

**The Whole Family Approach in
Policy and Practice:
the construction of family and the gendering of
parenting.**

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Abstract

This thesis interrogates what a whole family approach is in Welsh policy and practice utilising an Integrated Family Support Team (IFST) as the case study. The study examines the construction of ‘family’ in policy, practice and by parents themselves and the impact of gender on practitioner and parental normative constructions of mothering and fathering as care practices.

Both the UK and Welsh governments locate their use of a whole family approach within a social exclusion framework that views strong familial bonds as the source of sustainable social capital. Documentary analysis is used to examine the policy construction of a whole family approach and of the target families themselves, as this has implications for the application of a whole family approach in practice and the type and nature of family engagement.

To date there has been very limited articulation of the therapeutic process entailed in a whole family approach. Through the use of practitioner interviews this thesis addresses that gap in research. It is imperative to gain an understanding of how practitioners conceptualise and engage with families within a whole family approach as this determines which individuals are included and excluded. This is a particularly pertinent issue given the well-rehearsed arguments regarding mother-blaming and lack of father inclusion within child protection practice.

Parental perspectives on the construction of ‘family’, and aspirations for both family life and their own mothering and fathering practices, are explored via analysis of parental accounts and values card-sort statements as recorded (and thereby mediated) by IFST practitioners. The findings from this analysis are that there is a considerable degree of constructive conceptual alignment between policy, practice and parental perspectives on the construction of family, and the gendering of parenting as care practices.

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1. Chapter One – Introduction

1.1. Significance of the Study

Under New Labour there was a shift in United Kingdom (UK) social policy requiring practitioners to *Think Family* in order to address the needs of highly marginalised, socially excluded families with the greatest needs and who were also perceived to be the location of greatest social problems (Social Exclusion Taskforce 2007). The family is perceived by policy to be a point of intervention for social ills and a whole family approach – one that builds on family strengths to promote family resilience and build social capital – is presented as being both more effective in preventing social problems and more sustainable in the longer term than multiple service interventions that focus practice either on the child or the adult (Morris *et al.* 2008; Social Exclusion Taskforce 2008). More recently the Welsh Government¹ has enacted a whole family approach ideology in policy and legislation (Welsh Assembly Government's Departments of Social Justice and Local Government *et al.* 2010a; Welsh Assembly Government 2008).

Empirical research is needed to provide an informed understanding of this shift in the focus of practice intervention from the individual to social roles and interrelationships within the family and the wider community. This study bridges the gap in empirical research into practitioners' understanding and use of a whole family approach as a therapeutic process. As Ferguson (2009) highlights:

Not nearly enough attention is given to the detail of what social workers actually do, where they do it and their experience of doing it.
(Ferguson 2009, p. 471)

¹ The Welsh Government and the National Assembly for Wales were established as separate institutions under the Government of Wales Act 2006. The Government is referred to in that Act as the **Welsh Assembly Government**, but to prevent confusion about the respective roles and responsibilities of the National Assembly and the Government, the devolved administration became known as the Welsh Government in May 2011.

This study explores via practitioner interviews practitioners' own experiences of embodying a whole family approach within their practice. However, it is worth noting that Integrated Family Support Teams (IFSTs) comprise of professionals from a range of disciplines and not just social work practitioners..

Pivotal to practitioners' use of a whole family approach is their understanding of 'family' and how parenting within the familial context is constructed and gendered in terms of mothering and fathering. Practitioner constructions of 'family' and 'parenting' within the context of a whole family approach are also areas that have received little attention in empirical research although this has a significant impact on practice. As Morris highlights:

The term 'family' is used indiscriminately in much relevant policy and practice literature emerging over the past decade (Morris *et al.* 2008), with various implicit assumptions about meanings.
(Morris 2012, p. 908)

Morris (2012) further suggests that there has been too much emphasis on parents and children, or working with vulnerable adults, with little reference to extended family networks, thereby limiting opportunities for whole family engagement.

Not only does working within a whole family approach problematise the construction of family for practitioners, but there is an implication in the use of the word '*whole*' that the approach may have potential to be more inclusive, for instance in relation to gender and the marginalisation of men in family life and service engagement, particularly in relation to safeguarding children (Ashley *et al.* 2006). As Morris (2012) states, 'in England and Wales, policy and practice developments concerned with engaging families in care and protection planning are set within complex and, at times, contradictory policy drivers' (p.907) that conceptualise families both as 'partners for change' and as 'the subjects of intervention' that are professionally or service led'. Further, Morris (2012) suggests that 'researching families and family-minded practice is underdeveloped in care and protection' (p. 911). This study addresses that underdevelopment by interrogating the use of a whole family approach within a child care and protection context.

The defining of 'family' (if it is not based solely on biological categorisation) is not fixed, nor immutable, but rather it is culturally, geographically, socially and temporally situated. As such, it is a highly contested and indeed an emotive topic. The contemporary acceptance of a right to privacy of family life and family functioning behind closed doors can provide a nurturing haven from the public world, or facilitate the secrecy needed for the perpetration of abuse and harm. Even the judgements made in determining what constitutes nurturing or harm are socially constructed and vary according to cultural, social and historical context.

How 'family' is constructed within policy and practice is pivotal to who is engaged within whole family interventions, i.e. in determining who is identified as a family member and what role this person has in relation to the child's welfare in promoting resilience, or as a presenting risk. Further, the way in which the family, and the roles of family members are gendered can also impact on who is included and excluded within the family in safeguarding children and perceptions of risk, resource and absence. Lone parent families, more accurately lone mother families, are characteristically the focus of such services which raises the question as to how families are labelled as 'lone mother' and how this then impacts on the construction of family and identification of who is a family member and who should, or should not, be engaged within the whole family approach.

In social policy the concepts of 'family' and 'parent' are used interchangeably, although the two are clearly different. Similarly, the idea of 'parent' is used interchangeably with 'mother', thereby rendering gender invisible (Daniel and Taylor 2006). Mothers and mothering practices become the focus of intervention and the mother carries the responsibility for the outcomes for the child, both in terms of safeguarding the child and in relation to the child's development. This can lead to an over-scrutiny of mothering, pathologising the individual mother (Daniel and Taylor 2006) and a focus on the mother as either ignorant and in need of parenting education, and/or morally deviant (Clarke 2006).

Whilst lone mother headed households are over represented in the child welfare system there is evidence to indicate that 72-88% of children at risk of maltreatment or reported to child welfare services have an adult male who plays a fathering role in their lives

(Dubowitz *et al.* 2000; Marshall *et al.* 2001) . Research in the United States based on a nationally representative sample concludes that the majority of families involved in child welfare have male relative involvement (Bellamy 2009). This challenges the notion that male father figures are absent within lone mother households, and therefore the engagement of men and more broadly gender inclusion are pertinent issues for policy and practice. Greater scrutiny via empirical research is required to understand the impact of such labels as ‘lone parent/mother headed household’ on working within a *whole* family approach and the impact this has on gender inclusivity and this study addresses that gap in the knowledge base. As Clarke and Hughes (2010) state:

The recent focus of government on ‘whole family’ thinking provides an opportunity to develop a critical space where the construction of ‘family’, of ‘complex’ family support requirements and of specific ways of working with families facing multiple difficulties can be examined.
(Clarke and Hughes 2010, p. 528)

1.2. Case Study: Integrated Family Support Team

This thesis provides a case study exploration of the enactment of a whole family approach in Welsh policy, namely *Stronger Families* (2008); and legislation, namely the *Children and Families (Wales) Measure 2010*, through implementation and service reconfiguration and thereby into practice. In addition, the research explores policy and practice constructions of ‘family’ and the gendering of parenting.

The Welsh Government has been pioneering Integrated Family Support Teams (IFSTs), which were initially focussed on families with complex needs where parental substance misuse coexists with child welfare concerns (typically children on the Child Protection Register (CPR) or at risk of entering public care). IFSTs are multi-disciplinary teams of practitioners working with the whole family to a single, therapeutic model of intervention and in that sense are also trans-disciplinary in that the model cuts across professional disciplines. Each practitioner works intensively with a single family at a time, drawing on the professional knowledge and skills held within the team and in that sense the teams are also multi-disciplinary. Traditional models of service provision would normally involve both adult and child and family services. Adult service

provision would likely focus on the parental substance misuse and child protection services in relation to the welfare of the child. The use of a whole family approach presents dilemmas for adult and child and family practitioners alike, in understanding the impact of parental substance misuse on child welfare and in addressing presenting needs (Taylor and Kroll 2004). This fracturing of service delivery between adult and child and family services has also led to concerns that the needs (and strengths) of the family are not holistically assessed. The solution proposed is integration of services across adult/child services and between health, social care and voluntary sectors via Integrated Family Support Teams (IFSTs). The intention of IFSTs as stated in *Stronger Families* (2008) is to 'promote systemic change in the delivery of services' via four inter related priorities: the provision of the multi-agency IFST service itself, the use of evidence-based interventions, training and supervision across the locality of service and in-built on-going evaluation.

