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Integrated Family Centres: Directions for Future Developments

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Integrated Family Centres: Directions for Future Developments

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Abstract

Two major types of family centre can be identified. The first type aims to support families in the community by offering a range of practical services to alleviate stress. The second type of centre focuses on assessment and therapeutic intervention in families where children are at risk of abuse. In practice, many centres fulfil both functions and can be termed 'integrated centres'. This paper reports on an evaluation of an integrated centre. The evaluation was conducted on three levels: the managerial level, the level of professionals who work in the centre, and on the level of the families who use the centre. Findings show a contradiction between the two different kinds of services provided by the centre. The contradiction results in the professionals experiencing tension in their role and the families expressing ambivalent feelings about the approach taken to them. The authors outline ways to resolve the tension by suggesting an alternative role for integrated centres.

Keywords: Family centre; integrated centres; professional role tension

Introduction

The development of family centres in Northern Ireland (since the late 1970's) has closely mirrored the picture in Great Britain (Keenan, 1989). Injection of funding into deprived inner city areas in 1977 (Ditch & Morrisey, 1979) gave rise to a dramatic increase in both statutory and voluntary centres in the province. However, the strategic rationale for these centres remained unclear up until the implementation of the Children (NI) Order 1995. Paragraph 10 of Schedule 2 of the Order, places an emphatic duty on statutory agencies to, 'provide such family centres as they consider

appropriate in relation to children in their area'. Similar legal requirements for family centres exist under the Children Act (1989) in England and Wales.

In keeping with these legal requirements, family centres in the United Kingdom have evolved into two main types (Downie & Foreshaw, 1987; Pithouse & Lindsell, 1996): a 'promotional' type and a 'client-focused' type. Promotional centres concentrate on an open and inclusive approach to families. Various authors (Gibbons, 1992; Holman, 1988; Smith, 1993; Cigno, 1998; Dale, 1992) have highlighted the effectiveness of this model in responding to families' needs; and the importance of promotional centres, as a new paradigm for practice in Europe, has also been underscored in the literature (Cannan & Warren, 1997; Gerzer-Sass & Pettinger, 1997; Robbins, 1994).

Client-focused centres differ from promotional centres, in that they offer services to families who have been referred for therapeutic intervention, or for risk assessment, where there are concerns about children's welfare. Pithouse and Lindsell (1996) compared this model favourably with fieldwork approaches to families, and Bond (1995), discovered that children in one client - focused centre valued the approach taken towards them.

However, in many instances centres combine these support and protection functions. Consequently, they can be viewed as 'integrated centres' (Gill, 1998; Southwell, 1994). Higgins, Switzer, and Pinkerton (1997) found, though, that integrated centres had difficulty combining these two disparate functions, because they presented the staff with competing objectives which were difficult to reconcile. On the one hand, the support function was based on a caring set of responses; on the other, the protection function was directed towards the management of risk.

This tension between family support and child protection exists not only within local services (such as family centres), but also presents a central social policy dilemma for Governments in Western Democracies. Governments must protect their most vulnerable citizens and, at the same time, enable support to be delivered to them. This produces a structural schism replicated at descending levels: that is, in politics, in legislation, in practice, and in service provision. For example, legislation in England and Wales (Children Act, 1989) contains duties for social workers to protect children at risk of 'significant harm' and identify and provide services for children 'in need'. Similar imperatives exist in Danish legislation (Egelund, 1996) with its guidance to both provide supports for those with 'essential problems' and to address situations which exhibit 'manifest risk'. In social work practice there is a tendency for child protection to predominate. This is manifest in a number of ways, one of the best

documented being the observed international tendency for an increasing number of family problems to receive child protection investigations. However, the majority of these investigations result in no further action. For example, studies by Gibbons (1995) in the United Kingdom, Besharov (1990) in America and Thorpe (1994) in Australia, have all demonstrated an increased number of referrals to social work agencies responded to as potentially abusive, with little corresponding increase in the number of children officially designated as 'at risk'.

