruitment of participants

How can a population group that is already hard-to-reach for prevention and health promotion services be included successfully in a study? Drawing on methodological literature [60], we resolved that challenge by carefully thinking through effective recruitment strategies and potential biases that could arise from applying strategies (e.g. by exclusively recruiting within the social services sector).

In several German-speaking cantons of Switzerland, we (two women and one man) directly approached adults on the street that could potentially be parents of a child aged 10 to 14 or that were accompanied by a child at that age. Guided by national and regional statistics, we were present in less affluent city quarters, in front of grocery stores that are limited to people with low socio-economic status, or in front of second-hand shops. We also asked persons to spread the information among their acquaintances. Every time we visited sites and locations, we placed and distributed flyers and sensitized persons at the site for our study. Further, we recruited online, placed study information and digital flyers in Internet forums for parents, and maintained a Facebook profile. Occasionally, we collaborated with mediators from the social sector. During the research process and onward theoretical sampling, we needed to also include families that made their way to FAPS in order to be able to qualitatively reconstruct processes of successful candidacy for FAPS. We therefore presented our study and distributed flyers at a parents' evening on addiction prevention.

When both parent/s and their child aged 10 to 14 consented to participate in the study, primary information was gathered: number of persons in the household, number of children and their age, parents' educational attainment, occupational status (incl. percentage of full-time work), and monthly net household income in the household in which the child mainly lived. When families met hard inclusion criteria, and depending on the status of the theoretical sampling, the respective family was either included in the study right away or was put on a waiting list.

Problem-centred interviewing

Interviews were conducted following Witzel's problem-centred interview, which is a loosely structured in-depth interview [61, 62]. Parent/s and the child were interviewed separately. The interviews with the parents lasted on average 93 minutes (range 34 to 157 min), the interviews with the children 57 minutes (range 39 to 83 min). Prior to the interview, researchers informed parents and children about the study (goals, data handling, etc.) and both parent/s and the participating child gave oral consent to participate. Parents moreover provided written consent (also for their minor child). Parents' interviews took place either with one parent or whenever possible with both parents. Interviewed families were free to choose the place for the interview (e.g. at their home, at a cafeteria). The present authors conducted most of the interviews, mainly the two research associates. The authors are trained and experienced interviewers; they hold either a Master of Arts in Sociology or a PhD in Educational Sciences/Social Pedagogy. The interviews were conducted in Swiss German, German, or French. Two native-speaking university students in Social Work and Teaching conducted interviews in Tamil and Kurdish with non-German parents and translated the interviews into German. The students were trained and supported by two of the authors.

The interview guides can be found in Additional file 2 (parent interview guide) and Additional file 3 (child interview guide). Following Witzel's problem-centred interview technique, our opening question aimed at encouraging narratives ([62], p. 68): "I am interested in how you live. As a family, what do you do all day? What are you engaged in? Please tell me about it." We then asked the parents about their everyday life and about the child's development (incl. substance use experiences) and health. We also asked parents about their knowledge and experience regarding FAPS and other support offers. When interviewing the children, we started with warm-up questions and asked about their age, class level, and leisure activities. Afterwards, the opening question, posed in a child-appropriate manner, invited the young respondents to talk about their day and what they were generally engaged in. Then, always following child's narrative, the overall same topics were covered as in the parent interview. At the end of the child and the parent interview, we used a semi-standardized short interview questionnaire to record socio-demographic characteristics. After interview completion, parents and the child received a small expense allowance (in form of a voucher for daily products). We then noted down the circumstances of the interview (e.g. setting of the interview, interactions between interviewer and interviewee) in a postscript.

Participant characteristics

The final sample consisted of 16 families (20 interviewed parents, 16 interviewed children) that resided in rural and urban areas (incl. urban agglomerations) in the German-speaking part of Switzerland in the

cantons of Basel-Stadt, Bern, Lucerne, Nidwalden, Obwalden, St. Gallen, and Zurich. For contrasting purposes, one family was included that lived above the at-risk-of-poverty threshold [53] (see all participant characteristics in Table 1).

Data analysis

The interviews were audio recorded, fully transcribed, and coded using MAXQDA software. We anonymized the transcripts and safely stored the data on a Swiss university server. The coding strategy followed the guidelines of grounded theory [51]. As suggested by the approach, the analysis oscillated between inductive and deductive proceeding, continuously asking questions and making comparisons. We started with open coding and gradually built, tested, reviewed, and enriched concepts to answer our research questions (axial and selective coding). After coding the parents' and the child's interview, we set them in relation to each other in writing a case characterization. This helped us to understand candidacy processes in the overall family unit. Every interview was coded in minimum by two authors. Case characterizations were always discussed and reviewed by the overall research team (three persons). The concept of candidacy served as sensitizing concept [51, 52], suggesting directions along this process. At final stage of the analysis, in a daily workshop with two external social work professors and one specialized addiction prevention practitioner, we discussed and validated the preliminary findings. The aim was to discover potential blind spots in the analysis and to ensure scientifically sound results that can instruct policy and practice.

Results

Mode of recognizing and handling problems in everyday life

As the way problems were recognized and handled determined not only what was seen as a problem but also when and what kind of action was required, families' modes of recognizing and handling problems in everyday life were found to be core phenomena that structure the process towards (non-)identification of candidacy for FAPS. We identified four different modes in the verbal data:

- Mode A – *existentially-threatening*: The family's current life situation was perceived as existentially threatening. The focus of coping was on the problem perceived as existentially threatening.
- Mode B – *normalizing*: The burden of multiple problems in the family's everyday life was perceived and experienced as normal (now). Problems were normalized, often not recognized as such.
- Mode C – *pragmatic-processing*: The family's everyday life continued on, despite financial precariousness. Problems were pragmatically recognized at a low threshold and dealt with pragmatically (mostly within the family).
- Mode D – *worried*: Problems were constantly produced in everyday life by worried and anxious parents monitoring their child. Problems were dealt with at an early stage (low problem threshold).

Mode A: Existentially threatening

Some families saw their existence threatened by one main problem. A high level of financial precariousness, unsecured residence status (e.g. provisionally admitted foreigners – Permit F), or a single father's incompatibility of poorly paid shift work (working poor status) with caring for his child were such existentially threatening problems. For instance, one mother, a social welfare recipient, sometimes ran out of food: *"I said there'd be money today. I checked. It hasn't come yet. I only have 2 francs... I bought potato chips for the children"* (NH, mother, age 36).

Parents' perception and identification of a main existential burden in their daily life created a specific pressure to cope with that issue first, because it was seen as the origin of all misery: *"…you know, I think if we get a residence permit, all my problems are over"* (GAA, father, age 50). Therefore, a specific and thematic focus on action and coping was set in these families. All other issues were regarded as secondary or as a consequence of the existentially threatening problem. The families' coping and survival strategies were focused on the existentially threatening problem even though identified problems were often beyond the parents' control due to Swiss legislation, social welfare practice, and low employment opportunities for low-skilled workers. As a result, few resources were freed up for dealing with other problems and issues on a day-to-day basis. Topics in the area of addiction prevention such as substance use, media use, or parenting skills were subordinated to the processing of and coping with the situation perceived as existentially threatening. Hence, health issues and problems were only perceived (if at all) when they were very acute (high problem threshold), which turned out to be a barrier to identification of candidacy for (addiction) prevention services. Moreover, parents with this mode of problem construction and problem handling, in contrast to modes C and D, seemed to have low agency. Probably caused by multiple deprivations and problem load, they preferred support for their children and not for themselves (e.g. in order to better support their child or resolve the problem on their own). Hence, they identified more easily with offers for children than with offers for parents, which led to non-identification of their candidacy for FAPS.