The IFSTs are intended to be change agents to re-focus services to deliver person-centred provision for the whole family in order to maintain children safely within their families wherever it is in the child(ren)'s best interest to do so. The aim of such practice as stated in *Stronger Families* (2008) is to promote children's resilience and welfare by changing parental behaviour and maximising strengths and protective factors in the wider family. The policy document points to the research undertaken by Slack and Webber (2007) which suggests that in assessing a family's resilience the unit of analysis should be the family itself, rather than the individual perceptions within the family.

This presents a dilemma to contemporary health and welfare professionals in determining what constitutes 'family' and its membership, and what constitutes a 'whole family approach' in managing risk and resilience in the context of parental substance misuse and child welfare concerns. In order for policy and practice to be effective in family intervention there needs to be some constructive, conceptual alignment regarding the construction of 'family', as well as some understanding of the lived experience of family life and parental roles. This study provides some insight about parental perspectives on the construction of 'family' and their aspirations of mothering, fathering and family life via the analysis of accounts made by parents and recorded by practitioners within the case files.

Thus the importance of this study is threefold. This is the first study to: (1) interrogate the Welsh enactment of a whole family approach in policy; (2) articulate from the practitioner perspective the therapeutic process of a whole family approach within the context of parental substance misuse, child protection and family preservation and (3) examine gender in relation to whole family policy and practice.

1.3. Research Aims and Objectives

This study addresses what Morris and Featherstone (2010) have stated as being the ‘contested and underdeveloped backdrop to whole family approaches’ p557. The aim of this research is to explore what a whole family approach is in Welsh policy and practice, how ‘family’ is constructed in policy, practice and by parents themselves in this context and what the impact of gender is on practitioner and parental normative constructions of ‘mothering’ and ‘fathering’ as parental care practices.

The research questions used as objectives to achieving these aims are listed below. The chapter which addresses this question is indicated in the brackets alongside each research question:

- How is the whole family approach enacted in Welsh policy and legislation (Ch. 5)?
- What is the Integrated Family Support Team (IFST) model of practice (Ch. 6)?
- What is ‘a whole family approach’ as embodied in IFST practice (Ch. 7)?
- How is ‘family’ co-constructed by practitioners and parents in practice (Ch. 8)?
- What is the impact of gender on practitioner and parental normative constructions of mothering and fathering as care practices (Chapters 8 and 9)?

1.4. The Thesis Structure

The next two chapters, 2 and 3, provide a review of the academic literature in relation to a whole family approach, the construction of family and the gendering of parenting. Chapter 2 focuses on the construction of family both in sociological literature and in policy, and family life in the context of parental substance misuse. Chapter 3 focuses on literature in relation to a whole family approach in UK policy and in terms of the therapeutic process. Given the lack of research into the therapeutic process entailed in a

whole family approach there is a review of the literature that exists on the broader range of family practice, such as family-minded and family-centred practice. In addition there is a discussion regarding the use of an ethic of care as a moral and analytic framework for relational practice. Chapter 4 provides an outline of the research design and methods and the rationale for the approach taken. As outlined above, the subsequent empirical chapters each address one of the research questions.

Chapter 5 addresses the first research question by providing the findings of a documentary analysis of Welsh policy and legislation in order to explore its enactment of a whole family approach and the policy and legislative construction of family. Chapter 6 provides an account of the IFST model as articulated by practitioners themselves which provides the backdrop to whole family working in this practice context. The documentary analysis of practice manuals, guidelines and practice toolkits when compared with practitioner articulations of the model, facilitates discussion within this chapter regarding the codification of practice in contrast to lived experience as embodied in practice. Chapter 7 provides a thematic analysis of practitioner interview data in order to construct an articulation of a whole family approach from a practice perspective.

Chapter 8 explores the co-construction of ‘family’ between parents and practitioners as part of the practitioners’ negotiation of their entry and ‘being invited in’ to work with the family. Drawing on numerical data collected from the case file analysis ‘family’ as structure and household composition is discussed. A thematic analysis of parental accounts of their preferred futures and values card-sort statements is used to explore parents’ normative constructions of ‘family’, ‘mothering’ and ‘fathering’. Chapter 9 focuses on the impact of gender on practitioner assessments and intervention by exploring practitioner constructions of ‘good enough parenting’ in terms of mothering and fathering care practices. The chapter also considers the impact of gender in terms of perception of risks, resources and absence. This leads to a discussion regarding father inclusion within a whole family approach. The final chapter, 10, provides a discussion of the key findings, conclusions and recommendations for policy, practice and further research.

2. Chapter Two – The Construction of Family and Family Life in the Context of Substance Misuse

2.1. Introduction

Chapters 2 and 3 combined comprise a review of the literature as it pertains to the research questions of this study. Literature reviews are essential in mapping the existing knowledge base prior to undertaking a research project and can also be helpful in clarifying key concepts and the construction of the research questions. As such this literature review situates and contextualises the research undertaken as well as identifying key gaps in the literature that this study seeks to address.

Whilst all literature reviews undertake a systematic approach, the conducting of a literature review could be said to be along a continuum from systematic to narrative reviewing. Mulrow *et al* (1997) define systematic reviews as ‘concise summaries of the best available evidence that address sharply defined clinical questions’ (p.389). The Cochrane Collaboration produce exemplary guidance on how to conduct such systematic reviews. Key features of a systematic review are the identification of a predefined question and search strategy and a strict protocol that uses explicit and rigorous methods to identify, critically appraise and synthesize relevant studies in order to answer the predefined search question. Within a systematic review predetermined inclusion and exclusion criteria are developed so as to ensure that only high quality studies that are relevant to the predetermined search question are included. At the alternate end of the spectrum are narrative reviews.

Whilst the literature review conducted for this study was systematic in its approach to comprehensively searching literature from a wide range of sources, the process by which this literature review was carried out was closer to a narrative review than a systematic review. The literature searching process was not a one off event but concurrent with the research in that it was iterative and recursive in informing the emergent research questions and later data analysis. Thus the literature reviewing process served three key purposes: (i) mapping the existing knowledge base relevant to the research questions; (ii) identifying any gaps in the existing literature as it related to the research questions and thereby refining the research questions; and (iii) finally, in

theory building within the data analysis based on emerging concepts and hierarchies. Such an approach to the literature review is consistent with the use of grounded theory (see section 4.4) in the data analysis. Given the breadth of the research questions the emphasis was on constructing a narrative review of this exploratory terrain that located the whole family approach within UK, and specifically Welsh policy and practice, and situated it within the specific service user group of parental substance misuse and child protection and the associated substance misuse and child protection practice. This served as the basis for the inclusion and exclusion criteria. Therefore, whilst whole family approaches may be embedded in a variety of social care practices such as family group conferencing, incorporating such literature would have diluted the focus. Similarly, some international literature was not included where it was not pertinent to the UK and/or Welsh context. The following paragraph outlines the search strategy.

The main database used was SCOPUS, although other databases and gateways, such as Social Care Online, Social Services Abstracts, Sociological Abstracts, SwetSwise, Psycinfo and the Web of Knowledge Service were also searched. Publisher databases searched included Sage Journals Online, Taylor and Francis and Wiley Online Library. Keywords were used to search for relevant material in both titles and abstracts. Key words used were “whole family approach” “family-focussed practice” “family-centred practice” and “family-minded practice”. As well as title and abstract text searches the search term “whole family approach” was used as a free text search of entire papers. In addition, further searches were undertaken in relation to construction of family: “parenting”; “mothering”; “fathering”; “fathering” AND “child welfare outcomes”; “father*” AND “child protection”; “mother*” AND “child protection”; “parental substance misuse”; and “family preservation”. Boolean operators such as AND/OR were used to limit and extend results of paired search terms. As indicated above truncated terms were also used, such as famil* and father* to ensure that variants of spellings did not result in exclusion of any relevant papers. Reference lists in identified papers were also used as a means of identifying further articles. Where relevant articles were identified author searches and citation links were used to identify whether the same authors had written other relevant articles and/or whether their works were cited in other relevant articles.

The literature review process did not identify any empirical research on a whole family approach that articulated its use in professional practice in terms of the processes involved and underpinning theoretical basis, nor specifically within the context of parental substance misuse, family preservation and child protection. This is clearly a significant gap in the existing literature. Currently, most published work on a whole family approach in terms of practice is on related topics such as ‘family- focussed’, or ‘family-centred’ practice, or in relation to ‘family preservation’ more broadly. Publications specifically focussed on a whole family approach tend to be reviews of family practice literature or discussion regarding policy. To date there has been no empirical research regarding the use of a whole family approach from the practitioner perspective as to the processes involved as a therapeutic intervention, nor is there such research regarding the practice process of a whole family approach in the specific context of parental substance misuse and child protection. These are important gaps in the literature which this research addresses. As such the research is exploratory and a single case study approach is the most apt in providing some initial, detailed mapping of this new territory.

As highlighted in chapter 1 the use of a whole family approach presents a challenge to contemporary health and welfare professionals in determining what constitutes ‘family’ and its membership and what constitutes a ‘whole family approach’ in managing risk and resilience. For IFST practitioners managing risk and resilience is within the specific context of parental substance misuse and child welfare. The *Think Family Literature Review* (Morris *et al.* 2008) found evidence that professionals found whole family approaches both challenging and controversial, resulting in on-going difficulties in engaging ‘*whole*’ families.

