CHAPTER 4

Prevention and family support

In Chapter 3, we looked at the skills needed to work with children and families. In this chapter, we will discuss prevention and family support.

Objectives

After reading this chapter, you should know the theoretical positions of prevention and protection on a continuum of services to families and children. You should understand the difference in practice between preventive and protective services, and between reactive and proactive approaches to prevention. You should also have an understanding of the distinction between primary, secondary and tertiary prevention; and this may inform your view about the state's right to interfere with the way that parents bring up children. You will know the legislative context of services for children in need and their families, including the duties of local authorities. You will have a fuller understanding of some of the issues within the provision of family-support services, for example, 'partnership with parents', the distinction between 'family support' and 'intensive family preservation services', and the difference between 'child-focused' and 'family-centred' services. You will also be introduced to the concept of quality in family-support services.

Let us begin by considering the continuum of services to families and children.

A continuum of services

Services to children and families may be placed on a continuum from preventive to protective services (see Figure 4.1). At the far left 'preventive' end of the continuum, universal services such as health care, education, and access to income are provided for everyone. Such services are non-stigmatising because they are universal and they provide the basic foundation of security, education and health that may prevent families and children from becoming 'at risk'. Obviously, the success of their preventive function depends on the degree to which they are sufficient, readily accessible, and disbursed in a manner which does not carry a stigma.

If the provision of universal services does not prevent families from becoming at risk of child abuse or neglect, one or more of a range of family-support services can be provided to ensure the child's safety while preventing the need to remove the child from home. For example, a social worker may go into the home on a regular basis to help parents learn non-violent methods of discipline and interact more positively with their child.

If these efforts fail and the child must be removed, protective services come into play. Such services may comprise some form of out-of-home care such as foster or residential care, and they are often seen as indicators of failure: failure on the part of the parent to parent adequately, and failure on the part of the social worker to prevent the child's removal. From a more

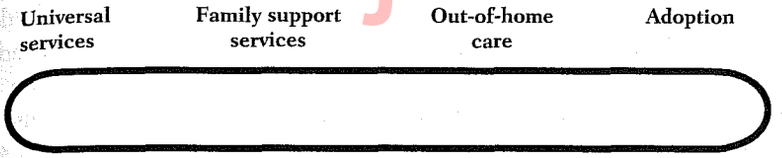

Figure 4.1 Prevention/protection continuum

positive viewpoint, however, a temporary separation can allow time for the parents and the child to do the work necessary to enable them to live together again successfully. Thus, a protective service such as foster care can also be a preventive service if it prevents permanent family breakdown.

In cases where the child has been removed and where attempts to reunite the family are unsuccessful, adoption may be considered. Adoption appears at the far right 'protective' end of the continuum and, indeed, it is a service that protects the child by providing a safe and stable environment. Nevertheless, it is also preventive in that children who are nurtured by adoptive parents are less likely to become 'at risk' of child abuse or neglect when they themselves become parents. Thus, the ends of the continuum may be joined to form a loop.

Preventive and protective services

We have said that child-welfare services run on a continuum from preventive to protective services. There is sometimes a very fine line between prevention and protection. Indeed, depending on what it is we want to prevent, we could theoretically classify all services as preventive. When we provide universal services, such as health care and education, we are trying to prevent some children being at a disadvantage compared with other children. If some children are at a disadvantage despite our efforts, we provide services to prevent them being neglected or abused. If they are neglected or abused anyway, we provide services to prevent them being removed from their homes and families. If they must be removed, our services are aimed at preventing permanent separation: and, if permanent separation becomes inevitable, we try to care for them in such a way that they will grow into competent adults whose own children will not be at a disadvantage compared with other children. Thus, our preventive efforts come full circle.

However, differently phrased, these same efforts could be theoretically classified as protective. Universal services are designed to protect children from such threats as disease, illiteracy, the general effects of poverty, and the poor parenting that often results from life stress. When universal

services are insufficient, family-support services aim to protect children who are neglected or abused or are at risk of being neglected or abused. If protection can be assured while the child remains at home, so much the better. If not, the child is protected by being separated from the family and is reunited only when safety concerns have been addressed.

In practice, the term 'prevention' is usually used to designate those services that are provided to prevent the child being separated from the family. If the child must be separated, then the investigation of alleged abuse or neglect, the child's removal when necessary, and all subsequent services are viewed as 'protective' services. This division between 'prevention' and 'protection' at the point of the child's removal is purely arbitrary since all services, both before and after, lie on the same continuum. However, we sometimes forget that the division is arbitrary. Many social workers view prevention and protection as separate, even opposite, services and this is an attitude which has very real consequences. The most damaging of these consequences is the perception that removing the child implies the failure of prevention: a failure that is laid at the door of both the social worker and the parents. Since removal is associated with failure, accommodating the child outside the parental home becomes a demonstration of failure, with all the accompanying stigma. The parents, having 'failed' in their parental role, may be viewed as 'bad' parents, by social workers, by foster carers and, worst of all, by their children and themselves. Children, too, are stigmatised. They cannot live at home, as other children do, and they may feel that this is because they are 'bad' children, seen as such by their parents, teachers, peers, caregivers and social workers.

Section 17 of the Children Act 1989 stipulates that the provision of accommodation for a child should not be viewed as failure by either the family or the social worker. However, it is usually not possible to change ingrained attitudes merely through legislation. Since actions follow from attitudes, it is often not possible to legislate actions either. The Act may include specific duties to be discharged by local authorities but, inevitably, some interpretation will be necessary to translate a written duty into a particular action taken with a family. The duty will be interpreted differently depending on the perceived needs of the family, the resources available, and the value base of the person doing the interpreting. Thus, the same duty may result in different actions by different local authorities and even by different social workers within the same authority.

Naturally, written guidance has been provided in conjunction with the Act to help with the interpretation, but it is almost impossible to write anything with sufficient clarity and lack of ambiguity to ensure that it is always interpreted by everyone in the same way. Thus, though obviously helpful, the guidance itself is open to interpretation, and specific services made available to families will still differ between authorities and social workers.

In this chapter, we will look at what the Act says about prevention, and the difficulties that have arisen with respect to interpretation.

The meaning of prevention

We have already said that, whereas all services might be viewed as preventive in theory, in practice, preventive services are only those services that prevent the child being removed from home. Holman (1988) considers that the key to the meaning of prevention lies in its aim or purpose: deciding what it is that we want to prevent. If we want to prevent children being disadvantaged – that is, if we want to prevent them becoming at risk through disadvantage – we must take some positive steps to accomplish this. This is the *positive* approach to prevention. In Holman's (1988) view, a positive view of prevention entails the promotion of policies and practices aimed at preventing children from failing to enjoy, in their own homes, the kind of parenting, the freedom from suffering, the standards of living and the quality of community life which are considered reasonable for children in our society.

If, on the other hand, separation is what we want to prevent, then we will not worry about providing services to prevent children being disadvantaged: we will merely react to prevent separation when their disadvantage puts them at risk. We are then taking a *reactive* approach to prevention. A reactive approach is defensive in nature. It concerns policies and practices which prevent the unnecessary separation of children from their parents and their placement away from home in public (or voluntary) care or custody. It also prevents children who are separated from having to remain in care unnecessarily, and it prevents them being stopped from maintaining physical and/or emotional links with their natural families. The approach that we tend to take in practice is the reactive approach.

Holman (1988) has defined prevention more fully, including both reactive and positive approaches, by identifying seven dimensions of prevention:

(i) preventing children being received into public or voluntary care away from their families;
(ii) preventing children entering custodial care;
(iii) preventing the neglect or abuse of children;
(iv) preventing the effects of poor parenting on children;
(v) saving children from those disadvantages in their homes and communities associated with lack of income, amenities and social experiences;
(vi) preventing children from having to remain in care (rehabilitation); and
(vii) preventing the isolation of children in care.

An earlier definition of prevention, still in use, employs terminology derived from the world of medicine and distinguishes three levels of prevention:

(i) *Primary prevention* comprises those services which give general support to families and reduce levels of poverty, stress, insecurity, ill-health, or bad housing. The aim of primary prevention is to ensure that all families have the basic necessities which make good parenting possible.
(ii) *Secondary prevention* is help offered after problems have arisen within families. Such services are likely to be restricted to those felt to be at 'special risk' (for example, children at risk of neglect or abuse) or who require special priority (for example, children with disabilities). Secondary prevention includes support and encouragement for parents in times of stress, welfare-rights approaches aimed at alleviating hardship, and initiatives designed as alternatives to care and custody.
(iii) *Tertiary prevention* seeks to prevent adverse consequences to children spending time in substitute care. It includes attempts to ensure high-quality substitute care and reunification of children with their families.

Bringing together the old and new terminologies, we might equate primary prevention with a positive approach to prevention and secondary prevention with a reactive approach. Tertiary prevention, though certainly included within Holman's seven dimensions of prevention, may be regarded as falling within the purview of protection.

Legal duties of local authorities and social workers

We come now to look at the duties regarding prevention which are laid down in the Children Act 1989, and the context within which those duties were formulated.

A major debate in child welfare concerns the degree to which the state has the right to interfere with the way that parents bring up their children. At that period in history when children were regarded as property, the state had no right, and some people at the extreme Conservative (or right-wing) end of the political spectrum would still argue that the state has no business, let alone duty, to intervene in the private lives of families. According to this view, parents' rights are paramount. At the other end of the spectrum, people would argue that bringing up children concerns us all and the state has an absolute right, indeed a duty, to override the parents' wishes when parents are not caring for their children adequately for any reason. In other words, the child's rights are paramount. Most social workers take a middle ground, believing that the best interests of the child must come first

but, given this, parents' rights, wishes and parental authority must be upheld by the state to the greatest degree possible.

The Children Act 1989 supports the latter view, seeking a balance between protecting the child and supporting the family. Under Section 17 of the Act, local authorities have a general duty to safeguard and promote the upbringing of children in need. To this end, they must facilitate the upbringing of children by their own families through providing services to both the child and the family. The term 'family' includes anyone with parental responsibility and anyone the child is living with.

This duty is restricted to 'children in need'. Hence, it is not proactive in the sense that services are universally provided to all; but it is proactive in the sense that local authorities are expected to seek out children who may be in need in their area and provide services to prevent family problems developing. A reactive approach, as we have learned, would involve waiting until the problems had already developed before intervening.

A prime question here is: Who are 'children in need?' The concept of 'need' is obviously relative. Probably no child living in the United Kingdom is 'in need' if compared with children living in the developing world. On the other hand, almost every child in a poor community is 'in need' if compared with children in a richer community. There is some merit to the idea that whole communities may be 'in need' and it is the community rather than the individual child or family which ought to be helped.

