

3

Models and Philosophies

The variety of provision

Goldberg and Sinclair (1985) after an examination of support services to families made the following comment about family centres:

They vary widely in their aims, activities, and staffing patterns, in the type of family for whom they cater, in the degree to which they are involved in their local community and the type of communities they serve.

This observation is echoed throughout the literature on family centres as the last chapter demonstrated. Thus family centres may share a common title and yet vary enormously in their nature. Some centres may have more in common with establishments bearing different names such as children's centres or neighbourhood centres. Only limited assumptions can therefore be made about the services, participants, methods or staffing on the basis of the title 'family centre'.

As we noted in Chapter 2, several influences led to the evolution of family centres and the multiformity of centres is in part related to these influences. Thus whether a unit represents new provision, results from the closure of a home for adolescents or has evolved from a day nursery will have considerable implications for its population, staff and style. A range of factors, which contribute to the differences between centres, will be explored in this chapter.

Different philosophies

There may be significant contrasts in philosophies among centres. For example, some may view difficulties in child care and the risk or existence of child abuse as resulting primarily from the dysfunctioning of individual families. Other centres may understand the same problems in terms of failures in social structures, while yet others may hold an interactionist stance which sees problems as resulting from a complex interaction between factors within the individual, the family and the wider social structures. Clearly such different perspectives will lead to diverse methods and approaches.

If the major contributing factors to child abuse are identified as parental or family 'pathology' then a centre will focus its activities on the parents/family with the objective of changing family functioning. If environmental conditions such as inadequate housing or lack of safe play facilities are viewed as significant causal factors then a centre's approach is likely to be based on a community development model. An interactionist philosophy is likely to lead to a combination of therapeutic and community development approaches.

Variety in philosophy will obviously lead to heterogeneity of goals pursued by centres. Garbarino (1982) makes a useful dichotomy in the nature of goals when he suggests that goals are either concerned with the minimisation of risk or with the optimisation of opportunities. This is closely allied to what he describes as the 'timing' of interventions which decides whether a service is preventive or remedial. As we saw in Chapter 2, prevention is best understood in terms of three levels: primary, secondary and tertiary (or remedial). There is diversity in terms of the level of prevention which centres believe to be their most appropriate concern and in the degree to which centres are concerned with the minimisation of risk or the optimisation of opportunities.

Common factors in centres

Before further exploration of the nature of differences between centres it is worth identifying and stressing the existence of

common features. As De'Ath (1985, p. 7) comments:

the phrase 'family centre' is increasingly being used as a generic term for any provision for parents and children where a range of services is offered to families living in a defined area and where the centre acts as a base for carrying out many of the activities.

Common factors among centres have been identified through a number of studies by for example: Phelan (1983), Hasler (1984), De'Ath (1985) and Holman (1988). It should be recognised that in the main these studies tended to look at voluntary sector centres and therefore some of the features may not be associated with local authority centres. The elements identified were that centres:

- tend to be located in neighbourhoods of high stress where there is marked incidence of factors leading to the reception of children into care;
- tend to draw out families' strengths rather than labelling them as a problem;
- tend to be accessible to local communities;
- work with parents as well as with children;
- emphasise user participation;
- have a commitment to increasing self-confidence and self esteem of users;
- provide a variety of services and activities for parents and children.

Categorisation of centres

A response to the considerable diversity found amongst centres has led to various attempts to classify them. Some examples of the different efforts at categorisation are given below.

The Social Services Inspectorate (1986) suggested eight descriptive categories:

1. Converted day nurseries.

2. Joint agency services for under fives.
3. Specialist non residential services for under fives.
4. Community/neighbourhood centres.
5. Multipurpose day centres.
6. Specialist day care.
7. Residential converted children's homes.
8. Residential special centres.

Downie and Forshaw (1987) suggest a twofold classification:

1. Neighbourhood-based community centres with an open, community-work orientation.
2. Centres for selected families, not open to all, with specific 'treatment' plans for individual families.

As indicated earlier, Holman (1988) provides three groupings:

1. Client-focused model.
2. Neighbourhood model.
3. Community development model.

The characteristics of a client-focused centre are its specialised activities, a concentration on work with referred clients, restricted neighbourhood outreach and professionalism rather than participation. The neighbourhood model Holman outlines as providing a broad range of activities, an open door, identification with the neighbourhood, local participation and flexible staff roles. The third model, community development, is characterised by indirect work, dissociation from traditional social work, collective action and local control.