How the family is co-constructed by practitioners and families – who is included and excluded and why - has a significant impact on the model of whole family approach adopted.

Whilst, then ‘whole family’ approaches may provide an important signal to examine all family members’ experience, contribution, and support needs, there are current concerns that mothers’ and fathers’ experiences and needs should often be heard as separate voices.

(Morris *et al.* 2008, p. 68)

Since gender is apparently rendered invisible by focussing on gender-neutral ‘parenting’ one would expect a whole family approach to be more inclusive of the contributions made by *all* family members as potential resources, including those of men, whether biological or social fathers. There is increasingly a shift in recognising that mothers are not the only care givers and that men’s involvement in family life requires recognition and sometimes support. However, concerns have been raised that the use of the word ‘parent’ in policy results in gender not being fully considered (Daniel *et al.* 2005). Ashley, Featherstone *et al.* (2006) make a plea for the need for further research on the ability of services to engage with fathers and not solely to do so when men are perceived as a ‘threat’ in child protection cases (Scourfield 2006).

In this chapter, 2, and the next, chapter 3, the academic literature on these topics will be reviewed. This chapter begins by discussing sociological perspectives on the construction of family in order to survey the analytical frameworks available for understanding family as a social construct (section 2.2). The subsequent section, 2.3 reviews the literature on different typologies of family discourse used in policy. As the specific familial context of IFST intervention is that of parental substance misuse the chapter includes a discussion of the impact of parental substance misuse on family life and on parenting (section 2.4).

2.2. The Construction of Family: Sociological Perspectives

Contemporary academic theory and research provide no single, consistent and universal definition of ‘family’, although there are consistencies in terms of constructing family around features such as kinship (whether on the basis of legal or biological bonds), shared residence within the same household or geographical location, or the function of caring for vulnerable adults or raising children (Morris *et al.* 2008).

Talcott Parsons (1956) propounded a functionalist approach in which he considered the nuclear family, with its delineated sex roles, as ideally suited to the needs of a post-industrial society as the smaller family unit had greater mobility to relocate to areas of industrialisation for work. However, research such as Willmott and Young’s (1957)

conducted in a working class area of East London, evidenced that extended family networks were very much still in existence, with women having a central role in maintaining those networks. Whether defining the family as nuclear or extended, both of these perspectives focus on the structure and function of family, and uphold family ideology, either in terms of emphasising change within family structure as socially adaptive, or a romanticised social connectedness.

The most systematic and comprehensive challenge to family ideology was led by feminist authors such as Oakley (1972), Millett (1970) and Mitchell (1971). Feminist theorists highlighted how family ideology rendered invisible the gender and power relations inherent within traditional ideological constructions of family. Gillies (2003) notes three major challenges brought by feminists: that the socially constructed normative gendered assumptions were presented as objective fact, that the division between public and private spheres relegated women to domesticity due to their caring and reproductive responsibilities, and that the family was represented as a harmonious, safe haven.

More recently, there has been a shift in sociological thinking from structures and functions to the complex, contingent, lived experience of personal relations. Theorists such as David Morgan (1996) place greater focus on the interactional processes within families and reframing family from who one is to what one does or ‘family practices’, i.e. the ‘doing’ of family. The concept of ‘family practices’:

...focuses on the everyday interactions with close and loved ones and moves away from fixed boundaries of co-residence, marriage, ethnicity and obligation that once defined the ...nuclear family. It registers the ways in which our networks of affection are not simply given by virtue of blood and marriage but are negotiated and shaped by us, over time and place.

(Williams 2004, p. 17)

Neale (2000) endorses this shift in thinking away from structure and composition to the ‘doing’ of family in everyday life. Finch (2007) has developed the notion of ‘family displays’ to draw attention to how family practices are intertwined with meanings. She draws on, and strengthens, Morgan’s identification of practices as fundamentally social

in nature, involving interaction between actors and wider systems of meaning. Finch argues that, if activities are to be effective as family practices, their meaning as constituting and being about family has to be conveyed and understood by others. As Finch (2007, p. 79) succinctly states, family ‘must not only be ‘done’ it must be ‘seen to be done’

Gubrium and Holstein (1990) similarly suggest that ‘family’ is more than simply family configuration or household composition, indeed it is not even a fixed entity but rather ‘family’ is a fluid dynamic of relations and relationships to which meanings are assigned. These relationships are best understood through social constructionism and the meanings assigned by family members themselves. Gubrium and Holstein (1990) emphasize the family as discursive and as a site in which relationships are constructed and maintained through routine communication between family members. Researchers such as Finch and Mason (1993) perceived what they saw as a shift from normative, social obligations to negotiated, contingent responsibilities within interpersonal relationships and kinship ties.

Giddens (1992) suggests a transformation of intimacy and personal relationships that allows for greater democratisation and negotiation of roles and family membership. He further suggests that, whilst ‘the inequality of men and women was intrinsic to the traditional family’ (1999, p. 54) modernisation and globalisation of the self as a reflexive project (Giddens 1991) opens up a reflective space within family life in which there is greater opportunity for equality between men and women and the capacity for children’s voices to be heard.

With the shift from examining the family in terms of function and structure to personal relationships and intimacy greater attention was given to adult relationships rather than parent-child relationships. Underpinning the intimacy and personal relationships approach is an individualisation hypothesis in which autonomy and personal freedom are paramount. Feminist theorists such as Gilligan (1982) and Sevenhuijsen (2000) have challenged such approaches and propounded a feminist ethic of care in which a relational ontology of mutual interdependence is assumed.

Gillies (2003), in her review of the sociological research on family and intimacy, identifies three major sociological perspectives on contemporary personal relations with theorists either emphasizing breakdown, continuity, or change with a concomitant moral ideology. Whilst both the New Right and New Labour see diversity and change within the nature of family form and social connectedness, their interpretation of its effect differs. The New Right consider the effects to be ‘atomisation’, i.e. moral degradation, over-reliance on the state and social disintegration requiring a return to ‘traditional family values’ of responsibility and obligation. Gillies (2003) suggests that New Labour theorists in contrast, view this as ‘individualisation’ and embrace the fluidity in family form as opening up new possibilities for equality and negotiated interpersonal relationships whilst disregarding the impact of wider structural inequalities. She considers this third group of theorists who emphasize continuity as perceiving personal values and practices of trust and caring as reflection of ingrained identities and power relationships that are resistant to change. Reframing the family, personal relationships and intimacy within a social capital conceptual framework emphasizes how such social networks and associations within the family and broader community generate resources and lessen reliance on the state for support or (punitive) intervention.

Williams (2004) argues that ‘we have a greater diversity of living arrangements and family forms’ (p.11) than ever before. Thus, ‘family’ as a social construct ceases to be a fixed, immutable, boundaried social structure but rather it is seen as a fluid, relational process: it is the quality of relationship rather than biological, household or legal status that determines a relationship as being familial. Williams points to the ‘ethic of care’ (Gilligan 1982) as the binding force within families.

Moral reasoning based on care informs the way people attempt to balance their own sense of self with the needs of others. What it means to be a good mother, father, grandparent, partner, lover, son, daughter or friend is crucial to the way people negotiate the proper thing to do.

(Williams 2004, p. 8)

Family practices are thereby embodied by measurement against normative ideals of behaviour, with the two parent intact family as the pinnacle of the aspirational,

normative ideal, despite the often substantial distance between this idealised construction and the reality of lived experience.

In determining this familial network of social relationships Pahl and Spencer (2004) suggest a distinction between ‘families of fate’, i.e. families into which we are born and have no choice or control of our membership; and ‘families of choice’, i.e. those people we freely choose to constitute as family members.

This review of the sociological theorising on the construction of family highlights the importance of interrogating the concept of ‘family’ as a problematized construct within policy and practice. The literature reviewed also suggests the relevance of exploring the conceptual and moral lens through which practitioners work with families. This is particularly important when working within a whole family approach as this informs the identification of family limits and the boundaries of family relationships and the underpinning family ideology. The next section reviews the academic literature in relation to the construction of ‘family’ as presented within policy.

2.3. The Construction of Family in Policy

The shifting configuration and diversity of family constructions presents a challenge to policy makers and practitioners alike in meeting the needs of diverse families in which ‘family’ is considered to be the source of both risk and resilience. There is a long history of social policy aimed at addressing ‘the problem family’ as the incubator of social ills and irresponsible citizens from the 1930s onwards (Welshman 1999). At the core of such constructions is the assumption that families are where social learning and normative behaviour occurs and that poor parenting results in children who subsequently grow up to behave outside of acceptable social norms, such as anti-social or criminalised behaviour and thus the cycle of deprivation is perpetuated. Support to parents is intended to re-educate parents into more acceptable, middle class norms of parenting – that family cohesion is the key to greater social cohesion. This can also be perceived as having a moral or normative agenda to regulate and control the behaviour of marginalized and socially excluded families. This generates a core tension in debates relating to supporting parents and families between that of the right to private family

life and state intervention for the public interest in order to eradicate perceived social ills such as anti-social behaviour (Gillies 2005).