The Children Act itself gives only a very broad definition of what is to be understood by 'in need'. 'Children are in need if they require local authority services to achieve or maintain a reasonable standard of health or development, or they need local authority services to prevent significant or further impairment of their health and development, or they are disabled' (Section 17, Children Act 1989). The Act gives no clear indication of what is to be understood by 'a reasonable standard of health or development' or by 'significant or further impairment'. Again, the terms 'reasonable standard' and 'significant impairment' are relative, depending on what community is chosen for purposes of comparison and what standards of health and development are common in that community. The Act does say that these matters must be judged with reference to *'all other children in the local area, not only those who live in a similar, and possibly quite disadvantaged, community to that of the child in question'* (our italics; Children Act 1989). This would seem to indicate that local authorities are expected to set higher standards than those found in the poorest communities; neither are they permitted, under the Act, to limit services to those children at risk of abuse. On the other hand, the Act does instruct local authorities to give priority to those children who are 'most vulnerable'. Hill and Aldgate (1996, p. 7) note that these ambiguities have 'allowed some

authorities to close their doors to all except those seriously at risk. Such an approach is in danger of undermining the family support emphasis of the Act.'

The definition of need in the 1989 Act covers three categories of children: children who are not likely to maintain 'a reasonable standard of health and development' without services; children whose health and development are likely to be 'significantly impaired' without services; and children with a disability. This definition is broad enough to include any child who could potentially be helped by the provision of services: more children than social services departments could practically serve. Thus, it is often left to the social worker to decide how 'need' should be defined.

Colton et al. (1995a,b) carried out a comprehensive evaluative study of services for children in need in Wales under the 1989 Act (funded by the Welsh Office). This study included an examination of how social workers define need in practice. Colton and colleagues interviewed 103 front-line social workers, 21 leaders of social-work teams, 6 principal social workers and 16 Assistant Directors of Social Services with responsibility for child care. The interviews revealed that social workers interpreted the concept of need in a wide variety of different ways, with little agreement as to how a child 'in need' should be defined. There was also little agreement on how much guidance had been provided regarding the concept of need, and what that guidance said. Despite the wide variety of individual definitions of need, two lines of thought were prevalent among social workers. First, social workers believed that 'reasonable standard' and 'significant impairment' are opposite sides of the same coin; that is, a child who does not meet reasonable standards of development is significantly impaired. Secondly, a child who is 'significantly impaired' is one who is in need of protective services. Thus, by extension, all children who might be said to be 'in need' at all are in need of protective rather than preventive services.

Given the lack of adequate guidance on the concept of need, social workers were using material primarily formulated for use in child-protection work. This obviously reinforces, if it did not cause, the common belief that children 'in need' are in need of protection. Social workers were relying on their own experience as professionals and parents; the criteria used most often to decide whether a child was 'in need' were whether the child was reaching developmental milestones and receiving adequate basic care.

In addition, Colton et al.'s study asked managers to rank-order categories of children who would have priority for service under ideal circumstances, and also categories of children who did actually have priority. Proactive prevention came much higher on the 'ideal' than the 'actual' list, showing that managers wanted to give more emphasis to preventive work but in practice concentrated resources on children at risk of abuse and neglect. The level

of services available to support families was judged by both managers and social workers to be generally inadequate.

In the same vein, several other research studies have examined the implementation of services for children in need under Section 17 of the Act. For example, Aldgate and Tunstill (1995) found that local authorities were far more likely to see children for whom they already had a degree of responsibility as being 'in need' compared with other children in the community. Some 78 per cent of the authorities studied gave high priority to children at risk of harm and 74 per cent to children at risk of neglect or in care, but only 12 per cent gave high priority to children living in homes where the gas, electricity or water was disconnected, and 11 per cent to children excluded from school.

Colton et al. (1995a,b) argue that, if it is departmental policy to move away from an emphasis on protection towards proactive prevention, then procedures for accomplishing this must be specified. Such procedures might include:

- discouraging social workers from using protection material to guide them in preventive work by issuing alternative guidance designed to emphasise prevention;
- developing guidance materials in cooperation with other statutory and voluntary agencies;
- establishing indicators for prevention work along the same lines as the *Working Together* material (Home Office et al., 1991);
- issuing the guidance in joint training sessions together with other statutory and voluntary agencies.

As we have discussed, it seems that both local authorities and the social workers they employ have wide discretion in deciding which children are 'in need' of service, and often disagree. Nevertheless, there is some agreement on a number of categories (not mutually exclusive) of children who should be regarded as 'in need' within the terms of the Act. These include:

- children with disabilities;
- children at risk of abuse and neglect;
- children who are delinquent, or at risk of becoming so;
- children separated from their parents because of divorce, separation, hospitalization, parent in prison, immigration restrictions, and so on;
- children being looked after by local authorities;
- children with caring responsibilities (e.g., teenage parents, children of parents with disabilities);
- children whose home conditions are unsatisfactory (e.g., those who are homeless, in temporary or substandard accommodation, or in accommodation for homeless families);

- children who may be broadly defined as living in poverty and at high risk of family breakdown. (Colton et al., 1995a,b)

As might be expected, there is a relationship between the types of children 'in need' who are to receive services and the specific purposes for which these services are to be provided. It follows, for example, that if a service is directed at children who are at risk of ill-treatment or neglect, then the purpose of the service (and the concomitant duty of the local authority) is to prevent ill-treatment and neglect. Thus, the duties imposed by the Act on local authorities indicate the purposes for which family-support services should be provided. These duties are:

- preventing ill-treatment and neglect;
- reducing the need to bring care or related proceedings;
- reducing delinquency and criminal proceedings against children;
- minimising the effects of disability on children with disabilities;
- promoting family reunification and contact.

Now we have considered to whom services ought to be provided and why, the next question has to do with the nature of the services themselves. What sorts of services should local authorities provide? The Act refers to a variety of services that may be necessary to support families, including: advice, guidance and counselling; occupational, social, cultural or recreational activities; home helps and laundry; travel to services; holidays; family centres; accommodation for children and families; accommodation/cash assistance for rehousing abusers; assistance in kind; cash assistance; and day-care and out-of-school activities. The Act also stipulates that services should be provided in a non-stigmatising way, and should enhance the authority of parents. Children should participate in decision-making, and service provision should be sensitive to the needs of ethnic minority communities. Participation in decision-making is discussed later in the chapter, and service to ethnic minorities is discussed in Chapter 7.

As we have seen, local authorities are expected to seek out children in need in their area and provide services to them to prevent problems developing. The process of seeking out children in need includes publishing information about available services, and developing strategies which encourage children and families to come forward. It also includes facilitating the provision of services by others. The Act recognises that social services departments cannot provide the full range of necessary services themselves. Therefore, it enables them to call on other departments within local government – for example, leisure and recreation, health and education – to assist. This approach is particularly important in relation to children with disabilities whose state of health often requires special educational provisions to be

made available (Hill and Aldgate, 1996). However, assistance is not limited to other government departments. The Act also allows social services to request – and fund – assistance from voluntary and private agencies. Hill and Aldgate (1996, p. 7) rightly note that, while the voluntary agencies have a vital role to play in service provision, particularly of an innovative or specialist nature, consistency and continuity of provision of services is not always compatible with a market economy.

Contexts of family support

Let us now look at the contexts of family support: that is, the conditions which must prevail in order for family-support services to be provided – as the Act stipulates – in a way that is non-stigmatising, enhances the authority of parents while taking children's wishes into account, and is sensitive to the needs of ethnic minority communities. The first of these contexts is poverty.

Poverty

Although the Act encourages a proactive approach and does not permit local authorities to limit services to children at risk of abuse, we have seen that, in practice, authorities are constrained by limited funds to focus their attention on children who are already abused or neglected or are at imminent risk of becoming so. Holman (1988) sees a reason for this. He believes that proactive family-support services can only be effectively provided in a society which is working towards diminishing the gap between the rich and the poor. However, for much of the past quarter of a century, Britain has moved in the opposite direction. Social polarisation has occurred and levels of child poverty have increased (Colton et al., 1995a,b).

Holman (1988, p. 211) correctly states that social deprivation remains closely associated with 'children having to leave their parents and ... suffering severe disadvantages within their homes'. He therefore argues for a coherent strategy on the part of central government in relation to primary prevention. In his view:

> there can be little doubt that government policies directed at reducing poverty, improving the health of lower-income groups, and the provision of adequate housing for all would do much to prevent children having to endure either of these two outcomes.

Significantly, when asked what services they would like but were not receiving, the parents in Colton et al.'s (1995a) study of children in need in

Wales gave first priority to material goods and better housing. The study also found that, although children living in poverty are 'children in need' under the 1989 Act:

> (a) social services departments in Wales could not provide data on the number of children living in poverty; (b) because of limited resources, children living in poverty were accorded lowest priority in terms of service provision, despite the desire of managers to engage in more preventive work; (c) services designed to alleviate poverty were provided inconsistently to users depending on the particular social worker involved; and (d) given the resource constraints, child care managers could see little hope of altering the situation. (Colton et al., 1995a, p. 102)

Some groups of children are particularly vulnerable to poverty. According to the LIF (Low Income Family) Statistics, over three-quarters of children growing up in lone-parent families were living in poverty compared with 18 per cent in two-parent families (Child Poverty Action Group, 1996). Likewise, Colton et al. (1995a, p. 30) reported that in the UK, people from ethnic minority groups experience disadvantage in many areas of their lives.

Reviewing the comparatively large body of research on the practice of child and family social workers funded by the Department of Health, Thoburn (1997, p. 291) reports that:

> All these studies show that children most in need of additional child welfare services tend to come disproportionately from certain groups in society. Amongst those who are over-represented are children from single parent or reconstituted families; those who are badly housed and living in deprived areas, and those whose families subsist on incomes below the recognized poverty line. The parents and children tend to have more physical and mental health problems than the general population, and children of mixed racial parentage tend also to be over-represented.

Colton et al. (1995a,b) argue that perhaps more than any other factor, poverty threatens the practical achievement of effective family-support services. The successful implementation of Part III of the Children Act, and indeed, community care policy more widely, necessitates that poverty be placed again at the centre of the policy, practice and research agenda. Quite simply, there is no substitute for action at the national level to tackle primary poverty. However, at the local level, social-welfare agencies and local authorities might develop anti-poverty strategies to help improve the financial circumstances of their service users. Such strategies would comprise three elements.