The Department of Health (1991b) also provided a three-fold system calling the three types:

1. *Therapeutic* 'in these, skilled workers carry out intensive casework with families experiencing severe difficulties with the aim of improving the ability to function as a family . . . Some such centres provide accommodation to do this.'
2. *Community* 'local voluntary groups including churches may

provide a neighbourhood based facility for parents to use as a meeting place and take part in particular activities.'

3. *Self-help* 'these may be run as a co-operative venture by a community group and are likely to offer various support services for families in an informal and unstructured way' (DoH, 1991, p. 19).

Warren (1990) propounds a typology 'in the light of the family and child care climate heralded by the Children Act':

1. Family support centres.
2. Community development centres.
3. Integrated centres.
4. Parentcraft centres.
5. Day care 'plus' centres.
6. Assessment and 'treatment' centres.
7. Creative residential centres.

Cannan (1992) suggests that family centres can be viewed as falling between two poles of social-work/child-protection or community-development/neighbourhood-centre. She concurs with Holman's classification but adds a fourth category, adapted from Walker (1991), of the service centre. The service centre 'is based on the assumption that the centre provides a service which directly benefits the users, that the service is one which they freely choose and in which they participate as much or as little as they wish' (Cannan, 1992, p. 31). Cannan sees this model as closest to the neighbourhood model but providing an emphasis on a professional service.

Every classificatory system sheds some light on the distinctions to be made between centres but each has limitations. Some centres can be allocated to a category immediately whilst others appear to fit several categories or none. Each fails to encompass the range of significant dimensions along which centres vary.

Dimensions for identifying differences between centres

An alternative to a simple categorisation is offered, through the development of a multidimensional schema. This ident-

ifies a number of variables through which family centres can be differentiated and compared. Individual family centres change over time and this identification of key components to family centres helps to recognise and evaluate changes.

A series of dimensions will be explored which can be used to distinguish centres from each other. Some of the factors which need to be considered when choosing between different positions on a dimension will be examined. The list is obviously not exhaustive but the following pivotal features have been selected:

1. Origins
2. Funding sources and sponsoring agencies
3. Context
4. Age of children
5. Referred families or open door
6. Target for intervention
7. Catchment area
8. Child or parent or family focus
9. Residential or day provision
10. Role of families in the centre
11. Staffing

1 Origins

As indicated earlier, centres come from differing origins. Some centres have slowly evolved from changing practice in day nurseries, others have involved the conversion of children's homes and the redeployment of staff. Many centres have been planned as new ventures.

The origins of some centres lie with local authorities, others have arisen from the change in emphasis of voluntary child care agencies and a minority of centres have been established from partnerships. Some partnerships have been between voluntary bodies and the local authority social services department whilst others have involved joint ventures between health and social services or education and social services.

In addition there are family centres whose origins rest with self-help groups such as Gingerbread or the Preschool Playgroup Association.

Factors to consider

A new venture has the clear advantage of the lack of previous history. Such a centre is usually set up in response to identified need and staff can be appointed with the skills to meet the nature and style of centre needed. In these circumstances it is often appropriate and feasible to involve the local community in plans for the new project. A disadvantage of a new unit can be that if the provision is needed urgently, the time involved in finding or building appropriate accommodation and in making the detailed plans, can lead to frustration for staff and for potential users.

An advantage of the conversion of existing provision is the converse of this disadvantage; the existing accommodation and the ready availability of redeployed staff can lead to a service being provided more immediately. However as Phelan (1983) concludes, 'changing an existing operation into a family centre is a long, difficult and disruptive process'.

The disadvantages of changing existing provision into a family centre arise from the difficulties associated with achieving effective change. The building may not be ideal, it takes considerable time for a changed identity to be recognised by outsiders and the centre's staffing may include individuals who have not chosen to work in a family centre except as an alternative to redundancy or some post to which they felt even less suited. The challenges of changing an existing establishment may be as great when the change is apparently minor as when it is sizable. Planning is needed as to how the changes are to be conveyed and implemented, for staff, current and future users and other agencies. Inherent conservatism which exists in most people and organisations can result in a denial of change and unconscious attempts to minimise the transformations required. It can be helpful to involve affected staff in identifying what is to be retained and what needs to be different.