Barker and Hunt (2004) reinforce that public, policy makers and practitioners' alike share a view that family is the fundamental societal foundation and key to primary socialisation. Consequently, dysfunctional or 'problem' families, i.e. those families that fail to achieve these functions to expected social norms and standards, create social ills and that substance misuse is one such cause and/or symptom of dysfunction. Whilst there is a vast literature on family and substance misuse Barker and Hunt (2004) provide one of the few studies on how the family has been theorized in the fields of alcohol and drug use. They suggest that there are both similarities and divergences between the ways in which 'family' have been theorized in the drug and alcohol fields which relate to social attitudes to the substances themselves. Alcohol being considered more socially acceptable, the 'family' is seen to be both the cause and solution to alcohol misuse. However, drug misuse is viewed as criminal, deviant and with far less tolerance than that toward alcohol use where the drug user is characterised as isolated, alienated and often ultimately excluded from both the family and wider society. In common, the two fields of alcohol, and drug misuse, share a view of family derived from classic structural-functional theory based on family structure, family sentiment and family activity. Barker and Hunt (2004) suggest this lack of problematisation of the 'family' and accepted use of functionalist modernist theory of family is insufficient to account for the complexities, fluidities and diversity of contemporary family life. Bauman (2003) refers to this fluidity in terms of the 'liquidity' of family relations and sentiment.

Spratt and Devaney (2009) identify three ways of discussing families, and concomitantly, three differing approaches to policy and practice intervention. Firstly, some families are considered as failing due to structural and environmental conditions and requiring support in order to achieve acceptable child welfare outcomes. Secondly, there is an individual pathology approach based on deviant lifestyle in which families may be endangering their children and may therefore require social policing and support. Finally, some families are seen as unable to care for their children and therefore require the state to share parental responsibility.

Further, Spratt and Devaney (2009) use the term ‘families with multiple problems’ to describe families who share a range of characteristics including drug and alcohol use, the presence of domestic violence, and physical or mental health problems on the part of one or more parents, which result in repeated incidents of child maltreatment. Such families with complex, chronic and enduring issues are unlikely to have their needs met via short incident-driven intervention which is characteristic of child protection approaches and instead they may require longer term intervention. Spratt and Devaney (2009) carried out a comparative investigation across Australia, the USA and the UK to determine whether such families shared similar characteristics and whether practitioners and managers were able to identify such families. They conclude that what is required for families with multiple problems is targeted services focussed on early intervention and long term working.

An alternate typology of policy constructions of family is suggested by Murray and Barnes (2010). Utilising *Trace Methodology* (Sevenhuijsen 2003), Murray and Barnes (2010) analysed 26 documents across seven policy streams and identified four main discourses within the selected documents: ‘the socially excluded family’, ‘the responsible family’, ‘the anti-social family’ and ‘the resourceful/risk managing family’. Socially excluded families are not only positioned as needy but also as potentially risky. Where a socially excluded family is also engaging in particularly risky and threatening behaviour this would fall within the anti-social family construction. Parents are perceived to be failing to instil normative standards of behaviour in their children which presents a risk to themselves, their children and the wider community. This legitimates state intervention into the private realm of the family in order to break inter-generational cycles of deprivation and anti-social behaviour and to safeguard children. Both the socially excluded family discourse and the anti-social family discourse are associated with family breakdown and the dissolution of the nuclear family as the normative ideal.

Social exclusion is about more than income poverty. Social exclusion happens when people, or places, suffer from a series of problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, ill health and family breakdown. When such problems combine they can create a vicious cycle. Social exclusion can happen as a result of problems that face a person in their life, but it can also start from birth. Being born into poverty or to parents with low skills still has a

major influence on future life chances (Social Exclusion Unit (1999) cited in Buchanan (2007, p. 189).

The re-focussing on child safeguarding, rather than more narrowly on child protection, also contains within it the desire to improve the life chances and opportunities of children at risk. As Buchanan (2007) highlights, this definition of social exclusion emphasizes the intergenerational transmission of deprivation and that preventative intervention is required to break this cycle. Implicit within this definition is that parental circumstances impact on outcomes for children, who subsequently become the adult parents of the next generation. The emphasis on short term intervention to protect a child who is being abused is therefore extended not only to minimising significant harm to children in need but further to those children who are in families at risk of social exclusion. Thus, a whole family approach is advocated by the UK Government, namely one that takes into account the circumstances of adult parents and the impact these have on children, both in terms of risks and protective factors in relation to social exclusion. The project of social welfare becomes a social investment strategy with long term goals that are future orientated.

Axford (2010) argues that social exclusion is a more useful concept for children's services than a 'child in need' model in which the focus is on risk and protective factors. The advantages of a social exclusion perspective are that it draws attention to the fact that children are themselves social actors and participate in mainstream society via integrating systems such as family and friends, the economy, the state and voluntary organisations. Thus the focus is on maximising inclusion rather than minimizing harm.

The concept of social exclusion also draws attention to the multi-dimensional nature of disadvantage (social and economic capital) and that multi-dimensional problems require multi-dimensional solutions provided through multi-agency working, namely 'joined up solutions to joined up problems' (Social Exclusion Unit 1997). Axford suggests that UK policy has tended 'towards the 'weak' model of social exclusion focused on the individual that is **excluded**, and away from the 'strong' model with its stress on the **excluder** in the form of broader social forces' Axford (2010, p. 744). However, the social exclusion model does draw attention to those people in society facing multiple disadvantage and particularly to those labelled as 'families at risk', defined as those

with, or at risk of, developing ‘multiple and complex problems such as worklessness, poor mental health or substance misuse’ (Social Exclusion Taskforce 2008, p. 4). The social exclusion paradigm also brings greater attention to the temporal, longitudinal effects of social disadvantage across and between generations and the spatial location in terms of geography and social location of community. This refocuses attention from a passive orientation of welfare that responds to disadvantage to a more proactive approach to welfare that aims at preventing social problems (Hills 2002). Finally, an awareness of social exclusion may be viewed as encouraging greater consideration on the role of services in producing or ameliorating, social disadvantage.

Whilst there are advantages to social exclusion as a conceptual paradigm in the delivery of child welfare services Axford (2010) does also indicate some inherent dangers. There is the potential to use the concept of social exclusion to reinforce the discourse of a self-excluded, moral underclass and a deterministic view of the intergenerational transmission of deprivation resulting in a blame culture. Similarly, a social exclusion approach may focus on identifiable administrative groups of people in society and treat those individuals as homogenous entities rather than the more individualistic approach inherent within a needs based model.

Social Exclusion, however, remains a contested and ill-defined concept. Whilst poverty, deprivation and social exclusion tend to be used interchangeably they are different constructs. Room (1995) defines social exclusion as ‘the process of being detached from the organisations and communities of which the society is composed and from the rights and obligations that they embody’. This definition emphasises processes of marginalisation and that social exclusion is a fluid and dynamic process regarding the production and distribution of social resources: labour market; family and informal networks; and the state. Mulgan suggests:

The concept of social exclusion is in part about power and agency: people's capacity to control their own lives. It is a dynamic concept, about prospects as well as current situations. And more than concepts of poverty, exclusion is about particular communities and particular societies.
(Mulgan 1998, p. 260)

The latter definition suggests that there is an identifiable group or subset of society who can be deemed as ‘socially excluded’ and that this relates to more than just income poverty. The Social Exclusion Taskforce commissioned a comprehensive review of the literature in 2007 (Levitas et al. 2007), which produced the following working definition of social exclusion

Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.

(Levitas et al. 2007, p. 9)

In order to make use of this concept in empirical research a matrix of domains and topic areas was constructed looking across four stages of the life course: childhood, youth, working-age adulthood and later life. This matrix, the *Bristol Social Exclusion Matrix* (B-SEM) (Levitas et al. 2007), contains three domains –resources, participation and quality of life - under which there are ten sub-domains. This broad definition would suggest that the policy focus should be on redressing inequality within society to create a more inclusive society (Levitas 2005) and emphasizes social exclusion as a relational process rather than as referring to a narrow, fairly static, subset of readily identifiable people who are estranged or ‘detached’ from mainstream society.

As can be noted from the discussion above the contrasting conceptualisations of social exclusion suggest differing policy intentions. Within a broader definition there is greater emphasis placed on relational processes which generate multiple deprivations and the aim is a more inclusive and equitable society. Within a narrower definition of social exclusion the aim of policy is to target an identifiable subset, or minority, of the population who are perceived to be the cause of social ills, criminal and anti-social behaviours, civil unrest and a substantial drain of the public purse. This represents a core tension within both academic and policy debates regarding social exclusion and the cause of some confusion as to whether the group being referred to as ‘socially excluded’ are casualties of multiple deprivations (‘troubled’) or the cause of criminal and anti-

social behaviours and civil unrest ('troublesome'). Contemporary UK Government policy suggests that these are not two separate groups of people, but are in fact the same target group of people.

Troubled families are those that have problems and often cause problems to the community around them, putting high costs on the public sector.

