



Confident workers, confident families: Exploring sensitive outcomes in family centre work in England

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Abstract

A case study approach was used to examine an English Family Centre as part of an international research collaboration which aimed to explore aspects of sensitive outcomes or “steps-on-the-way” to accepted longer term outcomes, such as changed behaviour in the child, or more confident parenting. Key learning came from understanding how the Family Centre staff created a culture of care which appeared to promote enhanced confidence and competence, both in families and in workers. The centre also appeared to be able to extend and export its culture to help look after external teams and individuals and to prop up ailing parts of its own local social services agency. These findings have implications for the children’s workforce and the way in which child and family services are planned and delivered within large organisations in a climate which is beginning to challenge defensive, bureaucratic and procedurally led practice.

Key words: professional confidence, child care outcomes, family support, child protection.

Introduction

Family centres: The English context

In England family centres are mostly offered as a component of family support and provide services that accord with the following definition from the Audit Commission in England and Wales (1994, p. 39):

“Family support is any activity or facility provided either by statutory agencies or by community groups or individuals, aimed at providing advice and support to parents to help them in bringing up their children”.

Family centres also fit within the remit of the England and Wales Children Act 1989 and the general duty of local authorities to provide or promote family centres as a means of meeting their protection and prevention responsibilities towards children and their families (Pithouse, Lindsell, & Cheung, 1998, p. 55).

However, family support services in England, as elsewhere, encompass protection against neglect and maltreatment as well as prevention. Recent English government guidance and legislation have emphasised the need for policy and practice to embrace preventive services and to incorporate the twin aspects of protecting children and promoting their welfare (Department of Health, 1999; 2000). The latest raft of government reports have reaffirmed this stance: "Child protection cannot be separated from policies to improve children's lives as a whole" (DfES 2003b, p. 5).

Within this complex and volatile debate, family centres have developed along a shifting continuum, from genuinely voluntary services at one end to more coercive or legally mandated aspects of provision, at the other end. Some centres span the range while the policy of other centres will propel them to incline more to either prevention or protection. Open access centres are more likely to be voluntary and act as a neighbourhood resource, promoting community development, while specialist centres focusing on serious family dysfunction and child protection are more likely to have restricted access via professional referral and thus be more distanced from the local community (Pithouse, et al., 1998).

In this respect many families attending a restricted access family centre may present particular challenges as 'involuntary clients' sent as part of a child protection plan and may be hostile and resistant to services. In 1994 the Audit Commission report cautioned that services should be targeted on those who can make best use of them if they were to be cost effective. A key challenge to effectiveness with 'involuntary clients', is arguably, to appeal to them in such a way that they become more 'voluntary clients' who are more likely to benefit from services. The characteristics of organisations like local authorities can appear to mitigate against services being appealing.

A number of authors have argued that attempts to improve child protection services in the UK and elsewhere have tended to focus on bureaucracy, procedures and performance management (Ferguson, 2005; Munro, 2002; Tilbury, 2004). This procedurally-oriented, target-driven approach has been said to "squeeze out" the psychological aspects of the work and fail to get to grips with the emotional and professional impact that hostile and needy families have on workers (Ferguson, 2005).

Psychodynamic theory tells us that the anxiety of professionals working with needy families where they are expected to somehow make up the deficits of poor parenting and protect children are high (Woodhouse & Pengelly, 1991). In order to manage these everyday anxieties, Cooper and colleagues (2003) argue that professionals must be self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions. Supervision and good support, they claim, is crucial. If management structures and staff support systems collapse, the result is often paralysis in the workers, or ill health, or absenteeism or other signs of stress (Brandon, et al., 2002). Family centres which can provide "protection, nurturance and avenues for development for parents and their children" (Lightburn & Warren-Adamson, 2005) may also have a part to play in extending this nurturance to staff, both within and beyond the centre.

Review of outcomes from similar services

The self esteem and confidence of parents can be important target variables. Improving how parents feel about themselves and their ability to care for their children can enhance their skills in parenting, and in negotiating help which in turn can produce more successful child development (Little & Sinclair, 2005). Thus the outcomes of successful family support generally include "alleviated stress, increased self esteem, promoted parental/carer/family competence and behaviour and increased parental capacity to nurture and protect children" (Hearn, 1995, p. 3). The expected outcomes of family centre work fall within this broad statement.

Tunstall (2003, p. 33) points out, however, that in the UK the New Labour vision of a span of universal and selective services creates problems in researching outcomes of family centre

work. Locating boundaries between different types of services, which may co-exist within the same centre, is difficult. For example, services which involve the assessment of parental competence, services which remedy identified deficits, and services which build on existing levels of parental competence where no deficit has been identified may not all produce the same outcomes.