Where there may be resistance by insiders and/or outsiders in acknowledging the changes required, ways need to be found of marking the distinctions; for example, by changing the name of the establishment and by a period of closure before opening as the family centre. Concern for the new service should not distract managers from the need to end and

'mourn' the old. Staff and users who have been part of an establishment are faced with feelings of loss when it is closed or changed and these need to be acknowledged and opportunities provided for them to be expressed and shared. Unless this essential work is done, staff will find it difficult to meet the challenges of the new provision.

2 *Funding sources and sponsoring agencies*

Phelan (1983) from her study of Children's Society family centres identifies the nature of a centre's funding as one of the biggest influences both on its instigation and its development. Cannan (1992) identified the policies of the local authority social services department and the enterprise of the voluntary child-care organisations as two of the main factors which create differences between family centres.

Family centres have a variety of funding sources and these may differ from the sponsoring agency and the centre's origins. This is particularly true of centres sponsored by voluntary bodies yet receiving a substantial amount of either local authority or central government finance.

In the main, centres tend to fall into one of four categories:

- Local authority centres
- Voluntary agency centres
- Joint ventures
- Self-help centres.

The funding source and sponsoring agency will both influence the nature of the centre. Thus Holman (1988) suggests that whilst some child care agencies may contain a larger number of client-focused centres, all the major voluntary child care agencies also include a large number of projects which fall into the neighbourhood- or community-development descriptions. In addition he noted that, although statutory and voluntary centres were not completely different creations, the majority of statutory centres were client-focused.

Factors to consider

Central government finance for family centres is invariably time limited. It is frequently an excellent source of 'start-up'

funding but leaves projects with major problems in securing longer term replacement revenue funds.

Centres sponsored by voluntary agencies carry the advantage of greater flexibility associated with the ability to take risks in innovating and experimenting. Their main disadvantage may be a recurrent uncertainty about finance. Conversely local authority centres often have less freedom but longer-term planning may be possible, although at times when major constraints operate on local government finance this latter advantage may not exist.

The development of contracts and service agreements may lead to voluntary organisations receiving funding from local government with very specific requirements about the family centre they provide. The advantage of such agreements is that there is greater clarity of expectation on both sides of the agreement. This can give greater security in funding terms, as it avoids the situation which has led to major problems for some centres when funds have been withdrawn without prior warning because the local authority has decided that the centre is not meeting the authority's priorities. The disadvantages are that it reduces the freedom of the voluntary agency and can restrict the degree of innovation and change its working style.

Joint ventures may offer access to two sets of resources, not only in terms of finance but also in terms of expertise and support services. However, not uncommon disadvantages are confusion about accountability and complex management issues arising from staff having different remuneration and conditions of service.

Self-help centres may offer great adaptability and greater freedom than any other model. There is always a danger that the model will be encouraged by central or local government primarily on a lowest-cost rather than a most-suited-to-need basis.

3 *Context*

Centres have distinct contexts made up of a number of components. The context includes the background to the development of the centre, its current funding and so forth. But in

addition its context can be considered to include the nature of other provision in its environs. A centre on a new estate with no preschool services may identify the provision of day care or the promotion of child-minding as a high priority. A centre in a town centre well served by day nursery and nursery education is unlikely to share the same priority. Another centre may view the degree of preschool provision as having no direct bearing on the development of its services. The degree to which a centre is responsive to its context and the individual components to which the centre responds will differ from centre to centre.

Centres have to accept changing contexts. For instance, over time a centre may discover that its local population has altered because of changes in the local housing policy or that changing provision in the area – for example the establishment of a community health project – leads to a reduction in the need for certain of the project's services.

Factors to consider

A centre whose direction is determined more by 'internal' factors, such as its goals or staffing, will have more control over its evolution but may at a future time face overwhelming external pressures which threaten its existence.

However, a centre can be too responsive to its immediate context thus leading to constant change in its programme with resulting confusion for users and referrers.

4 Age of children

There are some centres which serve all families with dependent children and even households without children. But age-specialisation is common and tends to fall into the two groupings of preschool and secondary age. This is partially related to the origins explored earlier but a more fundamental principle underlies the origins. The two age-groupings reflect the fact that the distribution of ages of children looked after by the local authority peak at preschool and adolescence. This relates to the particular stresses which face families at these life stages.