(Department for Communities and Local Government 2012, p. 9)

Levitas, in a working paper in the policy response series for Poverty and Social Exclusion in the UK (Levitas 2012b) and in an article on the London School of Economics and Political Science website (Levitas 2012a) vehemently challenges the conflation of these differing social groups and the misuse of research to support decision based policy evidence. Levitas (2012a) states that the Troubled Families Programme

. . . claims that there are 120,000 such families but there is no evidence whatsoever for this claim. The figure of 120,000 is a very rough estimate of the number of families who were experiencing severe multiple deprivation in 2004. The slide from families with troubles to families who cause trouble is wholly illegitimate and is accompanied by punitive rhetoric towards some of the poorest families in Britain.

Levitas points out that the research on which the figure of 120,000 troubled families has been based was a secondary analysis conducted by the Social Exclusion Unit in 2007 of a 2004 survey called the Families and Children Study (Levitas 2012b), the focus of which was multiple deprivation *not* anti-social behaviour or criminality. In other words the survey was not measuring what government from 2011 onwards (Department for Communities and Local Government 2012, 2013, 2014) were claiming it measured. Levitas (Levitas 2012a) suggests three possible explanations for this error: 'statistical incompetence'; an attempt to 'blame the victims' rather than take responsibility for Governmental and policy failings; or lastly, to distract attention from the extent of child poverty.

In his speech on 15th December 2011 to launch the Troubled Families Programme David Cameron made it clear that he considered those suffering multiple deprivation are

also the same people responsible for the bulk of criminal and anti-social behaviour, including rioting and civil unrest. Cameron states:

I want to talk about troubled families. Let me be clear what I mean by this phrase. Officialdom might call them 'families with multiple disadvantages'. Some in the press might call them 'neighbours from hell'. Whatever you call them, we've known for years that a relatively small number of families are the source of a large proportion of the problems in society. Drug addiction. Alcohol abuse. Crime. A culture of disruption and irresponsibility that cascades through generations. We've always known that these families cost an extraordinary amount of money but now we've come up the actual figures. Last year the state spent an estimated £9 billion on just 120,000 families that is around £75,000 per family.

(Cameron 2011)

Further into the speech it is also made clear that the failing is not only in the individuals themselves but also in the services intended to support them and address their needs.

Yes, it's the parents' responsibility to look for work but if the state is paying them more not to work, it becomes a rational choice to sit at home on the sofa. Yes, it's the teenager's choice to smash up the bus stop and torment their neighbours but if the criminal justice system doesn't draw a firm enough line between right and wrong, they're more likely to do wrong. That's why across all these vital areas - education, welfare, criminal justice - we're undertaking radical reform.

(Cameron 2011)

Thus in addition to the three possible explanations suggested by Levitas above maybe a fourth would suggest that these 'facts' are being used to legitimate an ideology of radical reform of the welfare state and its funding whilst blaming the recipients of welfare and those that work within it for the need for reform. In this discourse the rhetoric is both of 'failing families' and also of 'failing services'. Social exclusion happens when people, or places, suffer from a series of inter-connected problems such as unemployment, discrimination, poor skills, low income, poor housing, high crime, ill

health and family breakdown. When such problems combine they can create a vicious cycle. The policy narrative draws attention to the multi-dimensional nature of social exclusion and multi-dimensional solutions provided through multi-agency working, namely ‘joined up solutions to joined up problems’ (Social Exclusion Unit 1997).

Levitas (2005) argues that the concept of social exclusion actually ‘obscures the questions of material inequality that it was originally intended to illuminate’, in part because of its shifting use in political and policy rhetoric between three different discourses of social exclusion: a social integrationist discourse which equates social inclusion with economic productivity; a redistributionist discourse that focuses on lack of resources preventing the individual being able to participate fully in society; and finally, a moral underclass discourse which emphasizes moral and behavioural individual failings as resulting in social exclusion.

As noted at the start of section 2.3 in this chapter there is a long history of the discourse of the ‘problem family’ in policy (Welshman 1999). Subsequently, Welshman (2007) has charted its continuity in modern times from Sir Keith Joseph’s rhetoric on cycles of deprivation in the 1970s through that of social exclusion; and it now appears evident in the construction of ‘troubled and troublesome’ families. Louise Casey, who was appointed in 2011 as the Director General of the Troubled Families Programme, defines the target group of families as those who both ‘cause problems as well as having problems’ (Casey 2013, p. 460) thus continuing the legacy of the ‘problem family’ narrative. It is also of note that Louise Casey was previously Director of the Anti-Social Behaviour Unit and subsequently headed the Respect Task Force which promoted tools such as Anti-Social Behavioural Orders, Parenting Orders and Family Intervention Projects. The *Troubled Families Programme* could appear to be labelling, pathologising and stigmatising these identified families with complex needs. However, Tew (2013) suggests that when this is coupled with asset-based approaches and co-production the emphasis shifts from the ‘*transactional*’ exchange of services to the ‘*relational*’, with practitioners acting as catalysts or enablers, rather than as gatekeepers of overstretched services and resources. The label of ‘troubled family’ becomes a transitional one until they have reached the goal of rehabilitation and (re)claimed control over their lives, are able to manage their propensities for risk and deviance and can contribute to the

economy. Practice is thus focussed on ‘family recovery’ rather than ‘family preservation’ (Tew 2013).

Hughes (2010) suggests that there is a polarised representation of families evident in the Social Exclusion Task Force (SETF) documents (Morris *et al.* 2008; Social Exclusion Taskforce 2007, 2008).

Reflecting a conceptualisation of families as offering a resource to address ‘risk’, one such discourse presents ‘families with complex needs’ as requiring and/or being entitled to the support necessary to effectively address these needs. This discourse will be seen to give rise to strength-based, empowerment-focused approaches. The counter discourse constructs certain families as posing a risk to themselves and to others, and is instead based on a notion of ‘failing families’ who warrant and require state or professional intervention. Such a discourse will be seen to give rise to a deficit-based pathologising and professional-led response.

(Hughes 2010, p. 546)

Each discourse is located within a risk/resource paradigm, however, each discourse has a somewhat different emphasis. Each conceptualisation of the family results in a differing mode of engagement with families. In the former ‘complex’ family’s construction, families are considered as experts on their own needs and serving as an untapped resource to meet those needs. In the latter ‘failing’ family’s construction, families are perceived to be failing to fulfil an assumed normative role. Services and practice seek to address this deficit through professionally led responses. Therefore, the mode of engagement is professional, or service led, in determining decisions and the intervention may involve coercion and sanctions. Thus, there is also an inherent difference in the degree of partnership working with families in both constructions.

The composition of the family may itself differ depending on the conceptualisation of the family. In the former, complex family’s conceptualisation, professionals tend to work with ‘naturally occurring family structures’ (Hughes 2010) determined by the family itself. Individuals identified as part of the family are more likely to be based on support networks as identified by key family members and therefore consist of a

broader network than a more restrictive, prescriptive construction of family members based on biological, household, legal or other service-led categorisations concomitant with the latter, failing family's construction of family.

Klett-Davies (2012) provides a critical analysis of family and relationship policies in England and Wales 1997-2011. She suggests that New Labour shifted the focus away from the conceptual frame as being 'family', as this was seen to be repressive and traditional. Rather New Labour focussed on child welfare outcomes, although, latterly there was a shift toward greater consideration of the importance of adult couple relationships in child welfare outcomes in documents such as *Support for all* (DCFS, 2010). More recently the Conservative and Liberal Democrat Coalition government has made a return to the evocation of the traditional family conceptualisation as being at the heart of 'broken Britain' and attributes social problems to workless families, as a consequence of 'bad' parenting and/or the absence of fathers in children's lives.

2.4. Safeguarding Children in the context of Parental Substance Misuse

The initial target group for IFST intervention are families in which there is parental substance misuse which is impacting on parenting capacity. This section of the literature review explores the impact of parental substance misuse on children, on family life and examines gender differences in parental substance misuse.

The document that brought concerns relating to parental substance misuse and child protection to the fore was *Hidden Harm* (Advisory Council on the Misuse of Drugs 2003). The Advisory Council on the Misuse of Drugs estimates that there are between 200,000 and 300,000 children in England and Wales who have one or more parents with a serious drug misuse problem. This constitutes 2-3% of children under 16. Significantly 29% of case file records had no information on parenthood. Of those identified as having dependent children 69% were fathers and 31% were mothers, both having an average of just over two children. Only 37% of fathers and 64% of mothers were still living with their children and the more serious the drug problem the less likely that the child would be living with one, or more, of their parents. Most children not living with biological parents were living with other relatives and about 5% of the children were in care (Advisory Council on the Misuse of Drugs 2003).

Fraser, Mac Intyre *et al* (2009) found in one Midlands County in 2002 that parental drug or alcohol use was a factor in three quarters of families involved in care proceedings. In relation to initial Child Protection Case Conferences in one month in 2002 30% of the cases across the county recorded incidences of parental substance misuse. Parental substance misuse and its relationship to child welfare concerns is evidently an important area for investigation. The Advisory Council on the Misuse of Drugs (2003) suggests the effects on child welfare are both multiple and cumulative and include effects on child health and well-being, exposure to criminal behaviour, neglect and failure to thrive, educational attainment, poverty and social isolation.