Gauging outcomes is always problematic and much depends on the definition and timing of the outcome measured (Hill, 1999). There is, however, evidence that intensive family support programmes produce stronger outcomes of success than more didactic and periodic interventions (Hess et al., 2000; Nelson et al., 1990). Much of this work takes place in integrated centres.

There is also a small body of evidence which points up successful outcomes from more specialist centres operating primarily in the sphere of child protection and serious family dysfunction. In a study by Pithouse, Lindsell and Cheung (1998), a child protection oriented family centre was scrutinised. The effectiveness of the services for ten families who received centre services was compared with ten families who received services only from area team social workers. It was found that those that had been at the family centre were more likely to have improved family functioning and reduced involvement with the child protection system. All families said it was the centre that helped them to change, and spoke of their changed attitude, behaviour, self esteem and self-confidence as well as improved relationships with children and partners. These families suggested that change had been a gradual process rather than a single event and three families said they had been motivated to change by the threat of losing their children (Pithouse, et al., 1998, p. 75). The process of change is summarised by the above authors as "changes in self-ascription and attitude brought about through critical encounters with significant others and events" (p. 79).

It would appear that family centres can have an important contribution to make as a step-on-the-way to family and child well being and hence to successful outcomes. This seems to be particularly pertinent in relation to the powerful effects on parents and children of a supportive relationship which can help to disconfirm negative internal representations of the self and others that have been acquired (Rutter, et al., 1990). Yet the outcome literature in family support tends to pay less attention to the factors within the staff and the staff group which help to promote a positive sense of well being in children and families. Glisson and Hemmelgarn's (1997) study of the effects of organisational climate and inter-organisational coordination on the quality and outcomes of children's services sheds more light on staff attitudes and organisational factors. They point out that, since the effectiveness of services depends on the relationships formed between service providers and the people who use the services, the attitudes of the workers play an especially important role in the outcome of services. They found that effective casework relationships were more likely to occur in organisations where caseworkers agree on their roles, are satisfied with their jobs, cooperate with each other, and personalise their work (Glisson & Hemmelgarn, 1997, p. 406). Family centres seem to provide a well positioned environment for staff in which some of these attributes can be encouraged, rather than, for example, besieged area teams where caseworkers struggle to feel supported.

The centre studied: Policy and structure

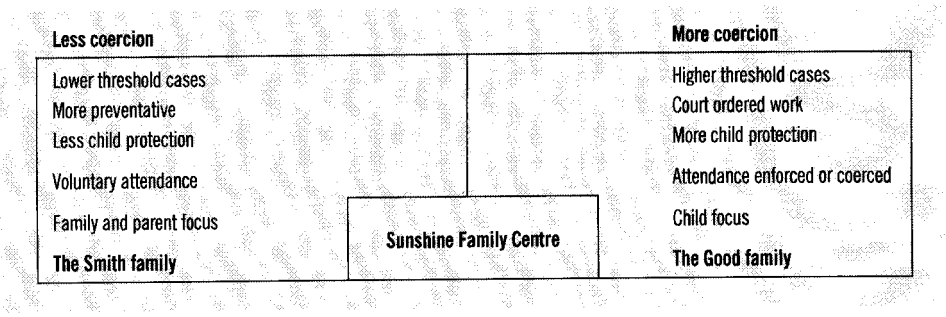
The case study selected as an English example, the "Sunshine Family Centre", is part of the local authority state-funded social work service for children and families. It is one of twelve local centres which all work to a set of tightly prescribed objectives. It can only be accessed by families who are referred to social services and meet the high threshold for service. In this respect the centre fits one of Holman's (1988) three models of family centres, which are not readily accessible to the community but offer specialist therapeutic services where aspects of

child protection are normally paramount. The centre works with families with children aged between five and eighteen who are experiencing trauma or stress. Whilst it works within the overall policy framework established by the local authority, 'Sunshine' also has its own individual aims:

- help people to help themselves in improving relationships between family members and taking control of their lives;
 - help children, young people and their families manage life experiences
 - promote the safe and healthy development of children; and
 - encourage and support parents and carers in maintaining their parental responsibilities
- (Centre leaflet, X Shire County, Council 2000).

The centre is required to meet targets for different aspects of the service which are set by the employing local authority. This then helps the local authority to meet performance indicators established by the English government, which provide funding for the achievement of specified outcomes (Department of Health, 1998). This target-driven system produces particular points of pressure, such as avoiding a backlog with the increasing number of public child welfare cases in court proceedings (Department for Education and Skills, 2003). Within the particular local authority involved in this study, for the year 2003-2004, a policy directive was issued requiring all of its family centres to organise their services so that 70% of their capacity was to be set aside for court assessments. The remaining 30% of each centre's time was left for preventive family support, which could be carried out if the core business of court work was undertaken.