Factors to consider

An advantage of specialisation is that families are concerned with different tasks and needs at preschool age and adolescence. Staff need different knowledge and skills to work effectively with these distinct age groups. The physical requirements in terms of building and equipment are notably disparate for the extremes of preschool and adolescence.

An obvious disadvantage of exclusivity of age range is that families frequently have children whose ages span a number of years. A recurrent issue for preschool-age centres is that of responding to families whose children have reached school age yet the parents still want and/or need some continuing provision but whose locality offers no particular support to parents of school-age children.

5 Referred families or open-door

Centres can be distinguished in terms of their referral policies. Certain centres focus their activity on referred families only, others have an 'open door' policy preferring to work with families who refer themselves. In some projects a mixture of referred families and self-referrals is encouraged. The source of referrals may differ, there being some centres which are set up primarily to work with families known to the local social services department and others which work mainly with families referred by health visitors.

Factors to consider

Stigmatisation is a major issue for centres who work with selected families. A review of one local authority's family centres reported that a phrase often heard from current and past users was 'It's the place you go when you bash your kids' (Buckinghamshire County Council, 1987). As a result, considerable thought and effort may need to be given to engaging families. In contrast, families who refer themselves to a centre are likely, in general, to have greater motivation for active involvement with the centre.

Working with selected families, particularly in times of limited resources, may ensure that scarce resources are targeted on families in greatest need. Centres operating an open-

door policy may not attract families in most need of their resources. In describing the Banbury Family Centre, Smith (1987) states, 'Debate continues on how best to reach those families and children most in need with an "open access" service.'

6 *Target for intervention*

This has links with the previous dimension. A major distinction can be made between a therapeutic/client-focused model and a community-development approach. These can be viewed as at opposite extremes of a spectrum. There are also centres which seek to combine both approaches.

Factors to consider

As indicated when identifying differences in philosophy, decisions about the appropriate target for intervention rest on the definition of the problem. Focusing exclusively at either end of the spectrum may neglect important factors which are a major contributory cause of the problem being tackled.

Describing a client-focused centre Holman (1987) suggests 'The focus on a few families allowed a planned programme for each user using such skills as counselling, play therapy and group work.'

In the same article Holman comments on the advantages of a community-development approach:

The benefits to be gained from the community development model were seen as threefold. Firstly, that the concentration on neighbourhood rather than individual needs conveyed no stigma. Secondly, that it enabled residents to develop their skills and confidence in order to have a greater say in shaping their own environments. Thirdly, less pressure on full-time staff as they were relieved both of the organisation of services and of intense counselling of individuals.'

Cannan (1992) indicates that the client-focused centre reflects organisational needs in a climate of emphasis on child protection. She suggests that it may also be preferred by staff as therapeutic approaches may be deemed, 'stimulating and

prestigious compared to the more mundane business of supporting families in practical and educative ways' (Cannan, 1992, p. 111). But Cannan also provides evidence of families' preference for neighbourhood models and social workers' acknowledgement of the relevance of neighbourhood centres for their clients' needs. She urges centres to broaden their goals and provide 'greater opportunities for women, enriched lives for children through play schemes and daycare, which in their own way can reduce the stresses for families' (Cannan, 1992, p. 140).

Gill (1988) documents Fulford Family Centre's philosophy and practice of integrating therapeutic work with a community-work approach. The major benefits he records are, 'addressing the appropriate factors in the stress of individual families; encouraging participation; decreasing stigmatisation; aiding personal and group change'.

7 *Catchment area*

This is closely related to the two previous sections. A therapeutic approach tends to work with a wider catchment area and a community-based approach tends to work with a defined neighbourhood. Centres may vary between the extremes of those serving several towns with a total population of more than 100 000 and centres relating to a particular estate with a population of 1000. The defined boundaries may be flexible or not negotiable. Willmott and Mayne's study (1983, p. 121) found that:

the boundaries of the catchment areas were, for some projects, constrained (if not imposed) by geographical considerations and for others by political ones. Other influences on defining areas were those of each project's purposes and their methods of recruitment of users.