Substance misuse can be perceived as both a symptom and a cause of a range of inter-related problems including mental health problems or illness, poverty, homelessness, domestic violence and criminal or anti-social behaviour. In Wales 17,500 children and young people are living in families affected by parental drug misuse, and it is suggested that 64,000 Welsh children may be adversely affected by parental alcohol problems (Advisory Council on the Misuse of Drugs 2003). Parental substance misuse is a factor in over 60% of welfare referrals to social services and problematic drinking and drug taking by mothers has been identified as a key factor in the increase in numbers of children subject to care proceedings since the use of the 1989 Children Act (Forrester and Harwin 2006).

Barnard (2007) highlights the lack of research based in the UK (currently most research is based in United States) on family life in the context of parental substance misuse, and the lack of research on the translation of policy in to practice. Problem drug use is linked with unpredictability, in part due to its illegality and chronic relapsing condition. The needs of the child become secondary to the overriding need to secure funds to obtain drugs and to obtain the drugs themselves. Physical abuse and neglect are the most common forms of maltreatment as a consequence of parental substance misuse (Chaffin *et al.* 1996) with there being three times more likelihood of being physically abused and four times more likelihood of neglect when parents misuse drugs or alcohol. The risk of neglect and child maltreatment is increased where parents use heroin (Barnard 2007).

Barnard *et al.*'s (2000) study sampled parents (mostly mothers) who were at different stages of drug use – drug free, methadone, chaotic or uncontrolled use - and it provides a clear picture of the lived experience of parents (mostly lone mothers) bringing up children in the context of problematic drug use. Women were almost always responsible for childcare and 64% were parenting alone. The vast majority had current relationships with drug using men and these relationships tended to be transient. A very small minority of children were still living in the same household as the biological father.

Barnard (2007) found that parental drug use impacted on children in several ways: unpredictable routines, meal times, bedtimes, erratic school attendance, lack of supervision and care, money being directed on drugs minimising money left for household e.g. food, clothes, heating and, finally, exposure to criminality, drug use, predatory drug users and police raids, witnessing and being involved in violence resulting in trauma. The often prolonged and inexplicable disappearances of parents e.g. while they sought and took drugs, left children feeling confused and anxious. Many of the children expressed the feeling that their place at the centre of their parents' love and affection had been usurped by the central role that drugs had in their parents' lives - that they just weren't there for them – resulting in anger and resentment. Many children took on parental or caring roles for the drug using parent in order to prevent them overdosing so that they were in a constant state of hyper vigilance and fear. The children were often left to fend for themselves, or in relation to older siblings, to take care of themselves and younger siblings. As Barnard states:

The heart of the problem for children is that they come second to their parents' relationship with drugs, and as a result they miss out on many of the most mundane, yet also most valued, nurturing experiences. Something as simple as knowing that their parent will 'be there' for them.

(Barnard 2007, p. 57)

Whilst parental love and family should provide stability and security, for these children their experience was one of unpredictability, fear, anxiety, danger and difficulty knowing whom to trust.

Although Barnard's (2003) earlier study specifically recruited people actively parenting at least one child, more than half of these parents were heavily reliant on high levels of childcare support from their extended families. Where a parent did not have an extended family from whom to gain support, it was almost certain that at least one of their children would have to be looked after and accommodated at some stage (Barnard 2003). This type of kinship care has been discussed by Minkler, Roe and Roe (1993) as 'unplanned parenthood'. The pattern is one of incremental care with the extended family, predominantly grandparents, and primarily grandmothers, taking on more and more of the care of the children informally and ultimately seeking to formalize that arrangement. This continuum of care has been phrased by Barnard (2007) as one moving from 'watchful guardianship' until a significant incident tips the balance resulting in (grand)parental intervention or 'changing gears'.

Whilst some recent research has considered the impact of parental drug use on the outcomes for children (Gorin 2004; Harbin and Murphy 2000; Kroll and Taylor 2003; Velleman 2004), most research does not distinguish between maternal and paternal drug misuse and assumes parents of both genders present the same risks and adopt similar protective strategies in their parenting approach. US and UK evidence suggests that children are more likely to live with maternal drug users rather than paternal and that the majority of these are lone mothers (with the caveat indicated in this literature review that lone mother does not mean that there is no male present in the household, nor that there is no non-resident male in a fathering role). Bancroft *et al.* (2004) found that of the 38 British 15-17 year olds they interviewed who had grown up with a substance misusing parent the majority had grown up in lone mother households, frequently with the mother as the continuous carer.

Scaife (2008) in her review of the research in relation to maternal and paternal drug misuse and outcomes for children in relation to risk and protective factors found little research on the protective strategies employed by paternal drug misusers. However, Klee (1998) suggests that fathers can be as concerned about their children as mothers and sometimes more so. Fathers can have a high emotional attachment to their children, actively supporting mothers, and with some mothers feeling the father to be a more competent parent than they were themselves. Scaife (2008) highlights the greater focus in research on maternal, rather than paternal drug use and its impact on child welfare

outcomes and importantly that ‘to deliver a holistic response to families affected by parental drug misuse, practitioners need to be able to draw on a more gender-inclusive evidence base’ (p.59). Further, Scaife (2008) notes that there is little research providing direct accounts from fathers who misuse substances in relation to their parenting practices.

2.5. Conclusion

In reviewing the sociological perspectives on the construction of family it is evident that there is recognition of the fluidity and diversity of family forms in contemporary society. Increasingly, academic focus is on intimacy and interpersonal relationships rather than the family as a single unit bound by kinship and collective interest. For policy and practice to be effective it must reflect the diversity and lived experience of actual family life in order to fully engage those families and meet their needs. However, family policy presents a plethora of complex constructions of family as the incubator of social ills and thus the target of state intervention, whilst simultaneously endorsing the family as being the best place for child rearing and therefore supporting family preservation. Implicit within these constructions is that families with strong familial bonds will generate more social capital, and consequently be less dependent on the state to meet its needs, cause fewer social problems and create better citizens and future parents. Both at UK and Welsh Government levels parental substance misuse has been highlighted as a significant risk factor in child welfare outcomes and in terms of a drain in resources on the state. As such the families where both parental substance misuse and child protections concerns are present were the initial focus of IFSTs.

In reviewing the academic literature on family life in the context of substance misuse it is clear that parental substance misuse can have a significant impact on parenting capacity and consequently on child welfare outcomes. What is also clear is that gender is an important factor that can have a differential impact on parenting capacity within the context of substance misuse. The next chapter, 3, continues reviewing the academic literature, but in relation to whole family approaches, the impact of gender and the use of the ethic of care, both as a moral framework and in providing a relational ontology from within which to consider whole family approaches, and the gendering of parenting as a care practice.

3. Chapter Three - Whole Family Approaches, Gender, and the Ethic of Care

3.1. Introduction

In the previous chapter, 2, the literature reviewed was concerned with different typologies and frameworks for understanding the construction of 'family'. This chapter also reviews the existing literature (both academic and UK policy documents), but in terms of exploring what a whole family approach is in policy and practice. The following section, 3.2, begins by discussing UK policy in relation to whole family approaches and its location within a social exclusion framework. The next section, 3.3., reviews the academic literature in relation to a whole family approach as a therapeutic process highlighting the lack of literature on this topic. Thus, the therapeutic process is explored in terms of the constellation of models of family practice, such as family-centred, family-focussed and family-minded practice within which a whole family approach is situated. This literature review when combined with the findings of the research data in this study provides a basis for comparing and contrasting these models of family working with that of a whole family approach in order to ascertain whether there is anything distinctive about a whole family approach from these other family working practices. Section 3.4 reviews the literature on gender and child protection with a focus on mother blaming and the marginalisation of men in child protection practice. The marginalisation of men limits assessment of individual men and the degree to which they may present risks and/or resources in the care of child(ren). The final section in this chapter, 3.5, reviews the use of an ethic of care within social work academic literature and its potential as a conceptual framework within a relational ontology for examining the gendering of care practices such as mothering and fathering. The ethic of care will be used, in the form of *Trace* methodology (see chapter 4), as an analytic framework for interrogating gender effects within the policy and legislative enactment in Wales of a whole family approach ideology (chapter 5).

3.2. The Whole Family Approach in UK Policy

In 2007 the Social Exclusion Taskforce in England turned its attention to families with the publication of *Reaching Out: Think Family Analysis and themes from the families at risk review* (Social Exclusion Taskforce 2007). This was followed by *Think Family:*

Improving the Life Chances of Families at Risk (Social Exclusion Taskforce 2008), then subsequently *Think Family: A Literature Review of Whole Family Approaches* (Morris *et al.* 2008). These three documents placed ‘family’ and working within a whole family approach centre stage in policy developments. As such, given their importance, each of these documents will be considered sequentially.