The diagram in Figure 1 shows that 'Sunshine' worked with both willing and potentially less willing families and straddles the mid-point of the continuum of voluntary (less coercion) and compulsory (more coercion) attendance. Each of the two families studied, whose routes through the family centre were traced for this study, occupies one side of the diagram (i.e., one family's route was more voluntary and the other family's was more coercive). Mrs. Good and her children, for example, felt that attendance at the centre was essential to the children staying at home and thus might have experienced the work with the centre as coercive.



Adapted from Brandon et al., 1999, p. 102.

Figure 1
The Sunshine Family Centre

Centre activities

The core tasks and activities of the centre over the year April 2003-March 2004 involved a total of 126 cases (126 families and 211 children). Seventy-five family cases were referred from the courts (assessments of parenting capacity and parenting orders for families with child offenders) and 51 families attended voluntarily. Services at the centre included parenting

groups; play-based individual work with children; bereavement groups for children; counselling for parents; and joint adolescent and family sessions.

Many of the centre activities are carried out jointly with other professionals, so that there is collaboration with practitioners from health (including child and adolescent mental health services), youth offending, education, hospice staff and area team social workers. There is a multi-disciplinary approach in many of the services provided and this ethos is carried through into other professional activities aimed at staff development and support.

In addition, there is regular peer group supervision and members of the centre staff also offer consultation for area team social workers who present cases for discussion. Clinical consultation is offered to centre staff from a psychotherapist and a family therapist. Lightburn and Warren-Adamson (2005) comment that clinical services build capacity in family centres and clinically trained staff bring a developmental perspective that helps staff to understand parents' and children's emotional struggles as well as their own emotional needs.

Funding

In spite of the tight boundaries around eligibility, the centre tries to find creative ways of providing and resourcing preventative services. For example, it was successful in its application to the Children's Fund (government funding aimed at children aged 5-13 to combat social exclusion) and has used the additional funding to employ a counsellor for three days a week for a period of three years. Berry and Reed (2004, p. 48) have pointed out that funding streams have powerful effects on family centre services. In this instance, additional money has given the centre some autonomy and the ability to offer a service separate from the statutory requirements which would not otherwise exist. The counsellor is the only member of staff who does not keep family notes, and does not report back to the referring agency.

In spite of individual successes in meeting targets and securing additional funding, core funding for family centres cannot be guaranteed within local authority services. Cost effectiveness, added value and ultimately year-on-year savings are increasingly sought by employing bodies and established government performance indicators. As such, family centres are a potentially vulnerable stream of service provision. The national government has recommended integrated children's centres that offer multi-disciplinary and inter-agency services (Department for Education and Skills, 2003). Family centres, which already operate in a similar fashion, could adapt to fill this role, or alternatively could find themselves dismantled to make way for new ventures.

Exploration of sensitive outcomes

Negotiating access to the family centre

The Sunshine family centre was purposefully selected for study as an example of likely good practice. I was aware of its work through links with two of the centre's staff who were participating in a post-qualifying social work programme at the University of East Anglia in England. As I had hoped, centre staff members were eager to be involved in the study and the centre manager facilitated negotiations with senior management, which readily agreed to permit the project. The next step was to complete a detailed proposal for the individual case study, which was submitted to the local authority's Research Governance Group. The authority had developed a comprehensive framework and template for Research Governance, and approval was secured. Approval was similarly forthcoming from the University's research ethics committee.

Methods

The primary research question to be addressed is: What are the sensitive indicators, or “steps-on-the-way,” in a community-based centre. The case study approach adopted incorporates both process and outcome measures. The design for the research is based on collaborative enquiry (Reason & Bradbury, 2001); it is participative and allows for learning and growth across the relationships amongst researcher, practitioner and service user. The researcher joins with the practitioner and both examine the proposed intervention and the desired outcomes. In the dialogue between researcher and practitioner, we delineate intermediary stages, or “steps-on-the-way” to accepted longer term outcomes, such as changed behaviour in the child or more confident parenting. In this way we envisaged that some sensitive, mediating or “containing” outcomes would emerge (Berry, Bussey & Cash, 2001; Dawson & Berry, 2002). In addition, the routes of two families through the centre were traced. All families who were using the centre were approached to be part of the study and the first two families who consented were then tracked. (Families were not purposefully chosen to represent more coercive or more voluntary routes through the centre; this finding emerged through the analysis). For one family, standardised measures were administered to provide an additional illustration of outcomes. The second family only agreed to be contacted by telephone so standardised measures were not used with them. The data were then triangulated so that the interviews, case notes, centre records, reports, policy statements and the standardised scales were used to test the findings.