Clearly, attempts to combine child protection and family support imperatives in law, policy and practice are inherently problematical (Parton, 1997). Where services exist that attempt to combine these functions in one site - such as integrated family centres - they become an important area of research inquiry. Specifically, it is necessary to ask whether the effectiveness of integrated centres - in achieving desired outcomes - is influenced by the competing functions they provide. This question is central to a major debate in child-care in the United Kingdom, as to whether support and protection functions can be combined within agencies, or whether these functions should be undertaken by separate agencies (Parton, 1997). This paper contributes to the debate by presenting a study of an integrated family centre in Northern Ireland. The aims of the study were to (1) evaluate the effectiveness of the centre in achieving key managerial and professional outcomes (2) determine whether the centre's differing functions influenced its effectiveness.

Methodology

The Family Centre

The aim of the centre under study was to, 'offer assessment and therapeutic services to families whose children were thought to be at risk or in need, to enable those children to remain with their families and thrive' (Centre Business Plan, 1995 pg.1). To achieve this aim, the centre provided a range of practical services such as day care for children, and parent support groups. In addition, risk assessment and therapeutic work was undertaken with families using a range of methods such as family therapy, counselling, and behaviour modification.

A manager, six practitioners and one secretary staffed the centre. Families were either self referred or referred by other childcare professionals (for example, social workers, health visitors, and teachers). On average, 15 families attended the centre at any one

time. The duration and frequency of contact with families depended on the severity of the risk or need; in severe cases, there could be twice weekly contact, whereas in less serious cases, families were seen on a fortnightly or monthly basis.

Procedure

The study was based on a 'process - outcome' approach (Whitaker & Archer, 1989; Cheetham, Fuller, McIvor & Petch, 1992). This approach evaluates a number of key processes within a programme, such as social work interventions, management practices, or types of services provided. It is also concerned with 'outcomes': that is, with the end results which arise from process interventions. Outcomes relate to tangible improvements in the client's situation and are measured, for example, by client satisfaction.

Three dimensions of assessment were developed within this approach (Ovretveit, 1991). The first dimension involved the assessment of **managerial** 'process' and 'outcome'. This entailed asking whether the manager was effective in supporting and developing the staff. The second dimension entailed the assessment of **professional** 'process' and 'outcome'. This dimension focused on the quality of social work interventions. The third dimension was concerned with the **families'** perception of social work 'process' and 'outcome'. Critically, did the families believe the centre had made a difference to their presenting problems? These 'processes' and 'outcomes' are now described more fully.

- the method for setting aims and objectives for the centre;
- the systems for communicating important information;
- the style of leadership;
- the systems for staff support;
- the approach to quality assurance; and
- the system for convening and reviewing care plans.

Table 1

Assessed Management Processes

Dimension One: Assessing Management Effectiveness

A number of management 'processes' were assessed (see table 1) through a range of methods. First, a focus group - addressing staff supervision, training, induction, and appraisal - was convened with all of the staff *(n=6)*. Second, communication within a staff meeting and a group supervision (a formal meeting analysing case management) was appraised by using non - participant observation.

The approach taken here involved simultaneous note taking during the observations with a particular emphasis given to the content and process of participants' communication: who said what to whom and in what order (Lofland & Lofland, 1984). These exchanges were later codified into general themes before the analysis took place. Third, two semi - structured interviews were carried out with the manager covering leadership style (how objectives were attained and staff supported) and approaches to quality assurance (how standards were developed and measured). Fourth, a semi - structured interview was carried out with each of the staff addressing areas relating to management planning and monitoring. Last, care plans within eight case files were examined using a pre-formed checklist. The main items on this checklist addressed areas such as:

⇒ file management (that is, checking whether the file was up to date and appropriate forms present);

⇒ procedural correctness (that is, the extent to which the social worker had adhered to established procedure in performing key tasks);

⇒ outcome led work (that is, the extent to which clear objectives for each family had been recorded; and

⇒ accuracy of recording (that is, the extent to which fact and opinion were separated in recording).