First, policy-makers and senior officers within social-welfare agencies must acknowledge their own status as major resource holders. They have the capacity to invest in the human, physical and social fabric of impoverished communities by establishing local offices in these communities, employing local people, and purchasing goods and materials from local vendors. Secondly, within social-welfare organisations, traditional welfare-rights activities are presently located at the margin of organisational activity. Such activities need to be reaffirmed as part of mainstream work. An approach is required which recognises and seeks to redress the unfairness and discriminations within the system. Thirdly, with regard to the wider anti-poverty strategies of local authorities, the development of Credit Unions, cooperative buying schemes and Bond banks can do a good deal to improve the financial circumstances of groups in poverty. Moreover, they do this in ways which build upon the networks of mutual support that exist even within the most disadvantaged communities.

Ruxton (1996) suggests a number of measures to help families out of poverty. With regard to lone parents, he calls for an appropriate mix of employment training, child care, social security and maintenance arrangements. He also advocates specific action to improve the employment prospects of all young people, including those with inadequate qualifications and/or those who leave the education system prematurely. Further, he argues for an appropriate range of welfare benefits for low-income families and young people. These should be set at an adequate level and uprated on an annual basis. Finally, he recommends a comprehensive range of support services at a local level to counter the effects of poverty and social exclusion. These may include family and community centres, debt counselling services, credit unions, child health clinics and care and education services.

Having touched on the issue of poverty, we will now look briefly at another contextual factor related to family support: the way that services are organised.

Organisation of services

A second contextual factor in providing family-support services is the way that these services are organised. Research indicates that the organisation of service delivery as a whole is often incompatible with the concept of family support contained in Part III of the Children Act 1989 (Colton et al., 1995a,b). For example, rather than providing employment for local inhabitants, social service departments tend to draft in workers from outside the area, and operations are often directed from remote headquarters rather than locally. Indeed, it is difficult to escape the impression that

social services departments are designed to operate in ways that are bound to be self-defeating, and that frustrate any effort to develop effective family-support services, or to fashion an authentic partnership with parents, children and local communities.

An important family-support service, as we shall see later in the chapter, is the family centre. Here too, Colton et al.'s (1995a,b) study showed that the statutory sector has been slow in establishing these centres and does not always allow them to be run in ways that empower local inhabitants while boosting the local economy.

Types of family-support services

Having discussed two of the contexts of family support, let us look now at the types of family-support services which are provided. It might be noted that some family-support services are provided at a national or departmental level while others are community-based and are sometimes referred to as community prevention programmes. Let us begin with a brief, general discussion of community-based prevention programmes.

Community-based prevention programmes

In North America, a good deal of attention has been paid to community-based prevention programmes, a generic term which encompasses various types of family support and family preservation programmes and services.

Family-support services may be defined as:

> Community-based activities designed to promote the well-being of vulnerable children and their families. The goals of family support services are to increase the strength and stability of families, increase parents' confidence in their parenting abilities, afford children a stable and supportive family environment, and otherwise enhance child development. Examples include: respite care for parents and caregivers, early developmental screening of children; mentoring, tutoring, and health education for youth, and a range of home visiting programs and center-based activities, such as drop in centers and parent support groups.
>
> (General Accounting Office, USA, quoted in Whittaker, 1996, p. 117)

By contrast, '"intensive family preservation services" are brief, highly intensive services generally delivered in the client's home with the overarching goal of preventing unnecessary out-of-home placement' (Whittaker, 1996, p. 118).

Expanding on this, family preservation services are:

> designed to help families alleviate crises that, if left unaddressed might lead to the out-of-home placement of children. Although more commonly used to prevent the need to remove children from their homes, family preservation services may also be a means to reunite children in foster care with their families. The goals of such services are to maintain the safety of children in their own homes, when appropriate, and to assist families in obtaining services and other support necessary to address the family's needs.
>
> (General Accounting Office, USA, quoted in Whittaker, 1996, p. 118)

Whittaker (1996) notes that 'family support' and 'intensive family preservation' are the two dominant expressions of a shift away from child-centred to family-focused service. He distinguishes the following essential foundations on which family-oriented prevention rests:

- *Partnership* – the meeting of clients and professionals on common ground and as a unified team.
- *Mutuality* – creating an atmosphere where clients and professionals communicate openly about the most sensitive of concerns in a relationship built on openness, mutual respect and trust.
- *Reciprocity* – where we truly operate on … the 'helper principle', where giving help and receiving help goes both ways and between all the key players: professional to client, client to professional, professional to professional, and client to client.
- *Social assets* – where assessment begins not by looking at what is going wrong in clients (deficits), but at what is going right (strengths).
- *Resilience* – where we are always alert to those protective factors and mechanisms that blunt and divert the effects of known risk factors and permit individuals, families and groups to overcome extraordinary and difficult life situations.
- *Optimization* – where our goal is always on creating the conditions within which each individual, each client family, group and neighbourhood fully exploits its developmental potential.
- *Natural healing* – where our search is for those approaches to change which draw fully on the clients' ability to heal themselves through ritual, celebration and reflection.
- *Social integration* – where our work with the 'private troubles' of individual clients is seen in the context of raising public social concern about the critical function of individuals, families, small groups and neighbourhoods in maintaining social order and promoting public safety.

- *Coherence* – here used ... to describe processes through which individuals, families and groups discern a sense of meaning beyond the struggles of day-to-day existence.
- *Hope* – Finally, person-in-environment practice is about fostering a sense of hope: hope that things can change for the better, that the power for change resides within, that someone is listening ... and cares.

(Whittaker, 1996, pp. 123–4)

Now that we have noted some basic principles underlying community-based prevention programmes, we will turn to a few specific examples of such programmes. First, though, we should look briefly at who provides the programmes – community child-care teams – and the process through which the programmes are provided.

ACTIVITY

The reader may find it helpful to identify prevention programmes that exist in his or her local community. Consider who provides these programmes. Are they examples of primary, secondary or tertiary prevention?

Community child-care teams

Family support services are often provided through community child-care teams. As we have seen, in England and Wales, Section 17 of the Children Act 1989 requires local authority social services departments to provide a range of services for children in need. This responsibility is devolved to community child-care teams. Parents or children may seek help directly from these teams, or they may be referred by another agency (Thoburn, 1997).

When contacted, the child-and-family social worker must assess whether any child in the family is 'in need' under the terms of the 1989 Act and decide how the identified need can best be met (Thoburn, 1997). Some children may be in need of protective services. In such cases, the social worker is first required to seek to prevent the child suffering maltreatment or further maltreatment through the use of family-support provisions. There is also a formal child-protection administrative system designed to ensure a coordinated interdisciplinary response to children who may be suffering significant harm as a consequence of maltreatment. If parents do not cooperate fully and compulsory measures are required to protect the child, the social worker may apply to the Family Proceedings Court for either a supervision order or care order (Thoburn, 1997). These court orders will be discussed in Chapter 5.

The children served by community child-care teams have been characterised as 'victims, volunteered or villains', or a combination of the three.

'Victims' are children who have received less than adequate parenting, and may have been neglected or abused. The 'volunteered' are children whose parents request help. Such help may include placement away from home because the parents are unable to care for their children due to factors such as personal or interpersonal stresses, deprivation or disability. 'Villains' are older children whose difficult, delinquent or anti-social behaviour gives rise to concern on the part of either their parents or the authorities (Thoburn, 1997). It should be noted that 'villains' have usually been 'victims', and there is much merit in the argument that early preventive work – which still has low actual priority – would go far towards alleviating the rage and frustration which older children often demonstrate in the form of delinquent acts.

The daily work of the child-and-family social worker is a combination of assessment, social-care planning, and the provision of a social-casework or therapeutic service to children, parents and other relatives, on either an individual or group basis. The precise mix will vary with each case. Social-care planning requires skills in negotiation, mediation and advocacy. Complex cases, especially those involving the likelihood of significant harm to the child, necessitate that the social worker is effective in working with multi-disciplinary groups: a task which requires diplomacy, flexibility, and an ability to recognise and work within various, and occasionally conflicting, political frameworks. It is also essential that the social worker is skilled in direct work with children of different ages and with parents whose problems range from poverty to mental illness or learning disability. In addition, skills in recruiting, training and supporting volunteers, who may provide support or advocacy, are of increasing importance (Thoburn, 1997).

The exercise of professional discretion is a key part of the work of child-and-family social workers. In Thoburn's view,

> they are the 'general practitioners' of the child welfare system in the United Kingdom and retain responsibility for the assessment and reassessment of the needs of the child and family, and for the provision of a varied and flexible casework service. The results of their decisions will be life enhancing or life threatening. (1997, pp. 294–5)

Thoburn (1997) further notes that as a consequence of the emphasis on family support enshrined in the Children Act 1989, child-care social workers and managers have been encouraged by government to change their role from 'expert' to 'partner'. She argues that this has not been without opposition from child-and-family social workers who have worked in an era when high status was attached to skills in therapeutic methods, such as family therapy, or specialist aspects of work, such as child-abuse investigation and assessment, or permanent family placement.

The partnership-based practice required by the 1989 Act undoubtedly still demands the skilled delivery of therapeutic and protective services, but it also necessitates negotiation skills, and curtails some of the power of the professional social worker to decide on the methods to be adopted. In short, the skilled technician must also be a skilled negotiator. Thoburn (1997, p. 295) affirms:

> Child and family social work went a long way along the path of technical competence and practice dominated by official procedures. Consumer and outcome studies have ... shown clearly that neither will succeed in either engaging families or in achieving positive outcomes for children without the accurate empathy, warmth and genuineness which have long been known to be associated with effective practice.

It remains to be seen whether social workers are able to abandon the status associated with the 'expert' role and accept that the real 'experts' with respect to a family's functioning are the family members themselves.

Thoburn identifies five pointers to positive practice by child-and-family social workers, derived from the principles for practice required by the Children Act 1989 and its guidance (for example, Department of Health, 1991b,c). These pointers also derive from two important social-work values: respect for individuals, families and communities; and a commitment to maximising the rights and freedoms of children and parents and giving them as much choice as possible in the provision of services. The five pointers – factors which Thoburn believes to be particularly important – are as follows:

- Prevention (of family disintegration);
- Protection (of the child and other vulnerable family members);
- Permanence (the importance of the child's sense of);
- Partnership (with family members and with other professionals);
- Preparation (of the social worker and of family members before important meetings, courts, etc.).

Community-based teams may provide the services discussed in the following sections. It should be noted that the examples of services selected for this text are by no means exhaustive.