In summary, the following researcher activities took place to understand how the centre functions and connects with its employing agency, as well as the overall approach to work with individual families and groups:

- visits to the centre to carry out focus group discussions with the staff and individual interviews with its ten staff members;
- tracing of two families’ routes through the centre;
- scrutiny of centre workers’ case notes and information prepared about each family for the purposes of the study;
- interview with parent;
- interviews with children;
- administration of standardised scales by the centre workers at the beginning and by the researcher at end of the intervention;
- scrutiny of centre publicity, policy and reports.

Two families’ routes through the centre were traced. Interviews were carried out with all of the centre workers, and with the first family Mrs. Good and her two children Joshua aged 12 and Kelly aged nine. Neither Mr. nor Mrs. Smith in the second family agreed to be interviewed, but a telephone interview was carried out with their son David, aged 15. Due to space limitations, only the work with the Good family (the family served within a more coercive referral stream) is included here. The entire study and its findings can be obtained by contacting the author.

Findings: the culture of the Sunshine Family Centre

The concept of containment, drawn from object relations theory, of absorbing and holding the projected anxieties and emotions of vulnerable families, appears to be important in the success of family centres. Warren-Adamson and Lightburn (2004, p. 220) describe centres as a “safe haven, a holding environment that supports and challenges”. Interviews with centre staff helped to shed light on how “Sunshine” creates a sense of containment, primarily through its culture of care. Factors contributing to the culture generated by the centre, and ultimately to the culture of care, are considered below.

Location and physical attributes of the centre

The centre is located in a densely populated urban area with high levels of deprivation – in one of a number of “new towns” in the outer London suburbs. These towns were built in the 1950s and 1960s in order to house families moved out (not always willingly) from the slums of the east end of London. The town has experienced growing levels of unemployment and poverty and some estates of public housing have already been demolished and rebuilt, using government urban regeneration funding, in an attempt to combat crime and social disorder.

The centre itself is not in an area of high crime but is an ordinary detached house situated in a relatively quiet and peaceable estate of public housing. The centre house is slightly larger, but otherwise looks similar to its neighbouring dwellings. It has no sign outside indicating its identity as a family centre and only a car park at the side, next to the garden, to distinguish it from other houses. Staff members say that they aim to blend into their surroundings. Inside, the centre is comfortably furnished, well stocked with toys, well maintained and decorated. It has no graffiti or apparent damage and is visibly well cared for.

There is little interaction between the centre and its neighbouring community. In this respect it is *in* rather than *of* the community and the services on offer are not directly available to the community, although many of the people who use the centre live nearby.

The Staff Group

There is a fully staffed group of nine workers at the centre, with an additional member, a qualified counsellor (who is also a psycho-sexual therapist and family mediator) who is employed three days a week. All staff members are female. The centre is led by a social work-qualified manager and there are five other qualified social workers, one unqualified social worker and two support workers. All centre employees are experienced and well trained and all of the qualified staff, including the centre manager, are currently undertaking some form of post-qualifying study. There has been full staff retention (100% over the past year) in a local social services area which carries a very high vacancy rate in social work teams. This compares to a national social work vacancy rate of 11%, which rises to 20% in London (Department for Education and Skills, 2003, p. 85). As one member of the “Sunshine” team commented: “Staff stay for a reason – people want to work here. You feel you’re given time, space and flexibility. Caroline (*centre manager*) is our biggest asset here”. Six of the staff are white British and three are South African (one white, one black and one Indian). All of the South African workers have been in England for at least three years.

The centre’s approach to the work

Although each case is individually referred, often with a specific remit if it is a court-ordered assessment of parenting capacity, the centre has a common approach to cases:

“... We always start with the referral meeting without the family, with the referring social worker and at that point we look at the chronology, look at what the family themselves have asked for, look at what the referring social worker is aiming to achieve. And at that point we try to think: OK, what’s the task? And from that it may be direct work with the child or with the parents; it may be family work or a mixture of all of these” (*Caroline, centre manager*).

Within this broad approach, there is a sense that the order in which services are offered is important, and that parents need to be at the right stage to embark, for example, on a parenting programme. The preferred centre order is for parents to see the counsellor first. This has resonances with the approach advocated by Crittenden (1992) and Howe et al. (1999; p. 278), who suggest that “practitioners should manage and plan their interventions in some broad developmental order,” beginning with emotionally supportive interventions like counselling, before considering, for example, behavioural techniques. Gemma (*centre social worker*) com-

mented: “We take a lot of care around how we start the work here. We think and reflect a lot about the best way to do the work”.