Factors to consider

Willmott and Mayne's study noted that certain physical barriers can impose insurmountable problems but they can have a positive impact of delineating a very clear boundary and thus an obvious territorial identity for a project. The advan-

tage of a restricted catchment area is the possibility of integrating the centre with appropriate networks both formal and informal.

Warren (1986) suggests that not all centres need to be neighbourhood-based:

Many underorganised families present strong arguments to attend centres out of the neighbourhood . . . Labels and real difficulties for parents with major problems can mean that neighbourhood centres can exclude them. Hierarchies of 'copers' and 'non-copers' may emerge which may militate against serious involvement of families in centres.

Like many other features, the nature of the catchment area will relate to the aims of a centre. If the aims include encouraging mutual support amongst families then drawing the users from a wide catchment area will not serve such an objective. Tibbenham (1986) in his study of the West Devon Family Centre commented that the continued success of work with families rested heavily on 'phasing' them back into a more self-reliant situation in the community. But this task depended on staff building up a network of links in a local community and this was very difficult for a centre serving the whole town of Plymouth.

8 Child or parent or family focus

Centres differ in their focus of activity. Centres which provide a day-care service are likely to lean towards a child focus. Similarly centres working with adolescents and their families may define the adolescent as their client and work with families will be viewed as a subsidiary activity. Other centres may concentrate their services on parents, and activities for children will be more tangential. Some centres only work with whole families and their major focus may be family interaction, rarely providing separate activities for parents and for children. As indicated in the first chapter, parents and children sometimes have competing needs. Centres often have to seek a balance between these needs.

The extent to which fathers are involved in centres varies considerably. As indicated earlier, the providers of welfare services frequently assume that mothers are the prime carers of children and family centres may reflect such assumptions. Holman (1992a), summarising the benefits demonstrated by studies of family centres, comments:

Women who attend the client-focused type centres learn child management skills in an environment which protects their children.

This suggests either that men do not attend client-focused centres or that they learn different skills. In fact there are centres which, when working with two-parent families, insist that both parents attend to learn parenting skills. Centres working with adolescents may find fathers easier to engage than preschool centres. Social expectations of fathers often include responsibility for the influence and control of older children but not the care of younger children.

Some of the predominance of mothers over fathers as participants in family centres may reflect particular demographic factors. Trowell and Huffington (1992) describe referrals to the Monroe Young Family Centre as including twice as many female adults as male because of lone parenthood. Gill (1992), in a study of forty families living in the vicinity of Fulford Family Centre, found nineteen lone-parent households with all but one being headed by a woman. Cannan (1992) states from her own and others' research that, 'lone parenthood features prominently amongst users of family centres' (Cannan, 1992, p. 120).

Factors to consider

In addition to the aims of a centre, the staff's training and background will have some influence on the target. Staff with nursery-nurse or teacher training may more readily take a child focus whilst staff trained in social work may tend towards a parent or whole-family focus.

Focusing solely on the child's needs, where parents also have pressing needs, may lead parents to 'compete' for staff

attention and be surprisingly counter-productive in encouraging parents to meet their children's needs.

Focusing primarily on parents' needs can lead to neglect of the children's needs as, depending on age and developmental stage, they are frequently reliant on adults to articulate their needs.

Concentrating on the whole family to the point of parents always being with their children in a centre may deny parents the benefit for them and their children of some respite from child-care.

The involvement of mothers and fathers in centres is a crucial and complex issue and will be explored in the final chapter. For the purposes of this section a brief outline of factors will be provided. The structure of the family, in terms of one or two parents, is an obvious feature. The pattern of individual family roles and responsibilities should be considered and cultural and class differences must be recognised. Staff and parental attitudes need to be explored to identify sexist assumptions. As Holt (1992) warns, 'Family centres and social services departments may be seen by both parents and possibly by the worker as a women's place, created in women's time.'

The aims of a centre should be dominant in deciding a centre's approach to the involvement of men and women. Thus an aim to enhance parenting requires attention to both fatherhood and motherhood. As Walker (1991) points out, the neglect of the role of a father suggests that mothers are responsible for the existence and resolution of family difficulties. However a centre which is concerned with providing a refuge for women who are suffering domestic violence may view the participation of men as inappropriate.