Social networking

One type of family-support service is social networking. Networking is a valuable method in the social-work repertoire that can be deployed in a wide range of preventive work with children and families.

Network analysis has largely developed from systems theory. A systems approach to social-work practice may be used to analyse the complexity of

forces – biological, psychological, social and cultural – operating in the relationships between social work and the informal social-support networks of a child or family (Reigate, 1996). Network analysis allows the social worker to understand clients' informal support networks (extended family, friends, church etc.) from their perspective. It also tells the worker what supports are *not* available so that she can assess how clients' social networks serve to help or inhibit their capacity to cope in the community.

A good deal of work on the potential of social networks to complement and support formal caring provision has been undertaken in the United States (Reigate, 1996). In the United Kingdom, the Barclay Report highlighted the vital role performed by informal caregivers, mutual aid groups and volunteers in the provision of social welfare to local communities (National Institute of Social Work, 1982). The report advocated that, in addition to undertaking their traditional tasks of counselling and casework with individuals and families, social workers should engage in ameliorative and preventive work with communities. In short, social workers are urged to create, stimulate and support networks in the community. The report proposed a new model of worker, the community social worker, a hybrid between community worker and social worker.

More recently, the Griffiths Report proposed that local authorities should arrange the delivery of packages of care, turning first to informal caregivers and neighbourhood support (Griffiths Report, 1988). These proposals were given legislative expression in the NHS and Community Care Act 1990. At first glance, it seems perfectly reasonable to seek informal help before formal processes are put into place, but an alternative interpretation is that agencies are seeking to avoid their own responsibilities by placing the responsibility on the community. Reigate (1996, p. 216) warns that 'social workers should respond with caution to pressures to use alternatives to formal provisions, particularly in times of economic restraint when agencies may be seeking to cut the costs of providing care and support to vulnerable people'. Thus, it is important to emphasise that, in mobilising community-based support systems, social-network analysis is a method that attempts to complement rather than replace statutory provision.

Working with social networks requires knowledge of the different types of networks and the part they play in the lives of clients. Knowledge of the communities in which clients live is also essential, particularly in relation to assessing current needs and the possibilities for developing new kinds of community support. Reigate (1996) distinguishes the following five strategies that may be useful in building upon social networks:

1. *Building on the personal links of clients* – e.g., relatives and neighbours – to help solve clients' problems or to enlarge clients' circle of support.

2. *Linking clients with volunteers* who have the experience and/or skills to tackle the clients' problems.
3. *Bringing together those with similar experiences or problems*, thus facilitating the formation of informal mutual aid networks aimed at: (a) developing further sources of support; (b) sharing knowledge; (c) building on existing community networks.
4. *Identifying and building on existing local networks* – e.g., neighbours or communities – with the aim of promoting social functioning and organisation.
5. *Forming groups to address local needs* through engagement with formal and informal groups (e.g., voluntary organisations, trade unions, churches, and formal agencies).

Reigate (1996) argues that networking enables the social worker to synthesise informal and formal welfare provision. In order to do this, workers need to be aware of: (a) the perceptions of clients; (b) how social networks serve to promote or inhibit coping; (c) the impact which formal intervention has on informal networks; and (d) the ways in which the social environment operates to strengthen or undermine the individual's social functioning (Reigate, 1996).

When undertaking network analysis, the relationship between individuals and their environments may be analysed at three levels:

(a) the *micro* level, which consists of the individuals' personal peer relationships or social support networks;
(b) the *mezzo* (or *meso*) level, where networks are examined in terms of issues of access to resources and social functioning;
(c) the *macro* level, which involves analysis of the relationship between people and more formal community organisations – for example, voluntary and political groupings, clubs, societies, etc. (Reigate, 1996)

You will remember these levels from our discussion of social ecological theory in Chapter 2.

Let us turn now from theory to practice. What strategies might a social worker use to understand a client's social networks?

Social networking strategies

It has been suggested that clients should be asked to record their lives using structured diaries. A standardised format should be used which incorporates a structure that reflects what is already known about the general pattern of a specific client's day. Diaries for adults and children should be kept for a fortnight and a week, respectively.

The social worker then undertakes a follow-up procedure with the client, again using a standardised format or schedule. Having read the diaries, the social worker asks the client, first, about the three most important activities engaged in and/or places visited during the diary period and why they are so important; and secondly, about the three most important people in the client's life. The follow-up schedule is usually completed by the social worker in consultation with the client, sometimes with a support person present. Where appropriate, the follow-up schedule may be completed solely by the client. In addition, other schedules may be used to compile further information on self-management skills, daily living skills and social skills. The aim is to identify problems or issues in each area of functioning, what support may be required, and the implications for resource planning and provision.

Next, a summary is produced regarding progress in areas such as home management, social functioning, communication and general confidence. The client is also asked an open-ended question about what she feels she has learnt over the specified period. A further open-ended question is put to the client regarding any lack of progress. The social worker then produces a diagram of the client's networks based on information from the diary and schedules.

Such a diagram is sometimes called an eco-map. An eco-map is a drawing of the client/family in its social environment and is usually drawn jointly by the social worker and the client. Figure 4.2 is an example of an eco-map which portrays information relating to a couple, John and Sue Hickson, who are caring for Sue's elderly father and trying to bring up two children of their own. This is a second marriage for both John and Sue. John is partly supporting his two children by his first wife, and this first marriage is a source of both financial and emotional stress within his present family. Sue's elderly father, Paul, was diagnosed with Alzheimer's disease five years ago and now needs round-the-clock care since he has trouble sleeping at night, wanders around the house, and starts shouting when he becomes confused. He is cared for during the day by Sue's sister Jean, who also provides care for John and Sue's two children when they come home from school. Jean, who has two teenagers of her own, has recently said she can no longer cope with caring for Sue's family as well. John and Sue, who both work full time to make ends meet, are suffering marital discord, and there has been an allegation by his teacher that their eldest son, Mark, is being physically abused.

The social worker tries to depict the family in its social environment by drawing an eco-map (Figure 4.2), using the common symbols shown in Figure 4.3, and placing the client family in the centre circle. To draw an eco-map, the social worker must also know how to draw a genogram – that

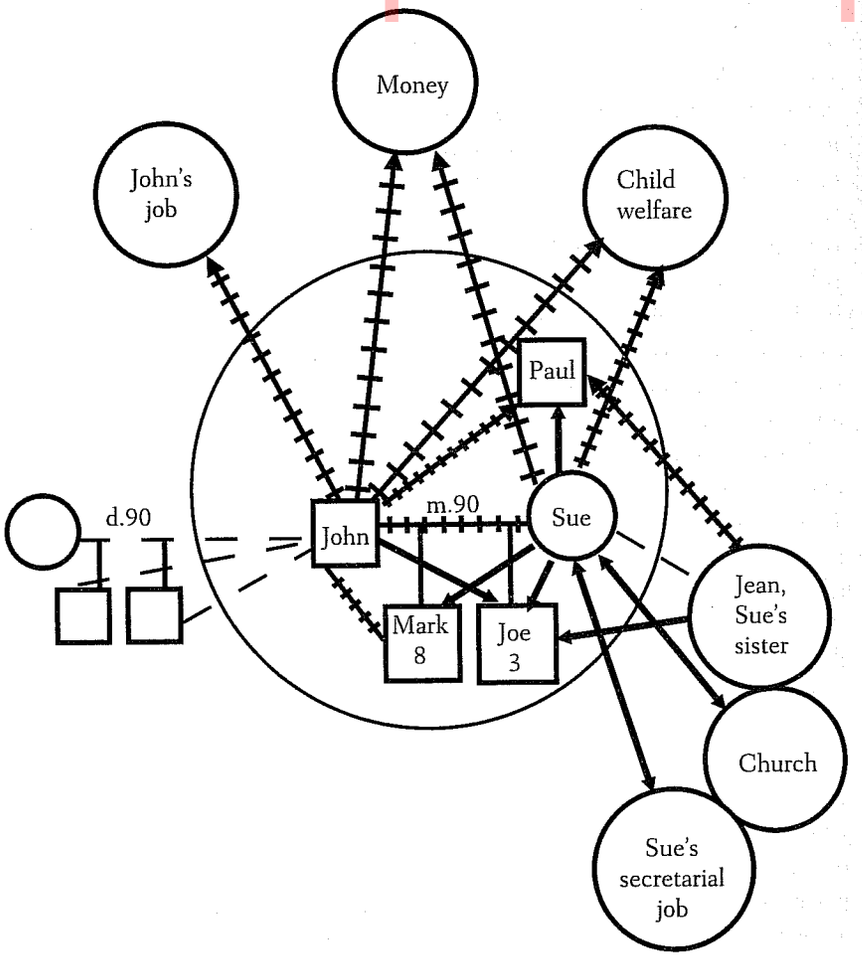

Figure 4.2 Eco-map of Hickson family

is, a family tree, or a diagram of the family's relationships over two or three generations. The common symbols used in drawing a genogram are shown in Figure 4.4.

As Figure 4.2 shows, John has a conflictual relationship with his father-in-law, Paul, his wife, and their eldest son, Mark. He has a positive relationship with his younger son, and a tenuous relationship with his divorced wife and his two children by her. Sue has generally positive relationships with her father and children but, as the arrows show, these relationships are giving on Sue's part and she feels that she gets very little back. It is apparent that an eco-map like this must be constructed with Sue's help if her feelings about the strength and direction of her various relationships are to be accurately portrayed. Similarly, other family members must tell

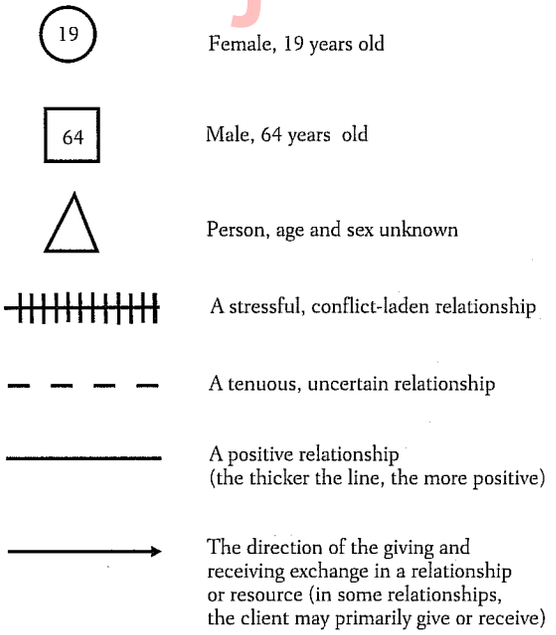

Figure 4.3 Eco-map symbols

the social worker how they feel about their own relationships. It can be quite revealing if, for example, a father says that his relationship with his son is strong and giving, while the son says that the same relationship is weak and conflictual. These discrepancies can give the social worker a place to begin when working with the family.