Two key 'outcomes' were also assessed :

- the extent to which the centre had achieved its aims and objectives; and
- the extent to which staff were equipped to perform the tasks expected of them.

A critical outcome measure here was the views of the staff on whether these outcomes had been achieved. The staff's views were obtained through the focus group and semi - structured interviews referred to above.

Dimension Two: Assessing Professional Effectiveness

Professional 'outcomes' were examined in terms of the effectiveness of social work interventions in meeting families' needs. The views of the referrers constituted a critical measure of these 'outcomes'. Twenty-three referrers in the area were sent a questionnaire and were asked to comment on the following areas:

- the referral process;
- the extent to which partnership had been achieved;
- the extent to which stated aims of intervention had been realised; and
- the effectiveness of the methods used by the centre staff.

Two professional processes were also examined:

- the method of assessing families; and
- the models of intervention used.

These processes were assessed, firstly, by carrying out a textual analysis of eight files (chosen at random). Some of Hammersley and Atkinson's (1983) cardinal questions for guiding ethnographic analysis of texts were used to shape the researchers' analysis of these files: How were the documents written? What was recorded? What was omitted? What did the writer seem to take for granted about the reader(s)? Secondly, non - participant observation of group supervision (see above) was carried out.

Dimension Three: Families' Perceptions of the Centre

The outcome being assessed under this dimension, related to the families' satisfaction with the services provided by the centre. To assess this outcome, structured interviews were undertaken with fourteen families (chosen at random) who were attending the centre at the time of study. The families reflected a wide range of care taking arrangements including two foster families, two natural families, and ten single parents. Eight of the families had been referred by Social Services because of child care

concerns; the rest were self referred. Four children agreed to interviewed with parental agreement. The interviews with the parents also focused on a number of processes:

- how the families were made aware of the centre;
- the families' perception of the referral stage and response times; and
- the extent to which the families believed partnership had been achieved.

The children were asked :

- about their understanding of the help given to them;
- what they liked and disliked about the centre; and
- what they liked best and least about the staff.

Methodological Issues

A number of methodological issues arose in the design stage. First, to ascertain whether the centre's diverse functions affected process and outcome, it was necessary to adopt a method which would identify contradictions or conflicting themes in practice. Discourse analysis (Burr, 1995) was used for this purpose. The method entails a close examination of language - whether in speech or in text - to reveal underpinning discourses of meaning. [A discourse can be defined as a collection of meanings, metaphors, representations, images, stories or statements - which produce a particular version of events (Foucault, 1977)]. In terms of the study, the method was used to examine respondent's speech in interviews. It was also applied to documents, such as case files. The purpose of this analysis was to: (1) examine whether protection and support discourses could be identified; and (2) analyse their impact on practice.

Second, it was necessary to ensure that interpretations of respondents' views, were reliable and valid. Silverman (1993), in discussing how reliability and validity can be maximized in qualitative research, recommends measures such as pre-testing of interview schedules and triangulating data and methods. Both measures were adopted in the study.

Third, it was important to take account of the limitations in defining and measuring outcomes in social work practice (Cheetham et al, 1992; Parker, Ward, Jackson,

Aldgate & Wedge, 1991). Social work is often a complex activity, involving a range of multi-dimensional aims and practices, which may not translate easily into concrete outcomes. Outcomes are also affected by confounding factors: factors that are external to intervention, such as poverty and genetic endowment. These limitations were offset, in part, by focusing on process as well as outcome. Therefore, the authors were not only interested in whether outcomes had been achieved, but also in the quality of practice.

To summarize, the objective of the process - outcome approach was to obtain cross-sectional rather than longitudinal data; the information was primarily of a qualitative nature; and finally, the process and outcome measures were selective rather than comprehensive.