Centres which encourage open informal groups, often of a parent/toddler composition, may find the centre gains an image of a women's place. Where women are active participants in a centre they may be ambivalent about the involvement of men. Eisenstadt (1986) recounts how mothers wanted the opportunity to be with other women. Women may find a centre a source of support and an arena where they can, for once, wield power and influence and they may be ambivalent or reluctant for men to be persuaded to attend.

9 Residential or day provision

The hours during which centres provide a service can vary between a few hours a week and a full-time residential service. The latter are in a minority but provide an important intensive service.

Factors to consider

The advantage of residential provision is that it can prevent unnecessary separation of the most vulnerable children from their parents and provide the opportunity of assessment over a prolonged period and at varied times and days. Centres which provide accommodation for individual family members in an emergency may help the family to negotiate a crisis effectively. A disadvantage of residential provision is that to some extent they create an 'unreal' situation in which to undertake assessment. It cannot provide a picture of the way that a family copes in the community with its particular pressures and stresses. Accommodating families away from their communities removes them from networks and makes it difficult for work to be done with the family on building up local supports.

A day family centre with restricted hours may not be open when families most need it. On the other hand it may encourage families to provide mutual support outside the centre's opening hours.

10 Role of families in the centre

The role undertaken by families in a centre varies and is linked to some degree to whether the centre is therapeutic/client-focused or carries some community-development focus. The differing roles can be defined as recipients of a service, participants in the service and controllers of the service.

Factors to consider

Recipients of a service may receive a highly skilled professional service but their definition as recipients may encourage

passivity, inequality and disempowerment. *Participants* may feel a greater sense of equality with other users and with staff but there may be lack of clarity as to the extent of their influence. *Controllers* will hold power, enabling families to influence decisions which greatly affect their lives. There may be difficulties in establishing effective and fair processes which define how (and which) parents become controllers of a centre.

11 Staffing

Staff are a key, and the most costly, feature of a centre. Staffing in centres varies in terms of size, qualifications, background, ethnic origin, gender and roles. Some centres may place priority on appointing a proportion of local people to the staff regardless of qualification whilst for other centres the nature of qualification and professional experience will be a vital attribute. The former will often be a feature of a community-development centre and the latter a concern for a client-focused centre.

Where staff are redeployed from establishments which have been closed, careful thought is needed. Individuals may have chosen employment in a children's home or day nursery because of their preference for working with children and may be reluctant to work with parents. Warren (1986) cautions, 'managers, honourably saving jobs, face serious difficulty in pressing people who have conventionally acted as home-makers and nursery nurses to become whole family workers.' Training and staff development are important issues for any family centre but are essential factors in preparing staff for a change of role. Stewart *et al.* (1990) in an article examining changing social work roles in family centres, quote a member of staff connected with a centre created from a former children's home:

I think the biggest hiccup is that we've left it [the Family Centre] trying to function instead of shutting it down and reopening it. I think we tried to almost change overnight and leave them physically holding the baby of as many as eight adolescents at one stage, and expect them to train and develop themselves.

Factors to consider

Most family centres are concerned with parents and children and employ a range of methods. As a result they benefit from a staff team encompassing a mix of knowledge and skills which include:

- a child orientation;
- an adult perspective;
- family and group dynamics;
- a variety of methods and activities.

Issues of race must be considered, especially as there is often an under-representation of families from minority ethnic groups. In addition to issues of equal opportunities, an all-white staff group will be more likely to project an image of a white centre which is discouraging to users from different ethnic origins.

Gender is also a factor to recognise. As already stated, fathers are less involved in family centres than mothers and this is likely to be more marked if the staff group is all-female.

A more detailed exploration of staffing issues will be provided in a later chapter.

Creating profiles of family centres

The foregoing exploration of the many variables distinguishing centres from each other highlights the limitations of any simple categorisation of family centres. The identification of a number of dimensions on which an individual centre can be positioned allows a more detailed profile of a centre to be created. This not only allows centres to be compared but also, if used over a period of time, enables any major changes in an individual centre to be recognised. The most significant variables which can be expressed visually are as follows:

Sponsoring agency

Local authority	Voluntary agency	Self-help group
-----------------	------------------	-----------------

Funding sources

Central government	Local government	Voluntary agency	Charitable trusts	Fund-raising
--------------------	------------------	------------------	-------------------	--------------

Method of admission/selection of families

Referral from SSD only	Referral from various agencies	Referral from agencies and self-referral	Self-referral only
------------------------	--------------------------------	--	--------------------

Focus of activity

Child	Family	Family in the community	Neighbourhood/ community	Social structures
-------	--------	-------------------------	--------------------------	-------------------

Role of users

Recipients of centre services	Participants in centre	Controllers of centre
-------------------------------	------------------------	-----------------------

Other dimensions which can be added relate to some of the concepts explored earlier.