The outer circles on the diagram show other systems which are important in the family's life. For example, Sue has been a secretary for nine years and derives some energy from a feeling that she does well at her job. John's job, on the other hand, seems to be an additional source of stress for him. Sue has support from her church: John does not go to church and seems to have no support systems at all. Money is a worry for both partners: and the recent contact with child welfare is also very stressful. It should be noted, if it is not already apparent, that these maps are drawn *from the point of view of the family or individual whose relationships are being depicted*. For example, John and Sue might both feel that the relationship with child welfare is conflictual and energy draining, while the worker concerned might believe that it is strongly positive and gives support to the couple.

If the eco-map of the entire family system becomes complex and confusing, the social worker may need to draw separate maps for each family

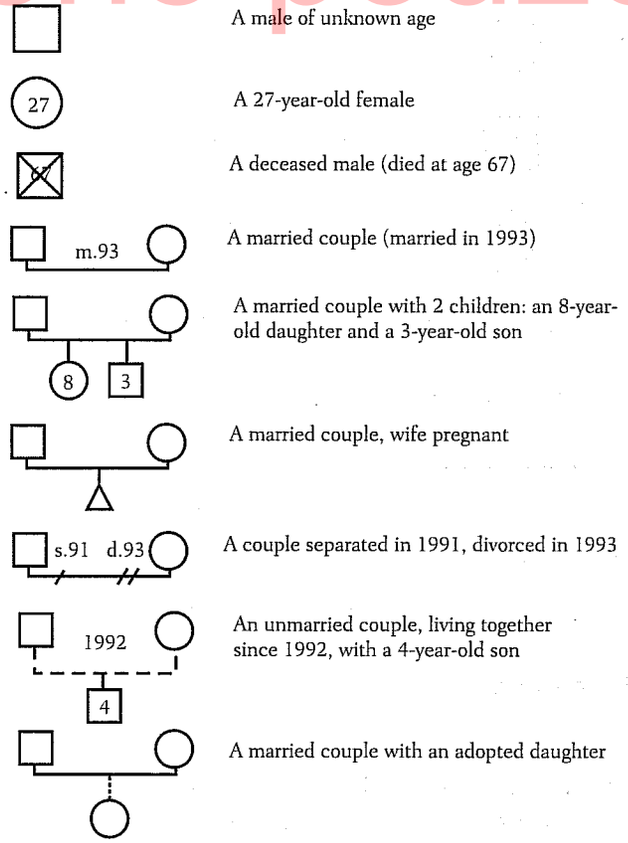

Figure 4.4 Genogram symbols

member, as shown in Figures 4.5, 4.6 and 4.7. Such separate maps will also be necessary if, as mentioned above, family members give conflicting information about their relationships with each other. In the Hickson case, for example, the social worker might well wish to draw separate maps for each of the children though these are not shown in the text.

The information collected through the eco-map and other forms of network analysis will help the social worker and the family to better understand the complexities of their social environment. This information may be used as a clinical tool to aid and direct work with the family, both immediately and for purposes of referral. It may also be summarised for use in case recording or to help in the monitoring of resources and their use over a given period. In addition, the network analysis will have significance in fieldwork assessments and reviews (Reigate, 1996).

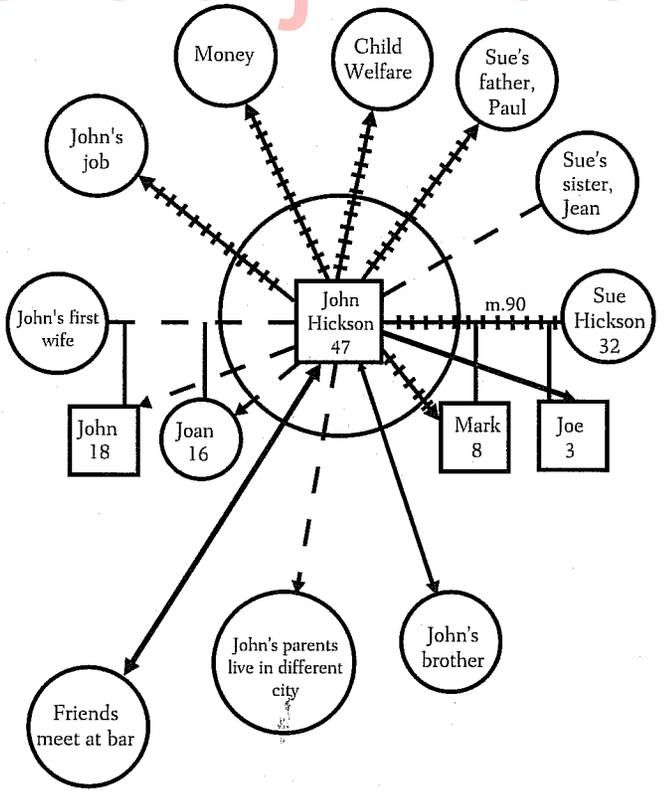

Figure 4.5 Eco-map – John Hickson

Neighbourhood services and family centres

A second initiative related to family support is neighbourhood services, particularly family centres. Under the 1989 Act, family centres constitute one of a range of family-support services which local authorities are required to provide 'as appropriate' in their area. Although these centres are formally recognised as a major element in preventive service provision, the phrase 'as appropriate' gives local authorities wide discretion over how many and what type of centres should be provided.

The term 'family centre' covers a range of community-based provision for parents and their children. Whilst there are many differences between facilities described as family centres, there are also common features. For example, they are located in neighbourhoods where there is a marked incidence of factors linked with family stress and the placement of children away from home. They emphasise family strengths rather than labelling families as problems and they do not stigmatise users. Their services are

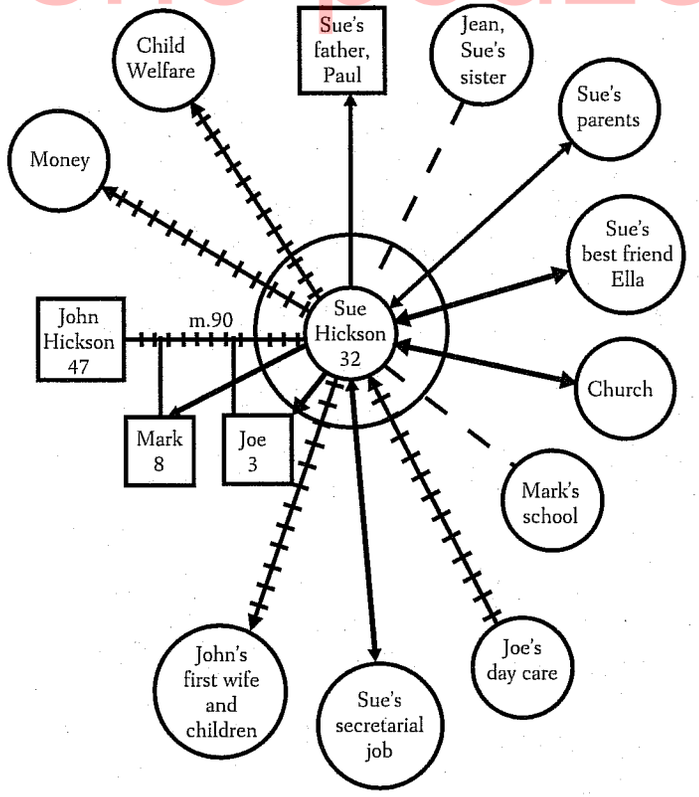

Figure 4.6 Eco-map – Sue Hickson

more accessible to local communities and more responsive to people's felt needs. They work with the parents as well as the children. They emphasise user participation, including control by users over such matters as the activities taking place in the building and the development of new services. They are committed to increasing the self-confidence and self-esteem of users, and they pursue preventive objectives (Holman, 1988).

Smith (1996) examined the operation and effectiveness of six family centres through the eyes of users. The centres were directly administered or supported by the Children's Society. Two of the centres worked mainly with referred clients and offered direct counselling, access visits, play sessions and advice on parenting skills, budgeting and diet. Two were 'neighbourhood centres' running various activities, some of them open to anyone and some available only to referred clients. These centres also provided counselling and space to other community groups in the form of office facilities and meeting rooms. The last two centres were run by local organisations and had adopted, or were planning to adopt, a 'community

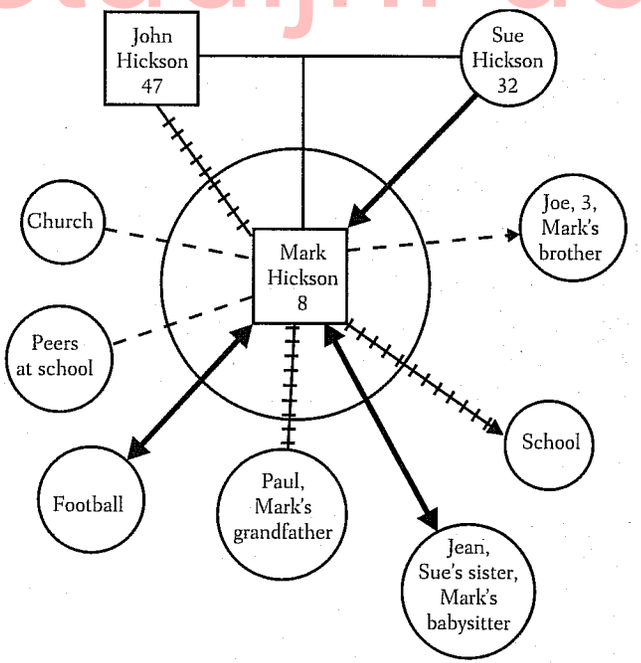

Figure 4.7 Eco-map – Mark Hickson

development' perspective. They provided space to other groups, and amenities and facilities for use by the local community; they encouraged local people to identify issues and needs, and worked closely with local groups and other professionals. Despite the differences in approach between the centres, they were all situated in highly disadvantaged communities with high levels of unemployment, low incomes, lone parents, and large families. One community also had a high proportion of black and ethnic minority households.

The parents interviewed in Smith's (1996) study identified common issues of concern in relation to bringing up children. These included the importance of safe neighbourhoods, the difficulty of 'making ends meet', and depression and health problems. Parents described difficulties of bringing up children as a lone parent, the need for day care so that parents could go out to work, the importance of free time, the value of social contact, and the importance of support networks – friends, family, baby sitting. They also indicated a desire to learn about child development.