Mode B: Normalizing

Some families, even though they were confronted with multiple problems in everyday life (e.g. financial deprivation, parent's mental illness, child's psychosocial problems), perceived this situation as normal rather than exceptional. Multiple problems and difficulties were constructed and perceived as part of the family's everyday life. For example, the aggressive behaviour of a 10-year-old son who had beaten his mother was framed by his mother as a kind of normal, male behaviour. Another mother felt there was no need for support (professionally or by herself) for her daughter after her ex-partner's (the girls' father's) second suicide attempt. The situation was normalized. The daughter just had *"…to go through it, he is her father, you know"* (SS, mother, age 44), the mother told us.

As demonstrated, the threshold to perceive something as posing a need for action was high. Circumstances that would be constructed as problematic in other families were not perceived that way and were therefore not relevant enough for the family to take action to change the situation. Many issues were accepted, relativized, or normalized, if they were not highly urgent, visible, and/or new to the family.

This was also the case concerning health issues. A health problem usually became an issue for the family only when it was acute and visible, for example when there were clear, acute complaints or signs on the body: *"…a little bad what I saw, she [the daughter/AP] has this thing with the… wrist cutting - I went with her to a counsellor"* (SP, mother, age 44). (Health) issues that did not become visible and a problem, that did not exceed a certain problem threshold, received little attention. Therefore, mode B was generally a barrier towards identification of candidacy for addiction prevention services. As in mode A, also here we reconstructed that the parents had low agency. If support was actually sought and received, it was mostly for their children and not for the parents in order to better support the children. This led to non-identification of candidacy for FAPS. However, by means of professional services provided to children, some children got in contact with health-promoting and life skill-oriented offers that were not family-related (non-participation of parent/s).

Mode C: Pragmatic-processing

In the families with mode C, everyday life took a more or less orderly course despite resource constraints. Issues and problems emerged from the surface of everyday family life, were noticed, and received attention. Problems and relevant topics were constantly discovered by the families, taken up pragmatically, then processed and worked through, one after the other. We therefore called this mode 'pragmatic-processing'. Conversations between parents and children were found to be a favoured strategy for tackling issues, as the following comments by a mother to her daughter illustrates: *"…and when that [menstruation/AP] comes, you don't have to be afraid, you can come to me, then we'll talk about that"* (AK, mother, age 35). Topics of prevention, also within the area of addiction prevention (media literacy, parenting skills), came into focus if parents observed a discrepancy between their conceptions and their children's behaviour, or if children brought up an issue. Thus, due to the recognizing of problems in mode C, paths to identification of candidacy for FAPS generally opened up. However, due to the problem handling strategies in mode C, identification of candidacy with addiction prevention services in these families often did not come about. Why? The dominant mode of handling issues and problems found in these families was: 'We'll find a solution by ourselves'. These families drew a clear line between inside and outside the family. They relied on themselves and their private network when resolving problems. Equipped with high agency and overall high problem-solving capabilities, these families had a high problem threshold before accepting (professional) help or service offers from outside the family, also concerning FAPS. But the data material showed that also pragmatic-processing families could identify their candidacy for addiction prevention services. Parents who saw it as a matter of course to participate in parents' events and who were firmly integrated in a (help) system, e.g. were part of a parents' council, attended educational and information events for parents regardless of the topic (see ' Experiences with offers and integration in systems of assistance' below).

Mode D: Worried

In families with mode D, relevant topics and (possible) problems were regularly produced in everyday life. This was due to the parents' worried and sometimes anxious approach to reality and daily living. In one

of the interviews this became evident in that the mother mentioned her worries over 17 times (e.g. worries about her son's safety, his emotional sensibility, or his future). The duality of worrying and caring for children is apparent with these parents; as one mother puts it: *"Well, I am rather the worried mother, I try to prevent all kinds of things"* (KG, mother, age 34). These parents monitor their child intensively in order to promote the child's psychosocial development and to provide the best possible future for their child.

The way that problems were actively constructed and produced within the family was the reason why even if (possible) problems were not yet present, or the problem threshold was low, these parents – in our verbal data, mothers – by definition were very sensitive in everyday life and had an impulse to act on before something became a problem. These mothers therefore quite easily identified the family's candidacy for addiction prevention services and other health-promoting offers.

In contrast to many families with mode C, these families were less oriented towards the inner family circle in their approach to preventive issues and dealing with (potential) problems. They actively and broadly put out feelers for supporting and encouraging information and offers in their social environment. For them, it was part of the normal case, part of their educational self-image, to constantly make use of offers, no matter what topic, and to independently process the knowledge that they acquired: *"Because (3) no matter what, you learn something. Even if it is bad. I see things this way (2). [...] I register for all seminars, everything that is offered by the parents' council and that comes from the school and I really go everywhere. There is a private school [...], they often have free offers for people and I go there too, just to listen. And sometimes there are topics that don't concern me at all […]. But still better to go and listen than (1) not participating in anything"* (IR, mother, age 44).

These parents, in contrast to parents with modes A and B, did not exclusively search for offers for their children or put their effort into resolving problems on their own (mode C). Drawing on strong agency as parents, parents with mode D sought support, information, and help in addiction preventive and health-promoting offers in order to better support and educate their child. FAPS, which aim to strengthen and develop the skills of parents, therefore fitted the needs and the habitus of these parents.

Structural anchoring of the modes

The qualitatively reconstructed modes of recognizing and handling problems in everyday life were not simply psychological modes. They did not exist detached from a social and structural context. Rather, socio-demographic and structural references became apparent in the data material, which served as the basis for the shaping of these modes. If one had to draw a line between the four modes A to D that separates families with a high level of and sometimes multiple resource deprivation from families with slightly better resources, the line would run between two groups, A/B and C/D. In A and B there were mainly families with very low educational attainment (even no school-leaving certificate, illiteracy) and low occupational status. Some of them were only provisionally admitted foreigners in Switzerland (Permit F). In A, the financial resources were very weak. All families were social welfare recipients. In B there were families receiving social welfare as well as unemployed parents (including those receiving a part of a pension from the Swiss invalidity insurance). Some families with mode B were characterized by

multiple deprivations and the burden of having many problems and challenges at the same time (financial, social, and health related). In contrast, families with modes C and D were generally slightly better off financially. Almost all of them had educational attainment ranging from basic vocational education and training (e.g. apprenticeship) to professional education/tertiary degrees (also from abroad, which were not formally accepted in Switzerland!). It is further noticeable that many of them had lived in Switzerland for a longer period of time (compared to families with mode A with a shorter period of residence) and/or had Swiss citizenship. Moreover, social networks tended to be better developed in families with modes C/D than with modes A/B.