The centre also likes to determine, in conjunction with the area team social worker and the families themselves, the duration of services, although there is pressure from management for short-term work:

“We have to battle really hard for the area team not to close the case too early. If you keep closing the cases too soon they come back as referrals. We prefer to hold them, and see them through to a managed ending” (*Caroline, centre manager*).

Most families work with the centre for up to a year although families can be re-referred and come back. The two families followed for the purposes of the larger study were at the centre for seven months (Good family) and one year (Smith family).

Centre staff explained that although they are part of social services, they are not perceived in quite the same stigmatising way by families:

“We are part of social services – but it’s not the first thing on families’ minds – because they have such a negative view. They focus more on the building and the people here. We have time and space, and listen and engage, and take genuine care, rather than running round with a hundred cases” (*Elizabeth, centre social worker*).

Layla (*a centre social worker*) explained that those outside the centre may have the attitude that work undertaken at Sunshine is a luxury but pointed out that workers are expected to provide a professional opinion: “Hard decisions are made here as part of court commissioned parenting assessments – the responsibility feels heavy and we need to be so self-aware – what’s going on for you and where that fits into the case.” These difficult professional decisions were often tested out several times: in supervision, peer support and in outside supervision with a systemic therapist. This ability to discuss and reflect on decisions in depth was important to the group, as the decisions made were often painful, involving recommendations that children be removed from – or not returned to – parents.

Staff care

Leadership of the centre by the manager was mentioned by most of the workers and seemed to have an effect in creating a culture of care which appeared to start with the staff caring for each other that then permeated to the care that was offered to families. Individual interviews with members of staff reflected this theme of care strongly:

“You’re not put in a position where you feel overwhelmed. Clients are protected as well because that’s what our work is about.”

“You feel cherished and cared for and protected. People do things to make you feel safe which helps you to cope with losses like bereavement.”

“Lots and lots of support – it’s a very supportive team. Everyone has had a personal crisis of some sort. It’s a nice place to work if things aren’t going right.”

“We’re lucky as a team because we get on quite well. There’s always someone to talk things over with.”

“I just, personally, just love it here, and love coming to work. If it wasn’t this good I’d be looking elsewhere but I’m happy to finish my working life here. It’s a nice relaxed atmosphere. It’s good for the clients.”

Lack of staff care for area team social workers

The feelings of care and support were contrasted by three of the social workers' views of their previous posts in an area team, and all of the workers' impressions of the current experiences of area team workers:

"In the area teams they ricochet from one disaster to another and nothing gets done properly – things do get done properly at 'Sunshine'; people get the sort of service they deserve."

"The pace is slower here – I didn't notice until I came here that area team people speak faster."

"Before I came here I was grinding my teeth and having palpitations. There was no support at senior management level, no resources and no back up. People didn't care about children and what was happening to them – they were just numbers and cases."

The effect that working in the apparently low morale, high pressure environment of the area team was illustrated by management of the 'Good' family's case before they came to the centre. The 'Good' case was described as a typical local case, with a context of high turnover of staff in the area teams and no continuity of care. The case was described as a catalogue of disasters, where the mismatch of family views and disagreements was mirrored in social services' ineffectual activity. Decision-making and planning either failed to happen or were not properly thought through and no agreement could be reached.

The culture of care at "Sunshine" appeared to enable the staff to reflect on the children's often painful experiences rather than to distance themselves:

"You think differently about families here. In the area team you feel shut off from children's emotional damage. Here we work more with the children and think more and discuss more. The impact of the damage and abuse becomes clear."

This statement resonates with Pithouse, Lindsell, and Cheung's (1998) study of the comparison of the work of a child protection-oriented family centre with that of area team social workers. They found that the centre work was less narrowly confined to technical and procedural matters than in area teams and could be more focused on the inner realm of people's lives. It appeared to be easier to offer therapeutic services in the centre, whereas mainstream area team social workers were more bounded by a preoccupation with 'risk reduction', which did not allow for more therapeutic interventions.

Staff confidence and awareness of theory

Overall there was a strong impression of confidence and theoretical awareness amongst centre staff members which appeared to help them to work creatively, and to an extent autonomously, within the tight structures prescribed by the agency. This was epitomised by a comment from the centre manager: "The messages from above [the local authority] are for short-term work only. But the messages from within are more important – we know what we're doing". This capacity to get the best out of the bureaucracy chimed with a finding from Glisson and Hemmelgarn's (1997) study which linked successful outcomes, in part, to workers' tenacity in navigating bureaucratic hurdles to engineer the best services for children. The confidence in the approach to the work – the "we know what we're doing" aspect – also came through in the individual interviews with the social workers and the counsellor, as exemplified in the following quotes:

"I draw in the child and let them know I'm interested in them. I start where they are. I let them be and find information at the same time. It's respectful. It works." (*Centre social worker*)

"I need to take families through a whole cycle and go on a journey with them, empower them and give them some of the tools and skills." (*Centre social worker*)

"Families and individuals talking to me, and telling me, can be the key to their moving on. I'll say to clients – this is the only thing you'll be offered for you. I'm not here to check on you as a parent but as a supporter for you and your family. I ask people how are you – what's happy for you with your family. People are very easy to engage." (*Counsellor*)

For newer members of the staff team, the above-noted confidence could be quite daunting. One said:

"It's a very skilled group of people – you can be left feeling inadequate and incompetent if you're the last one in – that you'll never be able to know what they know." (*Centre social worker*)

The 'Good' family's route through the centre

Family background

Mrs. Debbie Good is a lone parent with two children, Joshua aged twelve and Kelly aged nine. The family was referred to the "Sunshine" centre when the children returned home to their mother's care after spending six months with their maternal aunt, because of Social Services' concern about neglect at home. The return home was unplanned and followed a succession of family disagreements. Once home, both children were listed on the Child Protection Register under the category of neglect as there were still professional concerns about the risk of further neglect and about their safety at home.

Mrs. Good has a history of depression and substance misuse, Joshua has Tourette's syndrome and Attention Deficit Disorder (ADHD), and Kelly has a bowel problem. Mrs. Good separated from the children's father six years ago and they see their father and his new partner occasionally on weekends. Prior to the move to their maternal aunt, there was a history of concern from school about Joshua's behaviour and appearance of both children being poorly clothed, smelly and suffering repeated bouts of head lice.

The route through the centre for the Good family is outlined below at four stages: at the point of referral; engagement with the centre; using the centre services/building relationships with the workers; and follow up to the centre services.

At the point of referral – The family's readiness to engage

The extended family are critical of Mrs. Good, and make regular reports to social services about her failings as a parent. They are not supportive. Mrs. Good acknowledges she has a problem and to some extent is ready to engage with the centre. Centre staff feel she has no real choice but to comply, but as Mrs Good herself said: "I'd had a nervous breakdown ... and last year the house went downhill and the children were looking a mess. ... I needed help and I liked what was on offer from the centre."

The children were also ready to engage: "We went to 'Sunshine' because we got taken away and my social worker wanted me to have a say in my life, because I've never had a say in my life..." (*Joshua*) "We went to help me and Joshua" (*Kelly*).

Such readiness to engage was also found amongst the most successful families in a UK study of an intensive Family Preservation Service (Brandon & Connolly, 2001, p. vii).

The family's engagement with the centre

The children are shown around the centre and offered a choice about which room they would like to use for their visit. The staff provide play-based explanations about why the children were coming to "Sunshine" and obtain from the children play-based consent for the work.

Joshua said, "We thought it was really nice and good. I thought I'd give it a go – if I liked it I'd carry on, if not I'd stop."

Mrs. Good was more tentative: "I didn't know anything about it. It was the first time I'd ever had social services. I was very nervous... I had to wait about a month, I expected it to be longer". However, once she is engaged with the centre, Mrs. Good chooses the pseudonym 'Good' for the study at a time when her family and social services were not seeing her as a "good" parent.

Using the centre and building relationships with the workers

Play-based sessions were held with Joshua and Kelly, fortnightly for six months. "My work with them has focused on giving them the opportunity to speak with someone away from the home and to try and assess what their worries are and give a view to their general well being... Both children appear to have been extremely distressed about being removed from their mother's care (Joshua especially). I believe their anxiety at the thought of being removed again makes them fairly guarded about what they say" (*Centre report to social worker*).

Both children enjoyed the sessions. As Joshua said, "I could say whatever I needed to say to her. She let me play and agreed to change the times so I could play football and other things." Counselling sessions and a behaviourally-based 'Webster-Stratton' Parenting group were arranged for Mrs. Good over a three month period (Webster-Stratton, 2000). Mrs Good described the counselling as "the best service", and said the parenting group workers were "brilliant, fantastic".

There were also sessions for Mrs. Good and the children's father to discuss parental responsibility, and with Mrs. Good and her various partners to discuss parenting. In addition, there were also meetings with extended family, and a final review meeting with Mrs. Good to conclude the work at the centre.

Follow up to the centre's services

Follow up services were available and varied. Mrs. Good still has links with "Sunshine" – through the offer for the following year of a "Step Teen" group, and separate help is also being offered to Joshua: "Next I'm going to the boys' group at (another centre)... Now I need help with my school work, and I get it from my special needs teacher... I need more help but I'm getting loads."