A major finding was that levels of need were very high both among users referred by social workers and among those attending by choice, particularly where the latter were lone parents. It was also found that large numbers of children who were not living in families referred to the centres by

social workers and were not considered 'at risk' were nonetheless growing up in highly disadvantaged circumstances.

Encouragingly, most users felt that the family centres had had a positive impact on their own lives and those of their children: 97 per cent said they would recommend the centre to someone else; 86 per cent said that the centre had made a difference to them; and 84 per cent said the centre had made a difference to their children. Moreover, the family centres were seen as: accessible – a safe place to go, with welcoming staff; available – there was always someone to talk to; a community resource – to use the phone, get a lift, hire a room for a celebration; and a collective resource.

Smith concludes that all three types of family centre helped parents and their children. However, in view of the high levels of disadvantage found in many areas, she also considers that, over the longer term, the type of centre which gives open access to community members and supports existing community resources is likely to benefit more families than centres which are accessible only through social-work referrals.

Holman (1988) notes that family centres were first established by the major voluntary child-care agencies in the 1970s, including National Children's Homes (NCH) and the Children's Society. Local authority social services followed suit in the 1980s. However, by contrast with the voluntary societies, the establishment of family centres represented only a minor part of the statutory sector's response to social need. While progress has since been made, research suggests that family centres have still not been given the pivotal role in the activities of local authorities that effective family-support services necessitate (Colton et al., 1995a,b). Family-support services should play a central role in the delivery of services and need to be decentralised on a local neighbourhood basis.

Video Home Training

Video Home Training (VHT) is an innovative and increasingly popular technique for helping children, young people and their families. Janssens and Kemper (1996) note that, at the time of writing, VHT had already been used in the Netherlands for more than ten years. VHT is characterised by short-term, home-based, filmed video-feedback of family interaction.

The basic assumption underpinning VHT is that a child's behavioural problems are related to dysfunctional interaction between parents and child. Thus, the goal of VHT is to improve parent–child relationships by resolving communication problems between parents and their offspring. VHT seeks to improve the quality of parental communication by stimulating the kind of interactions which are seen as forming the basis of good communication. Such positive interactions include parents and children

displaying attentiveness to one another, looking at each other when speaking, using a friendly tone of voice, and so forth.

VHT is informed by social learning theory (remember Skinner and Bandura – see the section on 'Cultural issues in child development' in Chapter 2). First, VHT reinforces positive communication: desired behaviour increases because the video home trainer emphasises that the parents are able to react appropriately to their child's behaviour, and rewards and encourages positive interaction. Secondly, the home trainer applies the principle of negative reinforcement. During VHT, parents can observe that, owing to their own changed behaviour, the behaviour problems of the child decrease: this encourages them to respond appropriately to the child in future. In addition to reinforcement, VHT utilises the modelling principle, which holds that many behaviours are learned through imitation. While talking to the parents, the home trainer consistently applies the communication principles of VHT, thus serving as a model. The parents also serve as models for themselves in that the video recordings allow them to carefully observe their own positive behaviours.

Following an initial meeting on referral, the video home trainer visits the parents at their home, and explains the nature and purpose of VHT. If the parents agree to participate in the training, appointments are made for the forthcoming weeks. In the first week, the video home trainer records a typical sequence of everyday interaction involving the whole family, such as a meal-time or game, for 10 to 20 minutes. In the second week, the home trainer reviews a selection of positive segments of interaction with the parents. This is done to show the parents that they are able to communicate with their children in a positive way. Reflections are made on significant non-verbal communication – which family members usually have not noticed before – and all positive interactions are encouraged. This 'immediate video-feedback approach' seeks to reinforce positive communication in day-to-day family life. Recordings made during one week are reviewed the following week with parents. This process is repeated until the video home trainer and the parents concur that the parents can interact positively or communicate effectively with their children without further support. The average duration of VHT is 8 months (Janssens and Kemper, 1996).

Janssens and Kemper's (1996) research demonstrates that VHT is effective in improving the quality of parent–child communication and reducing children's behaviour problems. However, their research examined the short-term effects of VHT and they note that further research is required to establish whether VHT has lasting effects on communications processes and children's behaviour problems.

Further work is also necessary to ascertain whether VHT has a positive impact on other aspects of family functioning. In the meantime, Janssens

and Kemper take issue with those who appear to regard VHT as a panacea for solving all the problems of families in need. In their view, this is too ambitious, and the use of VHT should be limited to attempts to resolve communication problems within families. Other social-work methods must be adopted to tackle other difficulties.

Group-work approaches

Some parents and children have needs that lend themselves to group work; and we said, in Chapter 2, that social workers must be comfortable working with groups. Some self-help groups are organised and led by the participants themselves, but most child-welfare clients will benefit, at least in the beginning, from the services of a trained group facilitator. The purpose of group work is usually either therapy (directed primarily towards effecting change in the participant's personality or interpersonal relationships) or education (focusing on imparting knowledge that can be expected to have a positive effect on family life), or some combination of the two. Change is made possible by providing a supportive, safe environment where participants feel comfortable disclosing problems and can benefit from the help of other group members who share the same difficulties. Often, groups are run by male and female co-facilitators who select participants, organise and oversee group activities, model such skills as male–female interactions and conflict resolution, and monitor group dynamics so that no one individual becomes too dominant or is victimised by the others. Participants are selected for the group on the basis of characteristics important to group cohesion: for example, problem areas and gender in groups for male sexual-abuse perpetrators; age in groups for teenage parents; and problem areas in groups for parents of mentally disadvantaged children. The only criterion for exclusion is usually a perceived inability to function as a group member, due to mental disadvantage or behavioural or attitudinal problems.

Most groups consist of 10 to 14 two- to three-hour sessions, run once or twice a week; 10 to 14 sessions is often considered to be the longest time for which participants can be expected to keep their commitment to attend. However, if group cohesion occurs and a process of meaningful interaction emerges within the group, participants may miss the sense of security the group affords and wish to continue for longer than the allotted period. This is rarely possible since other groups must be run for other participants; and, indeed, many group facilitators complain that the process of change has just begun when the group is over. Often, group work is offered in conjunction with other services such as individual casework or community work, where the process of change might continue. However, where group work is the only service offered and the group cannot be extended because of resource constraints, facilitators do sometimes encourage the group to continue on a self-help basis. They explain that they are not 'the experts': group participants have learned and will continue to learn from each other.

Crisis support services

An important aspect of agency policy concerns the provision of an out-of-hours service when the social worker known to the family is unavailable. The emergency service provided by most agencies out of office hours is rarely a *social work* service. Client files are often not accessible to the duty worker: the worker does not know the family, is unable to contact the family's social worker, and so may be unable to take appropriate steps to resolve the crisis situation.

Local authority social workers are usually discouraged from giving their home telephone numbers to clients, for obvious reasons. Neither is it reasonable to expect that social workers, who are under considerable stress during working hours, should be expected to be available out-of-hours as well. Nevertheless, most specialist units (dealing, for example, with special needs or highly disturbed children) do provide an emergency service which is based on being able to access the family social worker. Paradoxically, such access is often reserved for foster parents, who have high skill levels and are more likely than the average caregiver or client to be able to deal with the crisis by themselves. However, as Thoburn points out (Thoburn et al., 1986), merely knowing that the social worker *could* be accessed if necessary builds confidence and may in fact lead to a less frequent use of the emergency service since the caregiver, with a back-up in place, now feels more able to try to resolve the crisis before calling in the social worker.

Thoburn et al. (1995) argue that it is the duty of all managers involved in child-care work to establish an adequate emergency system which is accessible and welcoming to all clients, where there is the possibility of access to client records, and where the family social worker can leave messages about clients together with suggested ways of handling foreseeable difficulties.

In cases where the agency does not provide an adequate emergency service, or for families who are not presently involved with an agency, help in crisis can usually be accessed through such community services as suicide crisis lines, sexual-assault centres, drug/distress centres, AIDS/HIV crisis lines, women's shelters, child-abuse hot lines, and so forth. Many communities sponsor drop-in centres; for example, crisis nurseries where parents who are feeling temporarily overwhelmed can leave their children and obtain advice and referral information, in addition to immediate assistance.

Homemaker services

Homemaker service is provided to enable children to receive care in their own homes when the parent, for any reason, cannot fulfil parental and homemaking responsibilities. In such instances, child welfare will provide a person (usually a woman) trained in child care and home management who comes into the home for a few hours or more a day, and sometimes for 24 hours a day. In addition to the help provided by the homemaker, child welfare will try to facilitate the provision of other social or health services needed by family members.

Homemaker service was originally conceived as a short-term emergency service to hold families together in a crisis. While it still serves this purpose, the present conception permits its application to a broader range of situations. For example, it may be part of an intensive effort at family preservation, where the homemaker acts as a role model and educator to the parent in addition to providing hands-on help. Matters addressed by the homemaker may include such things as how to discipline a child, and child-rearing techniques in general; problem-solving strategies; nutrition; budgeting and house-keeping; and safety.

Homemaker services can be helpful in a variety of situations. If a parent is temporarily ill or absent, the presence of a homemaker will prevent haphazard babysitting arrangements, children scattered among relatives, or no care at all. In cases of abandonment, a homemaker can spare the children the added trauma of leaving familiar surroundings while authorities try to locate their parents or make other arrangements for their long-term care. A child with a marked handicap may consume parental energy to the detriment of the other children or there may be a period of psychological turmoil while the family adjusts to the handicap. Here, the homemaker can provide support to help the parents cope constructively. She may also provide reliable observations pertaining to the child's development which will enable the parents and the agency to develop a sound plan for the child's care and treatment. If a child has a serious illness, perhaps a terminal one, the homemaker may enable the parents to balance the care of the ill child with the needs of the other children in the family. If children are at risk of being apprehended due to neglect or abuse, the homemaker may combine education in child-rearing with the kind of warm support which will enable the parent to accept instruction and advice.