Thematic relevance of addiction prevention

When looking at identification of candidacy content-wise, that is, whether addiction prevention – embodied by the topics 'substance or media use/misuse', 'parenting skills', or 'life skills' – was a major issue in the families' everyday life, we must clearly say no. How does that happen? What is the dynamic that content-wise identification of candidacy for FAPS – especially concerning substance use/abuse – mostly does not occur? Three influencing factors were identified: (1) attitude towards substance/media use/misuse, (2) parental perception of child's interest in substance use / media use, and (3) competing problems and competing educational issues.

Children's negative attitudes towards substance consumption served mainly as a barrier to their identification of candidacy for substance abuse prevention offers and related information: *"Well, I really don't care about that [psychoactive substances/AP], because - because I don't want to start with that. I don't want to know about drugs and stuff because (1) ((mhm)) because I think that's just gross and not=not cool for the body simply"* (AlK, daughter, age 12). Why should they learn about substances, if they already knew that substances were bad? This main argument was put forward by several children. In parents, the data material did not reveal any connection between negative attitudes towards substance or media use/misuse either for non-identification of their candidacy or for identification of their candidacy for FAPS. Overall, concerning future substance consumption of their child, most parents expressed the attitude that they did not want their child/ren to use substances, or only very moderately.

In general, parents considered addiction prevention as an important parental responsibility. Many of them educated and warned their child/ren especially about substances. But since parents perceived no discrepancy between what they defined as the desired pattern of consumption and what they observed in their children's behaviour, it was not relevant enough to them at the time, and no content-wise parental identification of their candidacy for FAPS took place. All of the parents assessed their child's interest in psychoactive substances as either non-existent or not problematic, even though children sometimes displayed interest or even indicated (first) substance use in the interviews. The parental (mis)perception that their child was not yet concerned with substance use was therefore an important prerequisite for non-identification of their candidacy for FAPS. The parents based their perception of the child's non-interest in substance use on the following aspects:

- Child's stage of development, believing that the child was too young or too far removed from the subject: *"…but I have a feeling she's still a little far from that [substance use topics/AP]. ((yes)) Well, she's not that interested yet. But I know this is something that's sure to come"* (VS, mother, age 35)
- Child's explicitly expressed disinterest in substance use in conversations with parents
- Child having no friends who used substances (assessment of the peer environment)
- Gender-biased risk assessment, thinking that daughters were less at risk of using psychoactive substances than sons

Interestingly, parents were more critical and sensitized to children's media use (games, Internet, smartphone, etc.) than to their substance use; there was a difference between the parents' desired media use by the child and the child's actual use (e.g. identifying excessive smartphone use). More families attended (preventive) programmes dealing with child's media use than programmes dealing with substance use, parenting, or life skills. It seems that content-wise identification of candidacy for FASP tackling media use was easier than for those tackling substance use/abuse.

Addiction prevention issues were in general deemed less important than other problem burdens and educational issues related to adolescence. Besides all families having to deal with scarce financial resources, the parents were mostly concerned about the education and school performance of their 10- to 14-year-old child, the child's physical changes and sexual development, new financial demands from the child (new clothes, shoes, etc.), and the increased autonomy of the child, raising parental questions about safety.

Experiences with offers and integration in systems of assistance

Positive as well as negative experiences with any services of social or health assistance, whether prevention or treatment, even informal help in private settings, shaped future journeys towards identification of candidacy for FAPS.

The experience with professional services was rated positively or negatively depending on the behaviour and expertise of the respective professional, the course and outcome of the intervention, and the conditions of the offer (e.g. free of charge vs. costly). The interviews revealed that negative experiences within a system of assistance potentially hindered further contacts with this specific system, whereas positive experiences facilitated contact; the positively evaluated system of assistance was then often the first reference point when families were confronted with further problems or unresolved questions.

Integration in professional systems of assistance (including close bonds with specific professional reference persons) could either hinder or further processes towards identification of candidacy for FAPS. A strong anchoring within governmental institutions that provide social welfare or advice concerning migration turned out to be more of a barrier than a resource for identification of candidacy for FAPS. Especially families with mode A and B were in regular contact with these institutions due to their resource deprivation. They were even often obliged to remain in close contact with these institutions, for example

in order to further qualify for social welfare or a residence permit. But because these institutions and professionals dealt exclusively with specific, acute, and urgent problems (e.g. providing social welfare, residence permit, etc.), there was no triage of these families to health promotion-related and addiction prevention-related offers by these professionals or institutions.

Other families – from all modes – demonstrated a firm connection to aid organizations and educational institutions, such as school, parents' council, community centres, charitable organizations, and so on. These connections turned out to facilitate the identification of candidacy for FAPS, as long as the providers conducted addiction-preventive courses. When once integrated in a system and firmly connected to it, families took part in offers from these institutions as a matter of course, regardless of the topic: *"I register for all seminars, everything that is offered by the parents' council and that comes from the school and I really go everywhere"* (IL, mother, age 44)

Private contexts (close family, friends, supporting neighbours) serving as a system of assistance for a family seemed mostly to hinder identification of candidacy for FAPS. Most issues were then handled within the private contexts (see also the description under mode C above).

Strategies to protect the family

The interviewed families responded differently to being (potentially) addressed as parents by FAPS. Some families used strategies to protect, in some cases even showcase, their role as parents or their family's image to the outside world. Protection strategies identified were proactive or defensive. Proactive strategies furthered the identification of their candidacy for FAPS, whereas defensive strategies hindered their identification of candidacy for these services.

Several parents with modes C and D applied proactive protection strategies. These parents expected that participation in parent events would have a positive effect on their image as a family or as parents. Therefore, these parents identified with an offer regardless of the relevance of the topic because they expected to protect or even booster their image by participating. When S. M., a single mother of two children, was asked why she took part in the parents' evening on psychoactive substances, she answered: *"I just thought that if I didn't go, it would look like I were a bad parent"* (SM, mother, age 43).

Parents using defensive strategies were aiming to protect their family's or the parent's image by staying away from FAPS. Two conditions built the context for defensive protection strategies and as a consequence for non-identification of candidacy for FAPS: First, some parents with mode A and B feared that an interest in certain topics could be seen as an indication of problems in the family. The same families tried to present an exclusively positive image in the interviews and reacted defensively when asked about problems with the child, even if it was about little everyday difficulties. Second, several families – with different modes – avoided certain places or persons, regardless of the topic of the event. Based on their often negative experiences, these families assumed that their image was questioned or even threatened in these places or by certain persons: *"I have very little contact with the parents [...] And I have no relation to the state school. So this is really difficult for me. Even after six years. I can't find any*

common ground with them. […] Even with the teachers. I have a completely different opinion than them" (VS, mother, age 35).