Results

The results are reported under the following headings:

(1) Planning: clarity over aims and objectives;

(2) Communication: clarity and accountability;

(3) Quality Assurance: standards, audit and monitoring;

(4) Responsiveness: prioritizing need and case planning;

(5) Effectiveness: referrers' views on outcomes of intervention; and

(6) Effectiveness: families' views of the centre.

Findings under each heading are divided into two parts: (a) findings relating to the evaluation of process and outcome and (b) findings relating to the impact of the centre's integrated functions on its effectiveness.

(1) Planning: clarity over aims and objectives

a) Evaluation of process and outcome.

Three main sources of data were analysed: the Business Plan, the perspective of the manager, and the perspectives of the staff. The findings indicated that the Business Plan made a useful distinction between three sets of objective: impact objectives -

referring to families' participation in the centre; service objectives - referring to operational procedures; and logistic objectives - referring to management practice. A statement of strategic intent - 'to extend and strengthen the range of preventative and support services available' - also showed that the plan was congruent with legislative and policy requirements. This said, there was no attempt to forecast future requirements, as might have been expected, and the reactive, operational tone was reflected in the plan's opening aim: 'to offer an assessment and therapeutic service to families whose children are thought to be at risk or in need.'

Moreover, the aims were not always outcome led, but mainly referred to prescribed activity. For example, one of the logistic objectives referred to the need to: 'monitor and explore the professional development of staff.'

When asked about the content of the Business Plan, the staff had difficulty recounting its major themes; but each of the staff were able to state their involvement in day to day planning. For example, one member of staff said: 'Yes I am involved in day to day planning. I feel we discuss the way we work from time to time and this is discussed by the team as a whole.'

(b) *Impact of centre's functions.*

A major factor affecting planning, was the role strain experienced by staff. This strain was associated with competing expectations. Crucially, the aim of protecting children did not integrate with the aim of working in partnership with families. This contradictory tension was demonstrated at a group supervision meeting where a member of staff stated: 'we are often pressurised to take on the role of child protection workers - to investigate cases of child abuse. This often compromises our role with the family, which is more about assessment and empowerment.'

(2) Communication: clarity and accountability

(a)*Evaluation of process and outcome.* In addition to the informal channels of verbal communication, four major formal channels were identified by the staff: the team meeting, group supervision, individual supervision, and practice developments slots. Written communication was conveyed in the policy and procedures manual, which provided direction on a range of legal and practice areas. Child protection responsibilities and accountability requirements were also clearly specified in this

document; for instance, there was a directive to report suspected or confirmed child abuse in writing.

Staff were content with information passed down from the manager. One said: 'Yes, I think there's time for team discussion and time for individual discussion. You are obviously constrained at times, but usually I find it very acceptable.'

Communication between the manager and staff was observed within one team meeting and one group-supervision. During the team meeting, a formal approach was taken by the manager i.e. an agenda was set, minutes were available and action was recorded. All staff contributed at least once. Their comments centred on a range of practical and professional matters: the computer system, toys for the children, and feedback from a recent conference.

During the group supervision, a reflecting-facilitating style of chairing was observed; for instance, the manager said periodically: 'what do people think?' and 'where do we go from here?' At this session, families were initially identified for discussion; details were clarified; referrers' expectations were summarised and accountability issues raised; the key worker then presented a review of the family in terms of background factors, areas of work and problematical issues which needed to be addressed. Staff participated in these exchanges by clarifying important information, problem-solving, and hypothesising.

(b) *Impact of centre's functions.*

Communication differed depending on the families' presenting problems and the services they required. In situations of need, group consensus - on the approach to be taken - was achieved quickly. However, in situations of risk, group consensus was more problematic. The issue related to the status of individual staff member's perceptions of risk and whether the group had a right to overrule. One staff member expressed the point as follows: 'we need to be more accommodating about our individual perceptions of what is happening in families__. the group tends to enforce its view. We need to develop rules for sorting out whose view counts.' Thus, decision-making was less contentious in family support cases but more contentious in child protection cases.