The preventive, protective and therapeutic usefulness of the homemaker service has been demonstrated in a variety of socio-economic groups and problem situations. It is an economical service compared with the cost of most out-of-home care for children; it is less stressful than foster care, especially when a number of children are involved; and it accords with the

value of family preservation. Nevertheless, it tends to be insufficiently supplied and continues to be primarily an urban service although it has been shown to be feasible in rural areas. Lisbeth Schorr (1991) has identified points of possible conflict between effective services in general and bureaucratic methods which may help to explain this. For example, most government programmes are funded according to categories, and people have to fall into the category to be eligible for the service. A service which encompasses many categories (or sometimes no category at all) may not be provided because the proposed recipient cannot be fitted into an appropriate categorical slot. Further, a service which requires flexibility and front-line worker discretion may be at odds with the traditional training of professionals and managers and with conventional approaches to ensuring accountability. Intensiveness and individualisation are at odds with pressures to ensure equity despite insufficient funds. A long-term preventive orientation is at odds with pressures for immediate payoffs. Finally, Schorr (1991) notes that a programme's ability to evolve over time is at odds with the pervasiveness of short-term and often unpredictable funding.

Shorr (1991) recommends creative funding approaches such as the decategorisation of certain categorical funds. These approaches could be directed to geographic areas that are at risk, so that eligibility for service would be linked to residency in the area, not to individual failure or need. Shorr argues that channelling money from various government agencies to a small geographic area would create a 'critical mass' of services that would be sufficient to make a difference at a relatively low cost. Such an approach would address the argument – mentioned earlier – that it is whole areas and not individual children in those areas which are 'in need'.

Day care

Day care defies simple description because day-care provisions are so varied. In general, day care can be divided into three major categories. The largest category, unregulated day care, consists of caregivers who operate independently of any regulatory agency, even though they may be subject to licensing or regulation by the local authority in whose area they live. The second category consists of caregivers who also operate independently but comply with government regulatory requirements, are periodically inspected and may lose their licences if any complaint is substantiated. The smallest category of caregivers, though it is growing in importance, consists of regulated homes functioning as part of a child-care system or network under the auspices of an umbrella sponsoring organisation.

Family day care offers several advantages to parents and children. Parents can often find daycare close to home, which makes transportation easier.

A good relationship with the care provider might ease difficult situations such as special needs on the part of the child or an unusual work schedule on the part of the parent. Some providers will even offer emotional support to the parent, information on access to other services, and advice regarding such things as child developmental stages, how to discipline, how to persuade children to eat or take a nap, and so forth. From the child's perspective, day care offers the stimulation of playing with other children and relating to other adults within the comfort and safety of a familiar setting.

The major disadvantage of day care is the lack of accountability. A parent who drops off a child in the morning has little idea of what occurs in the home during the day. The vast majority of care providers are not licensed or regulated and are not part of a network of providers. They work independently and without supervision. Often, they do not have the training to provide planned experiences for the children aimed at promoting cognitive development, and some may have taken the job simply to earn money while they stay at home with their own children. Levels of care vary from loving and competent care by experienced providers to abusive care by depressed and isolated women: and parents, whose choice of day care often revolves around location and cost, may not know which type of care their child is receiving. In addition, homes operated by individuals are often short-lived because the provider may decide to move, or have another baby of her own, or go out to work, or simply stop caring for other people's children.

Educational requirements for caregivers in child centres vary, and many caregivers, especially in rural areas, find it difficult to access training opportunities because of lack of time and money, and too few places in post-secondary early-childhood-education programmes. To alleviate the situation, at least in part, it is recommended that post-secondary institutions should provide coordinated training and education opportunities for the early-childhood workforce, expand their focus from centre-based preschool care to a full range of early-childhood services and family-support programmes, and provide additional courses to enable caregivers to increase their skills in the following areas: guiding children with behaviour challenges; providing culturally sensitive care and inclusive care for children with special needs; and working with young children in changing environments which include different work patterns and part-time and flexible child-care arrangements. To make the training more accessible, they should develop better credit and transfer procedures between institutions and reduce the barriers which limit access to training for some populations.

To further complicate the training issue, there has been little work done in the area of home-based care on which to base decisions about what constitutes good education for caregivers and how it should be delivered and supported.

Most providers derive a great deal of satisfaction from their work, but their benefits and working conditions leave a lot to be desired. The majority of caregivers do not receive paid benefits such as sick leave, retirement and pension plans, and medical benefits. They work long hours and face higher than average risks of physical injuries, infectious illness and stress. These factors contribute to caregiver turnover, which has a negative impact on quality care.

Petrie et al. (1995) carried out a survey of out-of-school play and care services for school-age children, a broad term which includes playschemes, after-school clubs, adventure playgrounds, out-of-school centres and day camps. The Children Act introduced a requirement that such services should be regulated if they took children under eight. The Act also requires that local authorities should provide out-of-school services for children in need.

The Petrie survey revealed numerous shortcomings in both day and open-door provision. Examples of good practice were found, but overall standards were unsatisfactory. The survey found that, out of the school services studied: 10 per cent did not keep an accident book; 15 per cent did not take up staff references, and 50 per cent did not do so for volunteers; 21 per cent had no kitchen area; 57 per cent had no policy on equal opportunities; 64 per cent had no hygiene procedures; and the majority of staff had no formal qualifications.

Candappa et al. (1996) examined day-care services for children under eight in England. More than 95 per cent of such care is provided by organisations (voluntary or private) in the independent sector. In England, there are currently over a quarter of a million childminders, day nurseries, playgroups, out-of-school clubs and holiday playschemes. Under the Children Act, all these provisions have to be registered and inspected annually. Roughly half of the playgroups and day nurseries and almost a quarter of childminders surveyed had accepted children placed by a social worker or health visitor. Although independent-sector providers were often ready to offer services to children in need, the potential of the independent sector was not fully utilised by local authorities.

Candappa et al. (1996) also found that the new statutory requirement that independent day-care services should 'have regard to' children's different ethnic and cultural backgrounds had limited impact on attitudes and practice. For example, almost a quarter of day-care providers in the study reported that the issue of equal opportunities and ethnic diversity was not discussed with them by the local authority when they were registered or inspected. Conversely, a large minority of day-care providers felt that too much emphasis was placed on equal opportunities by local authorities.

Similar findings were reported by a parallel study of day-care services for children in Wales carried out by Statham (1997). Whilst Welsh-language issues were being addressed by day-care providers, little attention was given to equal-opportunities issues and the need to help children develop positive attitudes in relation to cultural and racial diversity. Indeed, many day carers in Statham's study saw such issues as irrelevant to their role. As previously mentioned, Colton et al. (1995a,b) also found that insufficient priority was given to issues concerning ethnic, cultural and linguistic differences among service users in Wales.

Short-term accommodation/'respite care'

Under the Children Act 1989, the term 'accommodation' denotes out-of-home placements for children where the arrangements are made on a voluntary basis between social workers, parents and children. The 1989 Act repealed previous legislation concerning such voluntary arrangements, which 'placed sanctions on parents removing children from local authority care after six months' (Aldgate et al., 1996, p. 147).

The 1989 Act also introduced planned periods of respite care, of up to 90 days, as a single placement episode. Under Section 20 of the Children Act, local authorities are empowered to provide children with short-term breaks away from home as a means by which to support families and prevent family breakdown. As with the provisions for longer term voluntary care, the aim is to create a middle ground between keeping children at home and placing them in care. If accommodation is used as a form of family support, then children may not be living at home but they are still not formally in care (Aldgate et al., 1996).

Short-term placements, which used to be described as respite care, have traditionally been offered to families of disabled children. Aldgate et al. (1996) investigated their use in relation to other children in need. The study was funded by the Department of Health and was carried out in two parts over a four-year period. The first part reviewed 13 examples of short-term accommodation services for children other than those designated 'disabled'. This showed that effective short-term accommodation was being provided to a wide range of families, and children of all ages, by both statutory social services and voluntary agencies.

The second part of the study followed the progress of 60 families through a period of short-term accommodation, 'mainly in two city local authorities, looking at expectations, progress and outcomes from the perspective of children, parents and social workers' (Aldgate et al., 1996, p. 150). The accommodation typically involved two- or three-day visits to the caregiver's house at weekends. No child stayed away for more than four days at a time. The authors found that the provision of short-term accommodation met parents' expectations to a large degree, particularly in relation to the immediate benefits of time for themselves (which lived up to the expectations of 93 per cent of parents) and recuperation (which met the expectations of 86 per cent of parents). The longer-term benefits for parents included feeling less lonely and being able to cope with everyday life (which met the expectations of 96 per cent and 76 per cent of parents, respectively). However, parents' expectations that their children's behaviour would improve were met in only a quarter of the cases.

The authors conclude that short-term care can help to redress the imbalance between child-abuse investigation and the provision of family-support services. They state (Aldgate et al., 1996, p. 159) that their study showed:

> an early response to family stress can provide simultaneously a protective and supportive service. Nor was there any evidence to support the myth that if families are offered accommodation, they will take advantage and abandon their children to long-term placements. Indeed, the contrary was evident. Out of 60 placements, only two turned into long-term arrangements. Parents showed themselves capable of responsible and responsive behaviour. For them a service which offered family support was indeed the best option. Their only complaint was that there was not enough of it.

With respect to short-term care for children with disabilities, Robinson's studies are of interest. Robinson et al. (1995) evaluated the quality of services for disabled children, and produced self-assessment materials which services could use to develop their provision in line with the principles in the 1989 Act. The study looked at two types of children's services: short-term care for over tens and day care for under fives. The researchers developed a number of tools to enable disabled children to articulate their views about the service they received. For children under five, observation schedules were devised to monitor the quality of provision. Two packs of evaluation methods were formulated – one for short-term care and the other for day care.

Robinson and her colleagues found that some authorities had elected to hold review meetings less frequently than required by the Act because they felt that regular reviews were unnecessary for children placed away from home for relatively short periods. Moreover, full child-care plans had seldom been produced for these children. Few had social workers and short-term care staff did not see care plans as their duty. Where reviews were held, they tended to focus on short-term arrangements at the expense of key issues such as whether the placement was appropriate for the child

concerned. Colton et al. (1995a,b) also highlight problems with regard to services for children with disabilities under the 1989 Act.

Aldgate et al. (1996) note that short-term care can be offered either as a discrete service or as part of a package of care, and for the parent provides relief from the common stresses of parenthood, help with child management, and a link with the community for socially isolated families. For parents in difficult circumstances, it can provide relief from the stress of living in long-term poverty and relief for sick parents. It can also be a means of building parents' self-esteem and can act as an early diversion from potential physical abuse. For the children it can provide a different and relaxing experience, an alternative to long-term and/or full-time out-of-home placement and a relief from stressful family living.

The social worker has two important roles: as a direct service provider, and as an enabler. 'Social workers offer the resource of respite care – they also bring parents the opportunity of reflecting on their needs and of using counselling and support to look at how they might use their strengths most effectively to promote their children's welfare' (Aldgate et al., 1996, p. 150).