The first of these documents (Social Exclusion Taskforce 2007) identifies 140,000 families in 2005 across Britain, i.e. 2% of families in the UK were experiencing multiple problems that present high risk and were facing severe and enduring problems (Social Exclusion Taskforce 2007, p. 4). What is proposed in this report is that systems and services ‘think family’, in other words that there is ‘a shift in mind-set to focus on the strengths and difficulties of the whole family rather than those of the parent or child in isolation’ (Social Exclusion Taskforce 2007).

Families identified as being at risk are those families who experience multiple and complex problems which restrict their life chances, for instance where the effect of multiple parental problems impacts on the entire family. The report suggests that families at risk need a more integrated and holistic approach – ‘a whole family approach’- if the impact of cumulative, multiple disadvantage and consequent social exclusion are to be minimised.

The identification of these families as ‘high risk’ was based on the co-existence of five or more of the following risk factors:

- mother has mental health problems
- no parent has any qualifications
- at least one parent has a longstanding limiting illness, disability or infirmity
- family has low income i.e. below 60% of the median, or
 - family lives in poor quality or overcrowded housing
 - cannot afford a number of food and clothing items
 - no parent in the family is in work.

(Social Exclusion Taskforce 2007)

Whilst these risk factors all relate to the adults in the family and are addressed by adult orientated services, the consequences are felt by the whole family including the impact on child welfare outcomes. Whilst no single family type may deterministically result in social exclusion, some family types face a higher than average risk of experiencing multiple problems:

- families where the mother's main language is not English
- families living in social housing
- families with a young mother
- lone parent families

(Social Exclusion Taskforce 2007)

Parents can be both a source of resilience, and/or present risks to child welfare. Parents can provide protective factors such as a parental interest in the child's education, an authoritative parenting style that is both high in control and warmth, good parenting, and strong family relationships which develop the child's social and emotional skills. Conversely a harsh or inconsistent parenting style is a key risk factor, alongside other risk factors such as unemployment, poverty, debt, poor education and skills, poor housing, crime, anti-social behaviour, drugs, alcohol, mental and, physical health difficulties, relationship conflict and breakdown and domestic violence.

The aim of 'thinking family' is to minimise the harm resultant from risk factors by enhancing protective factors through the use of integrated adult and children's health and social care services that work holistically with families to build on family strengths. In other words:

Think Family to build on family strengths. Family belief systems, family cohesion and coping strategies can all have a major impact on how effectively family members are able to respond to adversity. Services that tap into these resources and build on the family's strengths may have a good chance of influencing behaviours and improving outcomes.

(Social Exclusion Taskforce 2007, p. 28)

The inherent problem in individualised approaches is perceived to be that they tend to be problem-focussed and fail to engage the whole family system and build constructive sustainable relationships within the family and with professionals to build on strengths. This would certainly reflect the traditional organisation of services around a specific issue e.g. adult drug treatment services and consequently the education and training of professionals in relation to specific specialisms, e.g. alcohol or drugs. Thus the Social Exclusion Taskforce report suggests that both the organisational structure and delivery of services, and the education and training of health and social care professionals, militates against a more holistic, family-focussed approach.

The Social Exclusion Taskforce (2008) suggests that such individualising of problems leads to the unhelpful pathologising of the individual, perhaps resulting in a tendency for practitioners to focus on needs and issues rather than to build on strengths. Social capital and family resilience (within an ecological framework) are presented as theoretical frameworks that can challenge pathologising either the individual or the family. What is advocated is a 'whole family approach' which stresses the importance of looking at the family as a unit, and of focusing on positive interdependency and supportive relationships. This approach takes the family's resilience and social capital as the foundations for achieving positive outcomes.

Broadly social capital refers to the values that people hold and the resources that they can access, which both result in, and are the result of, collective and socially negotiated ties and relationships (Edwards *et al.* 2003). The underlying assumption of social capital is that social networks are a valuable asset (Field 2003). Social Capital has been a popular concept across the political spectrum. Lynch *et al.* (2000) suggest that those on the political right view social capital as an opportunity to argue for a withdrawal of the state from welfare and social provisions, whilst those more towards the left maintain that state support is crucial to the accumulation of social capital (Baum 1999).

There are two main schools regarding the definition of social capital. The first school is influenced by the empirical research undertaken by Robert Putnam in both Italy and the United States on the relationships between social relations and civic engagement, and political and economic outcomes (Putnam R.D. 1993, 1995; Putnam 2000). Putnam (1995) conceived of social capital as a community level resource and defined it as

‘features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit’ (page 67). Social capital is viewed as a distinctively social feature that is reflected in the structure of social relationships and as such is both a public good and an ecological characteristic. The second main school draws on the work of Bourdieu (1997) who defined social capital as ‘the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition’ (page 248). This definition focuses on the resources that accrue to individuals as a result of their membership of social networks. Bourdieu argues that conflict is a fundamental dynamic of all social life and that this conflict occurs over symbolic resources such as social capital, as well as material resources. He suggests that social capital is inextricably linked to economic capital but cannot be reduced simply to an economic form. It is the concealment of this relation that enables social capital to be effective (Bourdieu 1997).

More recently authors such as Putnam (2000) are more concerned with social capital as a feature of communities rather than the focus given to individuals in the work of Bourdieu. Putnam’s approach, which has also been described as communitarian, calls attention to the notion of civic virtue, which is most powerful when embedded in a network of reciprocal social relations. Putnam (2000) argues that there has been a decline in civic life, associated with individualisation. His ‘bowling alone’ thesis and his emphasis on local communities as the way to revive civic engagement has gained popularity with the current government, as a remedy to ‘broken Britain’ partly through increased localism and devolution (Colenutt 2011).

Some theorists posit the existence of several types of social capital (Narayan D. 1999; Woolcock and Narayan 2000). Bonding social capital refers to horizontal tight-knit ties between individuals or groups sharing similar demographic characteristics. Such networks may be exclusionary and may not act to produce society-wide benefits of cooperation and trust. Bridging and linking social capital refer to ties that cut across different communities or individuals (Narayan D. 1999). Linking social capital in particular refers to vertical connections that span differences of power. Szreter (2002) argues that this form of social capital is particularly relevant in terms of reducing inequities because it encourages people to feel a sense of responsibility for people

beyond their bonded group. However, despite the analytical utility of such distinctions, there have been debates about the ability to distinguish empirically between these different types of social capital.

A significant contribution to the debate on social capital in relation to children and young people has been made by Coleman (1988; Coleman 1997) in linking social capital to educational processes that are likely to have an impact. Coleman defines social capital thus:

Social capital is defined by its function: . . . like other forms of capital, social capital is productive, making possible the achievement of certain ends that in its absence would not be possible. . . . A given form of social capital that is valuable in facilitating certain actions may be useless or even harmful for others. Unlike other forms of capital, social capital inheres in the structure of relations between actors and among actors.

(Coleman 1988, p. 98)

As such social capital is presented as a resource derived from people's social ties. Coleman makes a distinction between social capital within the family and outside the family. Social capital within the family is 'the relations between children and parents (and, when families include other members' relationships with them as well)' (1988, p.110). Whereas,

Social capital within the family gives the child access to the adult's human capital which depends both on the physical presence of adults in the family and on the attention given by the adults to the child. The physical absence of adults may be described as a structural deficiency in family social capital.

(Coleman 1988, p. 111)

For Coleman, single-parent and dual earner families lack social capital because parents do not have enough time to give their children sufficient attention. Similarly, too large a family that includes many siblings can also reduce the social capital of individual children. Social capital outside the family is found in the community 'consisting of the

social relationships that exist among parents, in the closure exhibited by this structure of relations, and in the parents' relations with the institutions of the community' (1988:, p.113). As such he saw working mothers and lone parenthood as two of the main causes of declining social capital and loss of community cohesion in modern society. In Coleman's view, changing family structures, specifically in terms of increases in lone mothers, 'absent' fathers and mothers working outside the home, have led to a deficit in social capital, as has geographical mobility.

There is a common narrative in policy regarding social capital and the construction of family. The narrative is one in which the erosion of the traditional family and shared traditional family values has undermined the generation of social capital, created greater reliance on the state, more anti-social behaviour, undermined social cohesion and created an identifiable socially excluded underclass (see section 2.3). As Edwards (2004) states

Like 'the family', social capital is often said to be the 'glue' that holds society together. But it is also said to be the 'oil' that lubricates social life . . . Whatever its consistency, however, social capital is portrayed as being eroded, and family change is placed at the root of this 'social capital lost' story, implicating particular forms of intergenerational and gender relations.
(Edwards 2004, p. 5)

Thus the shared discourse of family breakdown and consequent deterioration of social capital means that state intervention is required to bolster the traditional family and traditional family values in order to generate social capital (economic and human capital) and minimise anti-social behaviour, civil unrest and financial reliance on the state. As Edwards (2004) suggests

Within the dominant portrayal of the foundations of social capital then, 'traditional' nuclear families are present, accompanied by gender relations in which married fathers are breadwinners, and their wives are home-makers and dedicated to the care and socialisation of their (two joint biological) children as well as community activity. 'Non-traditional'

families, as the other side of this coin, are also present, but in a troubling and destructive role. Such families do not conform to the longstanding gender and generational order that underpins a stable, social capital rich society, but are ‘changing’ them in negative ways. Their influence needs mitigation normatively and/or through policy interventions.