(3) Quality Assurance: standards, audit and monitoring

(a) *Evaluation of process and outcome.*

Standards for the centre had been set three years before the evaluation took place. One of the service standards - that of client participation and choice - was examined in depth. This standard was chosen because of the current emphasis on user involvement in services in law and policy. The findings showed that:

- the centre encouraged referrers to work in partnership with families at the initial referral stage. This was reflected in one case file where the worker had written: 'I queried if the family were aware of the referral.'
- families were fully involved in pre-contract and contract meetings, where a client centred approach to agreeing areas of work was adopted; the following remarks (extracted from contract meeting minutes) reflected the families' perceptions of their needs: 'to help John's behaviour'; 'helping Jill to get over the abuse'; 'to help Sean get over the loss of his mum.'
- there was an emphasis on sharing information with families regarding open access to records and the families were all given copies of the complaints procedures.

(b) *Impact of centre's functions*. On the one hand, there was evidence of openness and sharing; this openness occurred in family support cases. On the other hand, there was evidence of restricting information to families e.g. professionals de-briefing in private after risk assessment sessions. This reticence to share information, occurred in cases where risk featured strongly. The manager was aware of this tension: 'we try, where possible, to share our concerns openly with families; but in some serious cases of risk, this is not possible. Its a big issue for us for us to resolve.'

(4) Responsiveness: prioritising need and case planning

(a) *Evaluation of process and outcome.*

Seven case plans, which were developed at the contract and review stages of case management, were examined. The files were chosen at random. Findings indicated that, for each of the families identified, a written plan was in place; the timescales and procedural requirements for planning and review were also adhered to; and pre-

contract and contract meetings were held in every case. However, the plans fell short in a number of areas. First, in each of the plans, there was a tendency to record areas of work, rather specifying outcomes. Comments such as: 'to examine John's feelings over the alleged abuse', indicated a process led approach. Consequently, reviews did not record whether outcomes had been achieved. Second, the key planning questions of 'who', 'what', 'when', 'where', 'why', and 'how' - were not fully addressed in any of the case plans.

(b) *Impact of centre's functions.*

Recording, in both family support and child protection cases, was mostly descriptive (rather than analytical). Written comments such as: 'Mr and Mrs Jones said they wanted to look at their marriage', were typical of a client centred mode of recording. Invariably, what the families told the staff, greatly informed what was written down. Accordingly, professional analysis was often limited in case files. The manager explained the reasons for this style of recording: 'We record in this way because we believe it is the best way of building partnerships with families.' However, the manager also admitted: 'this style of recording may not be sufficiently analytical for child protection cases. We are always trying to strike the right balance between child protection and partnership - but it is difficult to achieve.'

(5) Effectiveness: referrers' views on intervention

(a) *Evaluation of process and outcome.*

Questions on the centre's responsiveness to referrals, provoked very positive responses. For example, all respondents stated that they were satisfied with the speed of the referral process, and the timing and content of introductory and review meetings for families. Questions on the effectiveness of the work with families produced some interesting responses. When referrers were asked to specify the goals for the work, agreed at introductory meetings, these tended to be rather general in nature e.g. 'family work, lack of communication between family members'; 'work on bereavement'; and 'couple relationship work.'

Seven respondents indicated (on a questionnaire) that the specified goals for the family had been 'partially met' as a result of the work. The other did not respond to this question and, when referrers were asked to indicate whether or not they used 'external outcome measures to evaluate outcomes, there were no responses to this

question. It may be presumed that external measures of outcomes were not consciously employed. While these questions on the outcome of work indicated little sense of systematic evaluation, questions on the process of the work highlighted the referrers' view that the 'commitment of family members to the work' was of greater importance than either the 'personal attitudes of staff' or the 'methods of intervention' utilised, when it came to determining which factors were 'most influential' in determining outcomes for families.