The provision of short-term accommodation requires careful consideration of the details of practice and the organisation of services. Aldgate et al.'s (1996) work indicates that the following issues may be important when arranging short-term accommodation. Family worries should be acknowledged and discussed in decision-making. There should be no hidden agendas; parents and children must have a clear picture of what short-term accommodation is and what it is not. The partnership should be rooted in reality; families must know what is realistically available and what choices are open to them. Written agreements are essential; they exemplify partnership by setting out what is expected of all parties. User families should be given some choice in the selection of the caregiver family; this reinforces a sense of partnership and commitment to the success of the arrangements. Meetings to help with selection are best held in the caregivers' homes; this provides parents and children with a good sense of how it feels to be there. Placement with a family of similar ethnic origin and religion is most likely to meet a child's needs and safeguard his or her welfare most effectively. However, caregiver families with different cultural, ethnic or religious backgrounds are often able to understand and value these aspects of the child's family life sensitively; and there should be an emphasis on this in training. Understanding and communication between user and caregiver families is essential; among other things, it is important to attend to the details of expectations about family life in both families. Children must know that their experiences are being considered and that they are being cared for by adults who are concerned about them and have taken the trouble to find out about their needs and wishes.

Issues in monitoring quality

Now that we have looked at some of the types of family-support services which may be provided, it is time to turn to issues of quality. How effective are the various services in giving support to families? How do we know when they have been effective? In other words, what criteria do we use to indicate success?

Whittaker (1996) identifies the following critical issues concerned with monitoring the quality of preventive initiatives: outcome measurement; specifying intervention components; training and technology transfer; and the problem of 'ecological validity'.

Outcome measurement

Whittaker (1996) reports that virtually all major providers of child-welfare services in the United States are reconsidering the definition of 'success'. This increased interest in 'outcomes' is primarily driven by financial considerations. Funding for services is increasingly tightly tied to clearly defined outcomes, specified time-limited interventions and constant monitoring. This has made agencies and practitioners 'acutely aware of the need to specify precisely the intended outcomes of their interventions and then to live with the results' (Whittaker, 1996, p. 119).

For example, *avoidance of unnecessary out-of-home placement* was chosen as the primary criterion of success in relation to intensive family-preservation initiatives. However, Whittaker notes that this caused major problems for researchers, policy-makers and practitioners. For one thing, 'placement' has been found to be a relatively low-frequency event which is difficult to predict. Secondly, it is now well known that 'placement' as an outcome is subject to a wide range of factors independent of services, including: formal and informal administrative policies; the presence or absence of resources; and the discretion of juvenile court judges. Thirdly, it appears that for some families there may be a need for a brief period of residential treatment for an emotionally disturbed child. Thus placement cannot necessarily be equated with failure; and indeed, in the UK, as we have seen, Section 17 of the 1989 Act stipulates that provision of accommodation for a child should not be viewed as failure by the family or the social worker.

In the United States, a number of tragic and well-publicised child deaths and some inconclusive research findings have fuelled a serious attack on the use of 'placement prevention' as the primary-outcome measure in intensive family preservation. In light of this, some have called for greater emphasis on child safety as the primary outcome of interest, and it is generally felt that there should be less focus on the physical location of the child

and more on his or her development and the state of the family's functioning (Whittaker, 1996). We will look more closely at measures of children's development when we consider the Looking After Children (LAC) materials in Chapter 6.

Specifying intervention components

A related issue is the task of carefully specifying the intervention components of preventive programmes. Whittaker (1996, p. 121) astutely observes that

> model legislation is silent on the specifics of intervention while eloquent on its values. The result is all too often the veneer of reform without the substance. As is the case with all social welfare intervention, the central question is simple yet elusive:
>
> > What combination of treatment/education/social support/concrete resources for what duration of time and intensity will produce the outcomes of interest to differing types of children and families?

Although a good deal has been written about effective preventive programmes, their components have seldom been subject to rigorous empirical evaluation. In relation to family preservation, further research is required to establish the importance and contribution of caseload size, the teaching of cognitive problem-solving skills (such as anger management), and the mobilisation of social support, including the provision of concrete resources. Likewise, with regard to placement services, both residential and therapeutic fostering represent a series of 'black boxes' rather than a clearly specified and empirically validated set of interventions. Similarly, with respect to family intervention, fundamental questions about the length, intensity and nature of the intervention remain unanswered. Some of these questions have major implications for budgets as well as for treatment planning. For instance, 'family intervention' could mean any or all of the following:

- Periodic contact with a local and lightly trained family worker linked, perhaps, to mutual aid and self-help;
- Training in parenting skills from a highly skilled parent educator on a groupwork basis;
- Family therapy with a therapist trained to post-graduate level;
- Occasional consultation with a parent volunteer via telephone.

(Whittaker, 1996)

We cannot therefore talk about the 'success' of 'family intervention' without first defining both 'success' and 'family intervention'. We might talk instead

about the success of a group designed to increase parenting skills where 'success' is an increase in skills as measured by the increased frequency of certain desired behaviours in parents' interaction with their children. However, we will probably not make the measurements necessary to enable us to hold any such conversation. Very rarely do social workers measure the results of their interventions with children and families, even when they know, specifically, what the intervention was designed to achieve. They may have a gut feeling that they were successful, but the feeling is rarely translated into objective evidence of success that others can use and evaluate. If we do not evaluate the results of our work with individuals, how can we evaluate the success of our agency's programmes? And if we do not know the effects of one agency's programmes, how can we gauge the effects of *all* agencies' programmes, nationwide, to bring us to an understanding of the effectiveness, or otherwise, of policies enshrined in legislation such as the Children Act? The next time you work with a child or family, think about one thing, specifically, that you want to achieve. Then think about an intervention you might use to achieve that. Then think about how you will know to what extent you have achieved what you wanted to. How will you objectively *know*? How could you demonstrate to others what you did and how well it worked? This is not an exercise: it is an integral part of your life as a social worker.

Training

When outcomes have been selected, and key interventions chosen, the third issue arising in preventive work with families concerns staff training and the utilisation of knowledge. Whittaker (1996, p. 122) describes the general approach to family-oriented prevention in the United States as a 'train and hope' strategy. He argues that:

> If intervention is the 'black box', training is the 'black hole' in most social services departments. To the extent that it exists, it is often didactic and diffuse as opposed to experimental and skill-oriented. ... its content is driven by the desires and interests of practitioners rather than either the demands of client families or relevant intervention research on 'what works'. Moreover, much of our training is patchwork, episodic with little attention given to follow-up, worker supports and either training needs assessment or evaluation.

In Whittaker's view, more attention needs to be devoted to the careful and systematic development of training in family-oriented prevention to ensure effective dissemination of innovative interventions. In other words, when you have done something new and clever with a child or family and you

have demonstrated how well it worked (as discussed above), you need an opportunity to tell others about it so that they can do it too – and such opportunities need to be structured and regularly provided by the agency in which you work. And not only do you need to tell others in your agency about it – you need to tell people in other agencies and other disciplines. There need to be structured opportunities, in other words, for sharing information across professional and agency boundaries.

The problem of 'ecological validity'

In the field of prevention/intervention, ecological validity may be defined as follows:

> Does the environment experienced by clients in a service program have the properties it is supposed or assumed to have by the practitioner?
> (Whittaker, 1996, p. 123)

In other words, does the client's perception of her environment (family, friends, finances, physical living arrangements, etc.) fit with the social worker's perception? If it does not, it is apt to be the social worker's perception that takes precedence, probably to the client's detriment. Whittaker (1996, p. 123) considers that 'while environmental intervention lies at the centre of the mission of social work, it exists at the margins of its practice'. That is, we generally do not take the time to find out what environmental factors are important to the client and what those factors mean in the context of the client's unique view of the world. What does it mean to a deaf child, for example, that all of his peer group and his parents have normal hearing?

Whittaker (1996, p. 123) rightly argues that increased emphasis should be placed on ecological validity in all its forms:

> greater emphasis on culture, gender, and sexual orientation in crafting interventions; greater involvement of indigenous communities in the development of the intervention and its evaluation through participatory action research; greater focus on environmentally directed intervention and on 'situated practice' (i.e. practice that occurs in the real life environments of our client families, as opposed to the sterile context of the clinic or social agency).

In this chapter, we have talked about proactive and reactive preventive services and the categories of 'children in need' who are eligible to receive those services. We have also discussed the types of family-support services

which might be provided and the difficulties of evaluating the effectiveness of our efforts. We will leave this chapter now and go on to discuss protecting children, in Chapter 5. We will look at the definitions, causes and consequences of child abuse, as well as child-protection procedures and legal considerations.

Case example

Case example 4.1 Salimah and Tasneem W

Salimah W (6 years, 3 months)
Tasneem W (4 years, 7 months)

Salimah and Tasneem are the daughters of Iris (23) and Mohammed (36). Iris and Mohammed have recently moved from the Welsh valleys to London in hopes of finding work. Mohammed emigrated to the UK seven years ago from Iran. He says that he was a doctor in his own country but his qualifications are not recognised here and he refuses any other sort of work, saying that it is beneath him. Iris, who is Welsh, has found a job as a cleaner. She does this job in the evenings when Mohammed is at home to look after the children. She earns very little but gives all her income immediately to Mohammed who manages the family's money.

Iris has no contact with her family. She says her mother threw her out when she became pregnant at 16 and she hasn't talked to any member of her family since. Mohammed has extended family in another part of London. Iris says that six or seven of them visit every month or so but they talk in Mohammed's language and ignore her because she produced only daughters and she is white. Mohammed says his family is supportive and he couldn't manage without them.

Salimah, who was in school in Wales, has recently started school in London, and it was Salimah's teacher who referred the family to social services. The teacher says that Salimah talks hardly at all, either to her or to the other children. She is always spotlessly clean when she comes to school and never gets herself dirty. She does what she is told but the school work seems to be beyond her. She is mercilessly teased by the other children and seems to be an intensely unhappy child. The teacher has never seen bruises but wonders about physical and sexual abuse.

Salimah's home is as spotless as herself and her mother as silent. There are no toys in evidence and no sign that children live in the house. On the social worker's first visit, Salimah and Tasneem sat quietly on the sofa beside their father and refused to speak to her. She did manage to get Iris

alone in the kitchen for a few minutes but when they went back into the living room Mohammed did all the talking. Mohammed told her not to come again because he could look after his family and they were doing fine.

- What proactive preventive approaches could have helped this family?
- What micro, mezzo and macro factors come into play?
- What would you do now if you were the social worker?