The area team social worker continues to provide a service for the family. Mrs. Good says: "The best thing about the centre was lots of support, and I've had that from my social worker too. I've been quite lucky I think compared to other people's experiences with social workers."

Moves towards better outcomes

For parent and children

Successful family support aims to inculcate in parents the experience of themselves as worthy, and to foster self-esteem, self-confidence and enhanced competence as a parent (Hearn, 1995). These self-attributes stem from the emergence of trust through the experience of successful relationships (Rutter, et al., 1990). In this centre there is also a clear focus on children as having separate needs from their parents. Also, similar attributes are hoped for with both children and parents.

For Mrs. Good as a parent, these include the emergence of the self as likeable. During the time at Sunshine, Mrs. Good realised that her new social worker and 'Sunshine' staff now saw her as a 'good' parent and person. Another connected improvement was enhanced competence as a parent. This was evidenced by the children continuing to be clean and well presented. The children are encouraged and supported at home and at school and behave better at home. As Mrs. Good said, "The children are much calmer now".

The children’s names were removed from the child protection register two months after the family left the centre. There are still unresolved issues for Mrs. Good, including in particular, discord with extended family. The standardised scales (Abidin, 1995) showed marked improvement over time in her interactions with Joshua but the overall score gained at the end point of service was still just below the level that would be expected in the general community. The Rutter et al. (1970) Malaise Inventory, an indicator of the degree of emotional distress and depression, revealed that Mrs. Good’s health was poor, and indeed there had been a slight deterioration. These scales perhaps indicate that high threshold cases with deep-rooted problems will not be “cured” by short term services and appear to justify continued involvement with social services, as Sinclair and Little (2005) have pointed out. Improvements for the children included firstly, regular attendance at school (Joshua was awarded a prize at the end of the school term for good attendance). Secondly, clean clothes, no more head lice and more predictability at home (parent in control). Thirdly, their experience of some personal control over their lives, to “have a say” and to have some choices in their lives backed up by ongoing contact with practitioners whom they trust. Unresolved issues for the children were Joshua’s anxiety that things might go wrong again at home, demonstrated by his mixed feelings about continuing with social services: “I’m still here with social services on my back. It’s good and bad, a bit of both.”

For area team workers linked to the centre

The improved experience for area team workers, who join with the centre for as long as their referring family has links with it, seems potentially to follow a process comparable to that which characterizes families, as suggested in Figure 2.

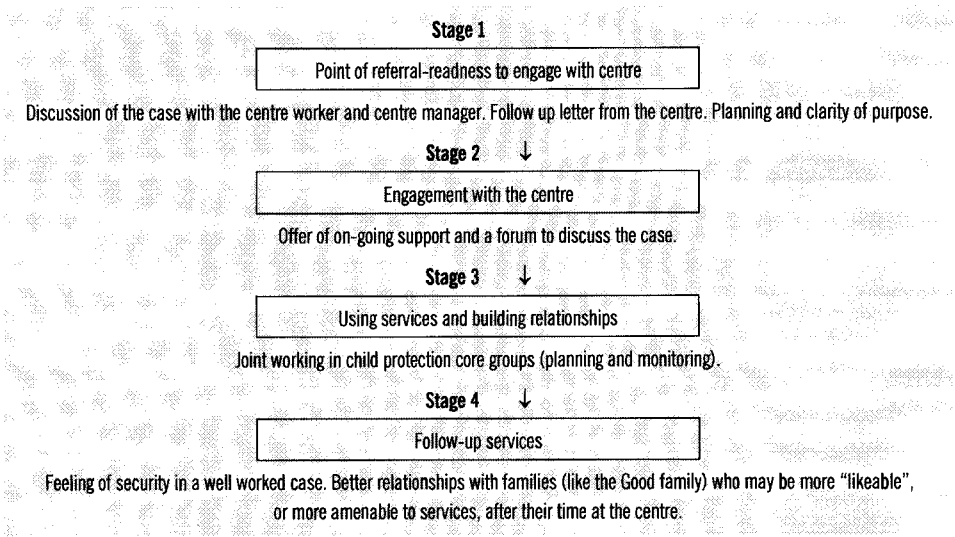
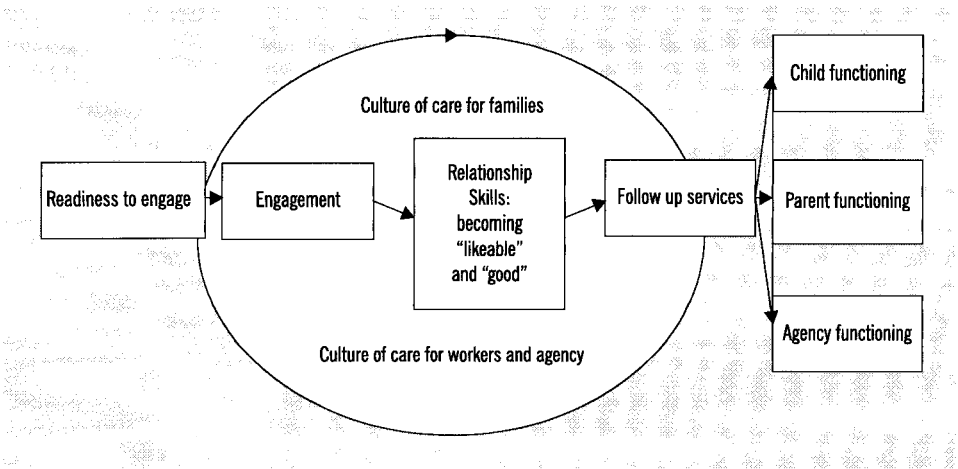