Only families with modes C and D applied proactive protection strategies. Defensive strategies were applied by families with modes A, B, and C. Therefore, families with modes A and B that applied no proactive and both defensive strategies were the most vulnerable for non-identification of candidacy for FAPS. Families with mode D applied exclusively proactive protection strategies and therefore had considerably better chances to identify their candidacy for FAPS.

Parents' search for information or support

Verbal data revealed that how families and parents searched for information or support and what search movements they applied was important for the process towards or away from identification of their candidacy for FAPS. Consistent with results already presented, some families looked mainly to the public space and professional offers (e.g. teachers, professional institutions). Other families were more oriented towards the private environment (e.g. family or friends), appreciated finding information and informal support from their relatives and close acquaintances. Furthermore, we found different communicative forms when accessing information: Information or (potential) support was accessed by families using interactive and non-anonymous channels, for example by entering into contact via phone or face-to-face with their preferred reference person (either a professional or a private person). Information or (potential) support was also searched via non-interactive or anonymous channels. For example, children or parents searched the Internet, read books or articles, or participated in anonymous online forums (e.g. forums for mothers): *"If I really don't feel like talking about the subject right now, I go into my room and just spend some time on the laptop. I'll just see what I can find out there. And if you find something there, that's fine"* (AlK, daughter, age 12). Even though families used different and often multiple communicative ways to access information or support, non-interactive or anonymous channels often required literacy in writing, reading, or command of the regionally spoken German language. Information and support were therefore less accessible for families with very low education, illiteracy, or no command of the regionally spoken German language (mostly families with modes A and B).

The orientation of the search movements (towards public vs. private, professional vs. non-professional, etc.) basically had two grades of activity. They were either active or passive, and they mostly took place in families' already established help systems (see 'Experiences with offers and integration in systems of assistance' above). In active search movements, the interviewees initiated the search process on purpose and they consciously sought information or support services. The search process was activated and guided by a topic demanding attention that was currently occupying the family. Based on our data, active search movements were focused mainly on financial issues. Passive search movements were characterized by the fact that they were not initiated by a topic demanding attention and a deliberate search decision. Rather, it was because of parents' general interest (not limited to financial assistance) that initial information on offers (e.g. flyers, advertisements, etc.) was perceived by the families and search movements were initiated: *"I'm the kind of person who collects information and hangs it on the*

wall. [giggles] Yes, and just on occasions I look at it and look at the date and sometimes I think, hey, that evening I have time to do something. […] Well, I took a few courses like that" (KG, mother, age 34).

Whereas general interest and the willingness and time to receive and consider information from providers formed the bases for passive search movements and could lead to identification of candidacy for FAPS, active search movements were mostly a barrier to identification of candidacy for addiction prevention due to the focus on topics demanding attention (e.g. financial assistance). Here again, families with mode A were the most vulnerable concerning non-identification of candidacy. They directed their search and coping strategies almost exclusively towards the problem that was perceived as existentially threatening and applied mostly active search movements, whereas families with modes B, C, and D – especially those with C and D – applied passive search movements as well.

Self-identified barriers to services

The modes and factors that were found to open up or close routes towards identification of candidacy for FAPS were the results of the qualitative-interpretative analysis using grounded theory methodology. In addition to those interpretative reconstructions, the interviewed parents themselves had an understanding of why they did not participate in offers, and they named explicit reasons. These understandings were subjective theories on the part of the parents about what they thought hindered them from participating in offers. Table 2 shows these self-identified barriers to services. The barriers identified did not refer exclusively to (substance abuse) prevention or health promotion services. Drawing on Meurer and Siegrist ([63], p. 11), we grouped the barriers named into different levels: person or whole family, the supply system, and concerning interactions between (potential) users and service providers.

Discussion

Our results confirm previous findings. Persons living in poor socio-economic circumstances are hard to reach for health promotion and prevention services [1–5]. This is also the case for socio-economically deprived families when it comes to services and offers specialized in family-based addiction prevention [6, 16, 35–37]. Put differently, and being critical towards social work and public health professions: *FAPS* are hard to reach for socio-economically deprived families. Determinants influencing journeys to and uptake of health promotion and prevention offers found in other studies [2, 3, 29], such as income/financial deprivation, education, occupational and migration status, were manifest also in our verbal data material. Families with modes A and B, with overall least resources regarding the social determinants mentioned, faced the most barriers towards identification of their candidacy for FAPS. As we included families with inconsistencies in SES in our study, such as financially deprived parents with overall good formal educational attainment and with mainly modes C and D, we could also identify that education may to a certain extent facilitate ways towards FAPS. Results of the Swiss Health Survey also demonstrated that in Switzerland education is a very important factor when it comes to the social gradient in health [64].

Further identified barriers for socio-economically deprived groups to access and utilize health services, such as handling health as a series of minor or major crises, normalizing health problems and symptoms, and using identity protection strategies ([5], pp. 98–101), are also prevalent when it comes to FAPS, as our results demonstrate. Moreover, also our participants mentioned classic barriers to services, e.g. lack of time and/or childcare, expected costs, transportation problems, and so on, as already identified by other reviews in the field of FAPS [6, 16]. Our results support previous conceptions that a good strategy to reach these families is by using measures of indicated prevention [16]. But, in consequence, this means that a lot of families cannot be reached at an early point, when problems of substance use/misuse or problems with media use have not manifested in children.

Adding knowledge to the existent body of scientific literature

It is well known that a social gradient for health literacy and for access to and utilization of health promotion and prevention services exists, thanks to quantitative models and quantitative research [2, 3, 29]. Our results, in an interactionist-processual perspective, now further the understanding of how socio-economic deprived circumstances shape daily family life and can, for example, manifest in different patterns and modes of recognizing and handling problems in everyday life. These modes and other identified factors (e.g. strategies to protect the family) are in turn either more facilitating or more hindering for families' identification of their candidacy for FAPS.

Previous studies – not restricted to socio-economically deprived groups – have already identified that engagement in preventive parenting programmes is heavily influenced by parents' awareness of a child's problematic behaviour or symptoms in the child. Children's mental health symptoms, for example, were found to be the only reliable factor in increasing parents' enrolment in preventive parenting programs for child mental health [31]. Spoth and Redmond [32] concluded that parents' rating of the severity of teenage problems in general (smoking, drinking, getting in trouble, etc.) as well as their perception of the likelihood that their own child would experience these problems influenced parents' participation in preventive interventions. Our results support these findings also for socio-economically deprived groups and FAPS. Parents who saw an interest in substance or (problematic) media use in their children were more likely to identify themselves as a candidate for FAPS. Our results give detailed insights into what factors and dynamics (e.g. gender-biased or age-biased parental risk assessment) shape and influence parents' assumption that their child is not yet concerned with substance-use topics, therefore furthering non-identification of candidacy for FAPS. Our data demonstrates, moreover, that parents' perceptions are deeply connected with the family's socio-demographic position. Parents are not concerned with addiction prevention programs as much as with other issues of everyday life, because of their lack of resources and other more pressing issues.