(b) *Impact of centre's functions.*

While the research into the management and operation of the centre reveals a preoccupation with child protection over family support, this is not replicated in the signalled objectives of the referrers who fail to mention risk reduction as a goal. This may indicate an unstated acknowledgement, on the part of the centre staff and referrers, that it is more important to spread the responsibility for addressing risks than to achieve a specified degree of amelioration. Consideration of measurable change were secondary and subsidiary to this primary concern.

(6) Effectiveness: families' views on the centre

(a) *Evaluation of process and outcome.*

Almost all the families interviewed appeared to reflect on their contact with the centre in a very positive light .One family, for example, was able to identify the help given with a specific child behavioural problem: 'very helpful, as we have a child coming on now and I know how to discipline her without smacking.'

Other families believed that they were now able to see more clearly the cause of some of their difficulties: 'it gave me real understanding of myself and how my reactions would aggravate a situation rather than cure it.' For another family it was obvious that their previous negative experience of social workers led them into not wanting to view the centre staff as social workers: 'the centre is very helpful, but its like this, you don't see 'C' as being a social worker_..you know, like, she's here to help__' Generally, the most positive attributes of the staff were seen as: listening, friendliness, support, and a personal touch.

(b) *Impact of centre's functions.*

The positive remarks highlighted above applied mainly to cases where family support was being offered. Families were more ambivalent about the staff when there was a child protection issue being assessed. One mother objected to the 'closed' family therapy approach: 'well I didn't like the way they watched you behind the screen. I thought they were looking for things against me.' Another parent felt that they were being blackmailed into staying at the centre: 'I think the worst thing was the feeling of being black-mailed...you see if I walked out, I was going to be reported to social services, so I had no choice but to stay.'

Discussion

As the results indicate, the attempt to juxtapose a child protection and family support approach, appeared to produce role strain for the staff, and ambivalent feelings in the families toward the centre. In particular, risk-oriented practices did not sit well with a needs led, partnership oriented approach. This contradiction made it difficult for the centre to demonstrate effectiveness in both areas simultaneously. There is also evidence to suggest that other integrated centres experience a similar tension (Higgins et al, 1998).

Because the contradiction is so central, integrated centres are presented with a key dilemma: whether to continue with the approach as it stands, or to separate the functions. However, the authors wish to construct a third option. In this option, the aim is make the child protection and family support functions compatible. This can be attempted through a number of measures. First, the family support function could, in theory, be expanded to include 'community social work' (Hadley, Cooper, Dale, & Stacy,1987). The focus here would be on identifying and supporting community networks through advocacy, group work and social action. Second, the child protection function could be re-constituted. That is, instead of concentrating on assessments of suspected and confirmed abuse, the centre could re-focus on the prevention of child abuse in the community (Hardiker, 1991; Garabino & Gillam, 1980). For example, early interventions with 'at-risk' populations could take the form of parent support and training groups and community education on child abuse. Third, family therapy could be offered to families experiencing relationship difficulties; but a 'closed' model - where the professionals develop their own hypotheses about family dysfunction - is replaced by an 'open 'model (Hoffman, 1990). In this 'open' model, the families' view of the problem (and solution) becomes the key narrative for change.

An integrated centre operating according to this model, would be more unified in its purpose. This is because the use of control and authority, which underpins the present child protection function, is removed. (This function could be retained elsewhere within separate investigative teams). The effect of these changes would be to mitigate the role strain experienced by staff and the ambivalence expressed by the families.

The rationale for developing a centre of this kind can be argued further. First, within the UK, it could provide an 'exemplar' of how child protection and family support services can be combined. Second, at a regional level, it could play a vital role in urban renewal. This is particularly apposite for Northern Ireland which has only recently embarked on an historic peace process (Anderson, 1998). Lastly, at an international level, it could provide a new service to combat child abuse and social exclusion.

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