Figure 2
Steps-on-the-way for area team social workers working with the centre

As seen in the experiences of successful groups, Centre staff members appear to have various needs: the need to feel *connected*, the need to believe one is *competent* or *capable*, the need to *feel valued* and that one *counts*, and the need to overcome fear and face challenges or to have *courage* (Lew & Bettner, 1996). Social workers coming to the centre are also able to take ad-

vantage of the culture of care offered and may then take on the above-noted attributes, which are associated with positive psychosocial development and therefore a healthier work force. How this culture of care works is illustrated in Figure 3.



Adapted from Chaskin, 2004 and Lightburn & Warren Adamson, 2004.

Figure 3
The culture of care

Lessons to be learned

The evidence from this case study shows that, as in the other parallel international case studies, families were able to benefit from their connections with the centre in a staged process where it was difficult to pinpoint any single turning point. The key learning from the study in relation to sensitive outcomes, however, has come from a deeper understanding of family centre staff from their own perspectives and their contribution to the culture or milieu created at the centre. This was most evident in the care that staff members took of each other, as well as care for the families, and indeed anyone who crossed the threshold of the centre. Centre staff were all well-trained and well-supported and secure in themselves and their roles. They were, for the most part, confident about the aims of their work and the theories and methods that underpinned their activity. The sum total of these attributes promoted a special sensitivity to the children and the families as well as an awareness of the impact of this emotionally draining work on themselves.

The “containment” offered by the group under the steady leadership of the centre manager functioned so that the group was a repository for the emotional states and needs not just of the families, but also the workers who referred the families and other professionals who worked alongside the centre. In this respect, the centre extended and exported its culture to help look after external teams and individuals. The centre apparently was providing a stabilising role to counter dysfunctional parts of the agency exemplified by low morale and high vacancy rates. These findings have implications for the way child and family services are planned and delivered within large organisations in a climate which is starting to challenge defensive, bureaucratic and procedurally led practice.

The enhanced confidence in the centre, particularly evident in the manager, enabled the team to work creatively and constructively and to exercise professional discretion, within tightly prescribed policy guidelines. Difficult professional decisions were made regularly about parenting capacity and the nature of this task forced the centre to be more child-centred than parent-centred. Staff were comfortable in this role and did not feel that it compromised their work in supporting parents; for example, efforts were made to extend the preventive nature of services by offering the services of an on-site counsellor, at a time when the prevailing policy was dictating a high preponderance of court-based work.

In terms of learning for future research, it would seem important to assess the emotional as well the structural climate and health of child care agencies and the way their services are offered. The table devised by Ezell (2004), illustrated in Figure 4, provides one means of accomplishing this. Future outcome research could also usefully consider the relationship between area team workers and family centre workers and also how area team social workers can and do offer a culture of care and containment.

Characteristics of caseworker	Characteristics of supervisors and managers, supervision and management	Organizational characteristics	Inter-agency variables
<ul style="list-style-type: none"> • Years of experience • Perceptions of supervisor/supervision 	<ul style="list-style-type: none"> • Style of supervision • Number of supervisees • Years of supervisory experience • Amount of supervisory training • Administrative support for caseworkers • Perceived support from management 	<ul style="list-style-type: none"> • Size (budget, number of employees) • Age • Auspice • Culture • Hierarchical structure • Degree of centralization • Worker autonomy • Funding sources and mix • Administrative costs • Financial strength • Ideology • Degree of formalization • Amount of red tape 	<ul style="list-style-type: none"> • Regulatory requirements • Funding sources and mix • Accrediting bodies and standards • Financing mechanisms • Competitive conditions • Structure of child welfare system (state versus county; relationships with other children's services; proportion of contracted services; degree of centralization; funding trends)

Figure 4
Potentially important macro factors (from Ezell, 2004)

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