Type of prevention-timing

Tertiary	Secondary	Primary
----------	-----------	---------

Nature of goal

Minimisation of risk (Child protection)	Optimisation of opportunity (Child development)
--	--

The latter dimension may have parallels with a care and control dimension.

Methods used

Individual counselling	Family therapy	Groupwork	Community work
------------------------	----------------	-----------	----------------

On some dimensions a centre can be pinpointed in one position, whilst on others a centre may be placed covering more than one point on the 'scale'.

An integrated model

The numerous variables explored in this chapter indicate how enormously and how subtly family centres may differ from each other. What is ideal, sadly, is too often unavailable because of limited resources and the influence of history. The exploration of factors to consider under each of the above sections tries to take account of the far-from-ideal world in which most family centres are established and operate. In times of constraint on resources and increasing emphasis on child protection, there may be pressures on family centres to move towards the left of each dimension. Thus centres may find themselves required to restrict their services to referred families where there are major concerns about parenting and actual or potential child abuse. This will be matched by an emphasis on tertiary prevention, the minimisation of risk, a target of child or family and not the neighbourhood. In such circumstances the families using the centres are more likely to be in the role of recipient rather than participant.

Different approaches each have their peculiar benefits and drawbacks. Yet, overall, cogent arguments can be presented for an integrated family centre model. The features of such an approach are as follows:

- **Open door policy** Referrals are accepted from all professional agencies and self-referrals are encouraged.
- **Several targets** The centre focuses not only on issues within the individual and his/her family but also on the structural and environmental components of the risks and opportunities facing families.
- **Neighbourhood base** The centre relates to a particular neighbourhood, thus enabling it to link with both the informal and the formal networks. This also facilitates a recognition of particular local pressures on families.

- *Combined focus* The centre recognises the individual needs of each family member but also addresses the family as a dynamic group.
- *Participants* The role of families using the centre is that of participants and not recipients. Families can not only be active in deciding the nature of their involvement in the centre but are also encouraged to influence the policy and practice of the centre. In some contexts it may be possible for families to move to a role of controller.

The advantages of an integrated approach are several. An open-door policy counteracts the powerful process of stigmatisation which so often occurs in centres restricted to referrals from professional agencies. It also recognises that families under stress do not always come to the attention of professional services and some may consciously avoid formal referral. An open door also encourages the involvement of a range of families each with their singular combination of strengths and vulnerabilities. Restricted referrals can lead to an unhelpful homogeneity of families who all being under particular and similar stress have limited resources to offer each other.

Selecting several targets for intervention, recognises the reality of the risks and opportunities which families face. As we have already indicated, the problems and potential that the majority of families face are neither restricted to their family functioning nor to their environment but to both.

A neighbourhood base encourages self-referrals and enables the promotion of informal networks. Research suggests that the extent and nature of support networks may be a significant factor in the quality of care a child receives (Polansky *et al.*, 1985).

The needs and fortunes of family members are closely intertwined thus it is more effective to address both the differing needs of children and parents and the interaction between them. Parents are able to provide a higher quality of child care when their own physical, social and emotional needs are being met. Children need experiences beyond their homes, they need relationships with other children and with adults who provide different models from their parents. If families are in

conflict and disorganisation the interactions within the family also need addressing.

Families who use family centres often prefer to be called 'participants' rather than 'users'. This is both related to associations of 'user' with drugs and also to their concern to describe their relationship with a centre more accurately. Participation emphasises activity rather than passivity. It suggests the possession of some power and influence. It can also lead to a sense of partnership both between families and between families and staff. This latter relationship will be explored in a later chapter.

There is, as yet, very little research into the effectiveness of different centres in order to provide firm evidence as to the appropriateness of different models. What is needed is more evaluation which compares the outcomes of different centres and explores the relationship between aims and models.