Discussing the results in the light of the concept of candidacy

Our results contribute knowledge to the existing corpus of research that used the concept of candidacy to better understand processes of a person's identification of their candidacy for various health and public services [39–44, 46–50]. Also for the field of FAPS, we can state that the concept of candidacy, used as a

“sensitizing concept” [52], helps us better understand journeys to services [45]. Furthermore, our study, by using the concept of candidacy, is as far as we know the first study that specifies processes and circumstances of socio-economically deprived families’ identification of their candidacy for FAPS. The study therefore extends previous notions and definitions of the stage ‘identification of candidacy’. Our data reveal that this stage is not just about how people perceive their symptoms needing medical attention ([5], p. 98), not only about people determining that they need and deserve it ([41], p. 590), and not solely about people viewing themselves as legitimate candidates for certain services ([39], p. 809): Identification of candidacy for services is also strongly influenced by the way that people recognize and handle problems in everyday life. The question is whether this finding, or at least part of it, is transferable to other areas of health promotion and prevention services. Further research is needed to clarify this.

Even though we focused on identification of candidacy, several references to the other stages of candidacy can be found in our results. This supports Mackenzie’s et al. view that the stages of candidacy do not follow each other in a linear sequence but rather constantly influence each other. And each stage of candidacy is embedded in meso and macro level influences [39]. We further agree with Mackenzie et al. that the nature of candidacy has to be reconsidered ([39], p. 820). Also in our data, we found families confronted with not one but multiple candidacies, which were competing or conflicting: competing for example, when families were confronted with multiple important themes and issues that they had to deal with and that were in competition with addiction prevention topics. They were conflicting, when we think of parents that were generally interested in receiving information and attending parents’ evenings but feared at the same time that their (potential) participation could be interpreted as showing that they had family or substance abuse issues.

Implications for policy and practice

Socio-economically deprived families cannot be considered as a homogenous group, also when it comes to a (potential) engagement with FAPS, as our results demonstrate. Therefore, there is no single strategy to reach these families. Policy and practice should build on a bundle of diverse strategies that stress especially interventions on the structural and environmental levels.

The reconstructed family modes of recognizing and handling problems can guide policy and practice towards what kind of preventive interventions and ways to reach the respective subgroup are appropriate. Our results indicate that from modes D to A, vulnerability increases concerning candidacy for FAPS. Especially for families with mode A and B, the existing separation of the offers in treatment-related or social welfare-oriented versus prevention-related or health promotion-related offers is not functional. These families could be better reached within their already existing networks and systems of assistance (social welfare, migration authorities, etc.). Therefore, boundaries between treatment-related and prevention/health promotion-related offers should be removed. Intersectoral collaborations should be strengthened, and FAPS should be offered by social welfare, migration authorities, etc. Offers addressing the current main problem burden of a family – for example, financial scarcity – should incorporate family-based (addiction) prevention measures. For group C, families that pragmatically recognized

problems at a low threshold and dealt with them mostly within the family and their close private social network, other ways of approaching them are appropriate. Gatekeepers situated close to these families (e.g. grandparents, close friends) should be sensitized and given the necessary skills to transmit health-related knowledge and support to these families. Furthermore, approaching parents as experts of their own situation and including them in offers by using participatory intervention approaches (such as a parent-led parents' council) might be a good way to reach type C families.

Drawing on our findings that content-wise identification of candidacy for FAPS is heavily restricted due to most families setting other thematic priorities, and that assessments of topical relevance are biased, we suggest the following strategies. In advertising FAPS, parents' biases and interests should be anticipated by focusing on aspects of puberty and general developmental themes in adolescence, for example. Themes of substance use/misuse, especially for parents with younger children, should not be put in the foreground. When substance use/misuse or other problem issues in adolescence are named in flyers, these themes should be appropriately framed, e.g. normalized as potential problem behaviour with which every family has to deal. This is in order to avoid defensive protection strategies on the part of the families, which could lead to non-uptake of offers. Moreover, offers of FAPS should be provided through different channels (interactive vs. non-interactive; anonymous vs. non-anonymous), providers (leisure facilities, school, social work, outreach work, etc.), and persons (teachers, social workers, psychologists, peer-to-peer counsellors) due to parents' and children's diverse strategies for searching for information or support and the potential refusal of certain persons or places irrespectively of the topic of the event. Financial incentives could increase identification of candidacy with, and uptake of, services as well as tear down or at least lessen classic barriers to services (e.g. lack of childcare).

Facilitating access to FAPS using appropriate and equity-oriented strategies is one but not the only way to strengthen health and preventing substance use disorders in children already experiencing deprivations. Taking the social gradient in health for granted, even a minimal improvement in income, educational attainment, and occupational status would be a benefit for socio-economically deprived families. A Health in All Policies [65] approach that increases overall socio-economic resources and stabilizes the life circumstances of these families (e.g. residence status) is therefore crucial. Levelling up the social gradient would not only positively impact health and social opportunities of these families in general but could also positively influence modes of recognizing and handling problems in everyday life. This in turn would facilitate families' identification of their candidacy for FAPS, as our analysis suggests.

Limitations of the study and further research directions

Tests for data saturation provided evidence that saturation was good overall. During axial and selective coding, already identified concepts reappeared and were supported by new interview data. The carefully theoretically sampled families and the stories and situations looked at were in our opinion diverse and rich enough to be able to construct a sound grounded theory on processes of identification of candidacy for FAPS.

Future research could deepen and further develop our grounded theory. We found no LGBTIQ+ families as study participants, even though we contacted a Swiss rainbow families' association. The results should be put also in an international context, by studies on socio-economically deprived and more affluent families in other countries. Similarities and differences could be found from which we could learn when applying measures of diversity-sensitive addiction prevention on the national and international level. Whereas this study focused on recipients of services and offers, future studies with an interactionist perspective could also include professionals working in services so as to better understand processes of candidacy from both sides.

Due to our methodological approach, we cannot make any assumptions about quantities. Therefore, it would be worthwhile to test and quantify the identified modes of recognizing and handling problems in everyday life in the overall Swiss population of families living in poor socio-economic circumstances. How many families can be located with modes A, B, C, or D in what regions in Switzerland? Answers to these questions would provide guidance for policy and practices regarding where and how to invest always scarce financial and human resources in (addiction) prevention practice.

It would be of great benefit to further discuss and enrich the present results and implications in a participatory manner with the target group and with experts from the field. The rising paradigm of participatory health research could be a promising methodology here [66].

Conclusions

Our results show what circumstances and processes hinder socio-economically deprived parents and their (pre-)adolescent children from identifying their candidacy for and participating in FAPS in the German-speaking part of Switzerland. The core category of the grounded theory that we built is four modes of recognizing and handling problems in everyday life (existentially-threatening, normalizing, pragmatic-processing, worried), which are anchored in different areas of family resources (e.g. degree of financial deprivation, educational attainment, social and health resources, residency status). Depending on the respective mode, routes towards identification of candidacy with services/offers are furthered or hindered. Beside these four modes, the thematic relevance of addiction prevention for a family, previous experiences with offers and current integration in systems of assistance, the strategies used by parents and children to protect the family, and families' search for information or support influence whether identification of their candidacy for FAPS comes about or not.

We conclude that overall, identification of candidacy for FAPS, and therefore also chances of access to and utilization of services, are limited in socio-economically deprived families. Our findings – drawing on the concept of candidacy – reveal different micro processes in daily practices of socio-economically deprived families, embedded in meso and macro level influences that lead to non-identification of candidacy for services and shed light on the diversity of this group, which is sometimes conceptualized as homogenous. As pointed out extensively in the Discussion section above, the diversity identified has implications for policy and practice. No single preventive intervention strategy can be applied. It is

important to stress especially measures on the structural and environmental levels, always taking into account the social context of deprived families. In our opinion, the results of this study have the potential to challenge existing frameworks and systems of health promotion and FAPS with socio-economically deprived groups in Switzerland and potentially also abroad. The results also contribute to a better understanding of the stage of 'identification of candidacy' in the framework of the concept of candidacy itself. Finally, the qualitative approach pursued in this study turned out to be successful in gaining scientifically sound knowledge that can guide policy and practice. Therefore, besides the very relevant and important line of quantitative research in investigating equity in access to health and social services that should be continued, more qualitative and also participatory research should be conducted.

Abbreviations

FAPS: Family-based addiction prevention services; SES: Socio-economic status

Declarations

Ethics approval and consent to participate

The Ethics Committee of Northwestern and Central Switzerland waived the need for ethics approval. The study does not fall under the 810.30 Federal Act of 30 September 2011 on Research involving Human Beings (Human Research Act, HRA). Both participating parent/s and the participating child gave oral consent to participate in the study prior to the interview. Parents moreover gave written consent for themselves and in their position as legal representatives for their participating minor child.

Consent for publication

Not applicable.

Availability of data and material

The verbal data generated for and analysed in this study are not publicly available due to the privacy and the protection of the participants. Even though the interviews have been fully anonymized (names, places, etc.), the participants' narratives could lead to individual identification by close family, partners, friends, etc.

Competing interests

The authors declare that they have no competing interests.

Funding

The Swiss National Science Foundation (grant number 169162) funded the study.

Authors' contributions

AP conceptualized the study and was the principal investigator. NK and SW served as scientific associates. NK, SW, and AP performed data collection, analysis, and interpretation of the verbal data. A first draft of the manuscript was written collaboratively by AP, NK, and SW. AP then finalized the manuscript and added an extensive discussion and a conclusion section. The authors have read and approved the manuscript.

Acknowledgements

We thank the Swiss National Science Foundation for funding the study. We are grateful to all the families that participated in the study and gave us insights into their family life – thank you! Further, we also thank university students Santhya Chandrapala and Evîn Yagci for conducting an interview in their native language and translating it into German. In a student project, social work students Luca Mayoraz and Magdalena Tännler elaborated recruitment strategies for this study in the Canton of Bern; we thank them. We thank the practice and scientific advisory board members for their input and their continuous support of the study. The authors thank Ellen Russon for checking and correcting the English language in the article.

References

1. Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Methodol. 2006;6:35. doi:10.1186/1471-2288-6-35.
2. Janßen C, Sauter S, Kowalski C. The influence of social determinants on the use of prevention and health promotion services: Results of a systematic literature review. GMS Psycho-Social-Medicine. 2012;9:Doc07.
3. Kowalski C, Loss J, Kölsch F, Janssen C. Utilization of Prevention Services by Gender, Age, Socioeconomic Status, and Migration Status in Germany: An Overview and a Systematic Review. In: Janssen C, Swart E, Lengerke Tv, editors. Health Care Utilization in Germany: Theory, Methodology, and Results. New York, Heidelberg, Dordrecht, London: Springer; 2014. p. 293–320.
4. Klein J, Hofreuter-Gätgens K, dem Knesebeck O von. Socioeconomic Status and the Utilization of Health Services in Germany: A Systematic Review. In: Janssen C, Swart E, Lengerke Tv, editors. Health Care Utilization in Germany: Theory, Methodology, and Results. New York, Heidelberg, Dordrecht, London: Springer; 2014. p. 117–143.
5. Dixon-Woods M, Kirk D, Agarwal S, Annandale E, Arthur T, Harvey J, et al. Vulnerable groups and access to health care: a critical interpretive review: Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). Leicester: University of Leicester; 2005.
6. Laging M. Zielgruppe Familie: Eine Herausforderung für die Suchtprävention. proJugend. 2012:4–10.
7. Thomasius R, Bröning S. Familiäre Einflüsse auf Entstehung und Verlauf von Suchterkrankungen. SuchtMagazin. 2012:11–5.

8. Arnaud N, Sack P-M, Thomasius R. Current State of Family-Based Prevention and Therapy of Substance-Use Disorders in Children and Adolescents: A Review. Praxis der Kinderpsychologie und Kinderpsychiatrie. 2019;68:376–401.
9. Viner RM, Ozer EM, Denny S, Marmot M, Resnick M, Fatusi A, Currie C. Adolescence and the social determinants of health. The Lancet. 2012;379:1641–52. doi:10.1016/S0140-6736(12)60149-4.
10. de Looze M, Harakeh Z, van Dorsselaer, Saskia A F M, Raaijmakers, Quinten A W, Vollebergh, Wilma A M, ter Bogt, Tom F M. Explaining educational differences in adolescent substance use and early sexual debut: the role of parents and peers. J Adolesc. 2012;35:1035–44. doi:10.1016/j.adolescence.2012.02.009.
11. Ewing BA, Osilla KC, Pedersen ER, Hunter SB, Miles, Jeremy N V, D'Amico EJ. Longitudinal family effects on substance use among an at-risk adolescent sample. Addict Behav. 2014;41C:185–91. doi:10.1016/j.addbeh.2014.10.017.
12. Ryan SM, Jorm AF, Lubman DI. Parenting factors associated with reduced adolescent alcohol use: a systematic review of longitudinal studies. Aust N Z J Psychiatry. 2010;44:774–83. doi:10.1080/00048674.2010.501759.
13. Tornay L, Michaud P-A, Gmel G, Wilson ML, Berchtold A, Surís J-C. Parental monitoring: a way to decrease substance use among Swiss adolescents? Eur. J. Pediatr. 2013;172:1229–34. doi:10.1007/s00431-013-2029-0.
14. Wang B, Stanton B, Li X, Cottrell L, Deveaux L, Kaljee L. The influence of parental monitoring and parent-adolescent communication on Bahamian adolescent risk involvement: a three-year longitudinal examination. Soc Sci Med. 2013;97:161–9. doi:10.1016/j.socscimed.2013.08.013.
15. Gilligan C, Wolfenden L, Foxcroft DR, Williams AJ, Kingsland M, Hodder RK, et al. Family-based prevention programmes for alcohol use in young people. Cochrane Database Syst Rev. 2019;3:CD012287. doi:10.1002/14651858.CD012287.pub2.
16. Ernst M-L, Kuntsche S. Bericht zum Stand der familienbezogenen Suchtprävention: mit Empfehlungen für die Schweiz. Lausanne: Sucht Schweiz; 2012.
17. Bundesamt für Statistik BfS. Armutsgefährdung. o. J. https://www.bfs.admin.ch/bfs/de/home/statistiken/wirtschaftliche-soziale-situation-bevoelkerung/soziale-situation-wohlbefinden-und-armut/armut-und-materielle-entbehrungen/armutsgefaehrdung.html. Accessed 17 June 2020
18. Baumann M, Chau K, Kabuth B, Chau N. Association between health-related quality of life and being an immigrant among adolescents, and the role of socioeconomic and health-related difficulties. Int J Environ Res Public Health. 2014;11:1694–714. doi:10.3390/ijerph110201694.
19. Chau K, Baumann M, Chau N. Socioeconomic inequities patterns of multi-morbidity in early adolescence. Int J Equity Health. 2013;12:65. doi:10.1186/1475-9276-12-65.
20. Henkel D. Soziale Ungleichheit und Konsum von psychoaktiven Substanzen und Glücksspielen bei Kindern und Jugendlichen: Stand der sozialepidemiologischen Forschung in Deutschland und

präventive Schlussfolgerungen. In: Marchwacka MA, editor. Gesundheitsförderung im Setting Schule. Wiesbaden: Springer Fachmedien Wiesbaden; 2013. p. 49–82. doi:10.1007/978-3-658-00528-3_3.

21. World Health Organization. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2014.
22. Becker HM, Rosenstock IM. Comparing social learning theory and the health belief model. In: Ward WB, editor. Advances in health education and promotion. Greenwich, CT: JAI Press; 1987. p. 245–249.
23. Rosenstock IM. Why people use health services. Milbank Memorial Fund Quarterly. 1966;44:94–127.
24. Ajzen I. From intentions to actions: A theory of planned behavior. In: Kuhl J, Beckmann J, editors. Action control: From cognition to behavior. Heidelberg: Springer; 1985. p. 11–39.
25. Ajzen I, Fishbein M. Understanding Attitudes and Predicting Social Behavior. Englewood Cliffs, NJ: Prentice-Hall; 1980.
26. Andersen RM, Davidson PL, Baumeister S. E. Improving access to care in America. In: Kominski GF, editor. Changing the U.S. health care system: Key issues in health services policy and management. 4th ed. San Francisco, Calif.: Jossey-Bass; 2014. p. 33–69.
27. Green LW, Kreuter MW. Health Program Planning. An Educational and Ecological Approach. 2nd ed. New York: McGraw-Hill; 2004.
28. Sørensen K, van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, Brand H. Health literacy and public health: a systematic review and integration of definitions and models. BMC Public Health. 2012;12:80. doi:10.1186/1471-2458-12-80.
29. Sørensen K, Pelikan JM, Röthlin F, Ganahl K, Slonska Z, Doyle G, et al. Health literacy in Europe: comparative results of the European health literacy survey (HLS-EU). Eur J Public Health. 2015;25:1053–8. doi:10.1093/eurpub/ckv043.
30. Bieri U, Kocher JP, Gauch C, Tschöpe S, Venetz A, Hagemann M, et al. Bevölkerungsbefragung "Erhebung Gesundheitskompetenz 2015": Schlussbericht. Bern: gfs.bern; 2015.
31. Finan SJ, Swierzbiolek B, Priest N, Warren N, Yap M. Parental engagement in preventive parenting programs for child mental health: a systematic review of predictors and strategies to increase engagement. PeerJ. 2018;6:e4676. doi:10.7717/peerj.4676.
32. Spoth R, Redmond C. Research on Family Engagement in Preventive Interventions: Toward Improved Use of Scientific Findings in Primary Prevention Practice. The Journal of Primary Prevention. 2000;21:267–84. doi:10.1023/A:1007039421026.
33. Dusenbury L. Family-Based Drug Abuse Prevention Programs: A Review. The Journal of Primary Prevention. 2000;20:337–52. doi:10.1023/A:1021366721649.
34. Spoth R, Redmond C, Hockaday C, Shin CY. Barriers to Participation in Family Skills Preventive Interventions and Their Evaluations: A Replication and Extension. Family Relations. 1996;45:247. doi:10.2307/585496.

35. Abbey A, Pilgrim C, Hendrickson P, Buresh S. Evaluation of a family-based substance abuse prevention program targeted for the middle school years. J Drug Educ. 2000;30:213–28. doi:10.2190/GT8C-ELWH-HY94-ECG9.
36. Al-Halabi Díaz S, Secades-Villa R, Pérez JME, Fernández-Hermida JR, García-Rodríguez O, Crespo JLC. Family predictors of parent participation in an adolescent drug abuse prevention program. Drug Alcohol Rev. 2006;25:327–31. doi:10.1080/09595230600741149.
37. Perrino T, Coatsworth JD, Briones E, Pantin H, Szapocznik J. Initial Engagement in Parent-Centered Preventive Interventions: A Family Systems Perspective. The Journal of Primary Prevention. 2001;22:21–44. doi:10.1023/A:1011036130341.
38. Babitsch B, Berger C, Borgetto B, Ciupitu-Plath C-C. Health Care Utilization: Insights from Qualitative Research. In: Janssen C, Swart E, Lengerke Tv, editors. Health Care Utilization in Germany: Theory, Methodology, and Results. New York, Heidelberg, Dordrecht, London: Springer; 2014. p. 87–100.
39. Mackenzie M, Conway E, Hastings A, Munro M, O'Donell C. Is 'Candidacy' a Useful Concept for Understanding Journeys through Public Services? A Critical Interpretive Literature Synthesis. Social Policy & Administration. 2013;47:806–25. doi:10.1111/j.1467-9515.2012.00864.x.
40. Klassen AC, Smith KC, Shariff-Marco S, Juon H-S. A healthy mistrust: how worldview relates to attitudes about breast cancer screening in a cross-sectional survey of low-income women. Int J Equity Health. 2008;7:5. doi:10.1186/1475-9276-7-5.
41. Koehn S. Negotiating candidacy: ethnic minority seniors' access to care. Ageing and Society. 2009;29:585–608. doi:10.1017/S0144686X08007952.
42. Kovandžić M, Chew-Graham C, Reeve J, Edwards S, Peters S, Edge D, et al. Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. Soc Sci Med. 2011;72:763–72. doi:10.1016/j.socscimed.2010.11.027.
43. Manthorpe J, Iliffe S, Moriarty JO, Cornes M, Clough R, Bright LES, Rapaport J. 'We are not blaming anyone, but if we don't know about amenities, we cannot seek them out': black and minority older people's views on the quality of local health and personal social services in England. Ageing and Society. 2009;29:93–113. doi:10.1017/S0144686X08007502.
44. O'Cathain A, Coleman P, Nicholl J. Characteristics of the emergency and urgent care system important to patients: a qualitative study. J Health Serv Res Policy. 2008;13 Suppl 2:19–25. doi:10.1258/jhsrp.2007.007097.
45. Pfister A. Qualitative Research with the Concept of Candidacy – Towards a better understanding of hindered addiction prevention service uptake. SUCHT. 2018;64:149–55. doi:10.1024/0939-5911/a000539.
46. Mackenzie M, Gannon M, Stanley N, Cosgrove K, Feder G. 'You certainly don't go back to the doctor once you've been told, "I'll never understand women like you."' Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. Sociol Health Illn. 2019;41:1159–74. doi:10.1111/1467-9566.12893.

47. Chinn D, Abraham E. Using 'candidacy' as a framework for understanding access to mainstream psychological treatment for people with intellectual disabilities and common mental health problems within the English Improving Access to Psychological Therapies service. J Intellect Disabil Res. 2016;60:571–82. doi:10.1111/jir.12274.
48. Mackenzie M, Conway E, Hastings A, Munro M, O'Donnell CA. Intersections and multiple 'candidacies':: exploring connections between two theoretical perspectives on domestic abuse and their implications for practicing policy. Social Policy and Society. 2015;14.
49. Mackenzie M, Turner F, Platt S, Reid M, Wang Y, Clark J, et al. What is the 'problem' that outreach work seeks to address and how might it be tackled? Seeking theory in a primary health prevention programme. BMC Health Serv Res. 2011;11:350. doi:10.1186/1472-6963-11-350.
50. van der Boor CF, White R. Barriers to Accessing and Negotiating Mental Health Services in Asylum Seeking and Refugee Populations: The Application of the Candidacy Framework. J Immigr Minor Health. 2020;22:156–74. doi:10.1007/s10903-019-00929-y.
51. Strauss A, Corbin J. Grounded Theory: Grundlagen Qualitativer Sozialforschung. Weinheim: Beltz - Psychologie Verlags Union; 1996.
52. Blumer H. What is Wrong with Social Theory? American Sociological Review. 1954;19:3–10.
53. Eurostat. At-risk-of-poverty threshold - EU-SILC survey. 2020. https://ec.europa.eu/eurostat/web/products-datasets/product?code=tessi014. Accessed 17 June 2020
54. Klein M, editor. Kinder und Suchtgefahren: Risiken - Prävention - Hilfen. Stuttgart [u.a.]: Schattauer; 2008.
55. Petermann H, Roth M. Suchtprävention im Jugendalter: Interventionstheoretische Grundlagen und entwicklungspsychologische Perspektiven. Weinheim: Juventa Verlag; 2006.
56. Pfister A. Saufen, Rauchen, Kiffen: Zur Funktionalität und Bedeutung von Suchtmittelkonsum für Pubertierende. Schüler. Wissen für Lehrer (Schwerpunktheft Pubertät). 2013:80–3.
57. Tossmann P, Baumeister S. Früher Substanzkonsum. In: Klein M, editor. Kinder und Suchtgefahren: Risiken - Prävention - Hilfen. Stuttgart [u.a.]: Schattauer; 2008. p. 181–189.
58. Lampert T, Kroll LE. Die Messung des sozioökonomischen Status in sozialepidemiologischen Studien. In: Hurrelmann K, Richter M, editors. Gesundheitliche Ungleichheit: Grundlagen, Probleme, Perspektiven. 2nd ed. Wiesbaden: VS Verlag für Sozialwissenschaften / GWV Fachverlage GmbH Wiesbaden; 2009. p. 309–334. doi:10.1007/978-3-531-91643-9_18.
59. Wittke V. Familien in benachteiligten Lebenslagen als Adressaten der Familienbildung. In: Lutz R, editor. Erschöpfte Familien. Wiesbaden: VS Verlag für Sozialwissenschaften; 2012. p. 191–207. doi:10.1007/978-3-531-93324-5_9.
60. Bonevski B, Randell M, Paul C, Chapman K, Twyman L, Bryant J, et al. Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. BMC Med Res Methodol. 2014;14:42. doi:10.1186/1471-2288-14-42.

61. Witzel A. Das problemzentrierte Interview. In: Jüttemann G, editor. Qualitative Forschung in der Psychologie: Grundfragen, Verfahrensweisen, Anwendungsfelder. Weinheim: Beltz; 1985. p. 227–255.
62. Witzel A, Reiter H. The problem-centred interview: Principles and practice. London: SAGE; 2012.
63. Meurer A, Siegrist J. Determinanten des Inanspruchnahmeverhaltens präventiver und kurativer Leistungen im Gesundheitsbereich durch Kinder und Jugendliche: Forschungsstand, Interventionen, Empfehlungen. 1st ed. Köln: Bundeszentrale für gesundheitliche Aufklärung BZgA; 2005.
64. Bundesamt für Statistik BfS. Gesundheitsstatistik 2019. Neuchâtel: BfS; 2019.
65. WHO. Health in all policies: Helsinki statement. Framework for country action. Geneva: World Health Organization; 2014.
66. Wallerstein N, Duran B, Oetzel JG, Minkler M, editors. Community-based participatory research for health: Advancing social and health equity. Hoboken, NJ: Jossey-Bass & Pfeiffer Imprints Wiley; 2018.
67. State Secretariat for Education, Research and Innovation SERI. Vocational and Professional Education and Training in Switzerland: Facts and Figures 2020. Berne: SERI; 2020.

Tables

Table 1: Study sample (*n* = 36 interviewed persons)

			Total
Parents (*n* = 20)	Gender	Female	14
		Male	6
	Age in years	30-35	3
		36-40	7
		41-45	6
		46-50	3
		51-55	-
		56-60	-
		61-65	1
	Educational attainment[a]	No compulsory education	3
		Compulsory education	1
		Upper-secondary level (vocational education and training)	13
		Tertiary level (professional education)[b]	3
	Country of birth	Switzerland	9
		Other[c]	11
Children (*n* = 16)	Gender	Female	10
		Male	6
	Age in years	10	4
		11	2
		12	6
		13	1
		14	3
Household (*n* = 16)	Type of household	Couple (married or living together) with child(ren)	8
		Single parent with child(ren)	8
	Number of children in household	1	5
		2	4
		3	4
		4-6	3

Financial situation	Above the at-risk-of-poverty threshold	1
	Income is about 60% of the median equivalent Income is 50% or less of the median equivalent income	5
		10
Main source of income	Employment	11
	Social insurance (old age or disability pensions)	2
	Social welfare	3

[a] In the Swiss Vocational and Professional Education and Training system ([67], p. 6)

[b] Some of the tertiary education qualifications were acquired abroad and were not accepted in Switzerland

[c] Five of them now have Swiss citizenship

Table 2: Self-identified barriers to services

Level	Self-identified barriers
Person or family	· Parents' lack of German language skills · General lack of time · Problems with securing childcare · Expected costs of the offer · Afraid of not meeting normative expectations of the other participants · Concerns about gossip · Assumption that offers were exclusively designed for actually experienced problems · Self-attributed low media literacy (hindering access to online services/offers)
Supply system	· Too far away / transportation problems · Unsuitable opening hours · Unfavourable time at which the offer took place · Costs of the offer · Poor advertising of the offer · Lack of outreach offers
Interactions between users and service providers	· General reservations about institutions · Lack of trust in professionals (e.g. due to young age of the professional, perceived little experience)

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- AddFile1COREQ.docx
- AddFile2ParentInterviewGuide.docx
- AddFile3ChildInterviewGuide.docx