(Edwards 2004, p. 7)

As Edwards (2004) highlights, what has been ‘absent or silenced’ are issues of power and conflict, for instance in relation to race, gender, class and oppressive divisions of labour; and of children’s own agency as active participants in shaping family life and caring relationships. In contrast to this dominant discourse of family breakdown and erosion of social capital within policy, theorists such as Giddens (Giddens 1991, 1992), Beck and Beck-Gernsheim (Beck Gernsheim 2002; Beck and Beck-Gernsheim 1995) have constructed a narrative of a post-traditional society in which men, women and children are progressively freed from definitive gender and generational relationships and obligations. In place of the norms of the traditional nuclear family, people have to make their own family and other lifestyle choices in an uncertain world, and are increasingly seeking intimate connections with others that are sustained on the basis of mutual understanding and respect for autonomy. Whilst such theorising is highly speculative it does challenge the dominant discourse surrounding the demise of the traditional family as a cause of social erosion and challenges the negative role accorded to non-traditional families in policy-dominant social capital theorising. Such theorising sees opportunity, seeing openness and promise in the rise of diversity and fluidity in family life. It also argues against a picture of collapse in trust and reciprocity as constitutive features of social capital. It provides alternative understandings of how they are now constituted in practice, based on reflexivity and negotiation concerning benefits that are mutual and shared rather than prescribed and regulated. Thus the view as to whether greater fluidity and diversity of family forms necessarily correlates with the demise of social cohesion and generation of social capital is largely one of ideology rather than based on evidence.

Furstenberg and Hughes (1995) in a study of 'at risk' young people (in this instance the adolescent children of teenage mothers), suggest that 'Coleman's notion of social capital is attractive because it provides a conceptual link between the attributes of individual actors and their immediate social contexts, most notably the household, school, and neighbourhood.' It also has the potential to link 'the overly narrow purview of psychology and the overly broad purview of sociology' and can help to identify ways in which 'parental investment is enhanced or undermined by the presence or absence of community resources' (1995, p.582). They suggest there is no unitary relationship: rather, it is more useful to examine how 'different types of social capital (parents' resources inside the family, the social network, and their embeddedness in the community) might be related to various arenas of success in early adulthood' (1995, p. 590). They emphasise the multidimensional nature of social capital and the effects on academic success, on conventional behaviour and psychological well-being. They conclude that we 'need to clarify the concept and probably recognise the problems of thinking that social capital is a common set' (1995 p. 590).

In relation to families Furstenberg (2005) suggests a consistent conceptual understanding of social capital needs to be formulated and the issues of measurement need to be solved. Furstenberg argues that several areas require further research: (a) the ways in which families generate and accumulate social capital, (b) how family-based capital is managed and utilised, (c) what the relationship is between family-based and community-based social capital, and (d) what the consequences of social capital are for the welfare of families as groups and for their individual members. In providing a definition of social capital Furstenberg also highlights the underlying assumptions of those, such as policy makers, who use the term 'social capital'.

"The stock of social goodwill created through shared social norms and a sense of common membership from which individuals may draw in their efforts to achieve collective or personal objectives. By membership or affiliation, actors (in this case members of a family or kinship system) may derive benefits through sharing objectives, sponsorship, connections, and support from others inside and outside that family." Thus, social capital - like human capital - presumably enhances life chances by mobilizing social re-wards, reinforcing commonly shared standards, and gaining

connections and assistance to achieve economic, political, and social ends. Or, at least these are the prevailing assumptions by most who employ the term.

(Furstenberg 2005, p. 810)

Donati and Prandini (2007) in discussing the relevance of social capital to family relationships propose the use of a relational approach in which 'social capital is a property and a quality of social relationships, not an attribute of individuals or social structures as such' (p.209). Further, they note that:

the family's social capital is defined as the reciprocal orientations of the family's members which are able to generate trust and therefore co-operative actions. Empirical evidence shows that the family's social capital is strictly connected to the emergence of pro-social attitudes in individuals, particularly in terms of social trust and participation in civil associations.

(Donati and Prandini 2007, p. 209)

This relational approach to social capital seems to concur with its conceptualisation in social policy and the re-focussing on interrelationships rather than on individuals. Similarly there is a relational refocusing on the construct of resiliency away from individual resilience and toward family resilience.

Resilience is a contested construct which has numerous definitions that encompass biological, psychological and environmental processes (Rolf and Johnson 1999). Glantz and Sloboda (1999) in their review of the literature found no consensus on measurement, use, interpretations or findings - resilience was used interchangeably as a personality trait, an outcome or a process. Generally, resilience is characterised by the presence of good outcomes despite adversity, the use of sustained competence under stress, and/or the ability to recover from trauma (Masten and Coatsworth 1998).

Shifting from individual resilience to family resilience entails a relational approach so that resilience is not considered a static, personality trait but rather a dynamic relational process that may change with time and circumstances (Cicchetti and Toth 1998). In relation to family resilience specifically, Hawley and DeHaan (1996) suggest that whilst

the term ‘family resilience’ may be relatively new, the concept builds on a body of evidence on family strengths and stressors. Further, if any one conceptual contribution can be identified as new, they argue it is the development of a family ethos (i.e. a world view or sense of coherence) encompassing shared attitudes and values held by a family that is at the core of its ‘resilience’. Walsh (1998) similarly places an emphasis on coherence and connectedness as a critical components of family resilience.

Walsh (1998) identifies three key processes for family resilience within domains of family functioning: family belief systems, organisation patterns and communication processes. Subsequently Walsh (2002) developed a framework for clinical practice in which she elaborates on each of the three domains and their facets. Firstly, the family have a shared belief system which assists them in making meaning from adversity. This belief system features a positive outlook, and nurtures transcendence and spirituality. Secondly, there are organizational patterns that are flexible, coupled with a sense of connectedness and the ability to mobilise social and economic resources. Finally, in terms of communication there is clarity of communication, open emotional expression and collaborative problem-solving.

Practitioners are urged by the Social Exclusion Taskforce to ‘think family’ as the problems of the individual do not exist in isolation. In other words, individuals within the family unit are interdependent in terms of their needs, and the resources available to meet those needs.

Understanding the family situation (both in terms of the circumstances of the individual family *and* the quality of their relationships) can be highly important in diagnosing the root causes of a problem and in developing appropriate responses. Even the most effective integrated responses from children’s services will only ever ameliorate the impacts of parent-based risk factors on a child. To reduce the *actual* risk factor at source, joint working with adults’ services is required to tackle the parents’ problems.
(Social Exclusion Taskforce 2007, p. 29) (Emphasis in original)

The key characteristics of a whole family approach as expressed in UK policy are that it builds on family strengths to promote family resilience and social capital, prevents

social problems, and is more sustainable in the longer term than multiple service interventions that focus on either, adult or child, rather than the *interrelationship* of needs and resources within the family and wider community (Morris *et al.* 2008; Social Exclusion Taskforce 2007, 2008).

The Social Exclusion Taskforce (2008a) suggests that the theoretical frameworks underpinning whole family approaches are social capital and family resilience (within an ecological framework) and that this provides a means of challenging the pathologising of either the individual or the family. Further, it outlines three models of whole family working – working with the family to support the service user; identifying and addressing the needs of family members; and whole family support. This classification could also be viewed as providing a scale for the extent to which a service could be considered a whole family approach, with only the third approach being identified in the report as being fully ‘*whole*’ family. Hughes (2010) refers to this third category of whole family approaches as being ‘clearly the broadest and least well-defined’, thus highlighting the need for further research and greater theoretical and conceptual clarity in regard to whole family approaches.

In the first model of working with the family to support the service user, the family is seen as a basis for supporting the individual service user and other family members are considered in terms of their ability to contribute support or provide assistance to the service user, e.g. parental responsibility in youth offending. In the second model while the focus is still on supporting the service user other family members are recognised as having their own specific needs arising out of their relationship with the service user. The third model focuses policy and practice on the family unit as a whole. Rather than focussing on the service user and/or individual family members’ needs in isolation, the focus is on shared needs and/or strengths in the interrelationships and collective resources of the family as a whole. Although aspects of service provision may have been delivered to the family together this model is distinctive in that the needs to be addressed, and strengths upon which solutions are based, are perceived to be held within the collective unit of the family. This provides a greater impetus for a strengths based approach to practice (Saleebey 1996) rather than a risks and deficits model.

The use of whole family approaches presents both opportunities and tensions. The family is part of the private domain, yet is perceived to be the foundation of society and as such the state may need to intervene either for the protection of mainstream society, or to protect from harm an individual who is in need of care when the family fails to provide this care. Thus, the right to private family life and the public interest in family intervention is a core tension within debates concerning the support of parents and families.

Whole family approaches are described as strengths-based, responsive, reflective and innovative (Social Exclusion Taskforce 2007). The challenges to full engagement in a whole family approach are presented as twofold: by focussing on either the presenting problem or the particular functions of an individual family member, this results in only partial engagement with the *whole* family and thereby, only partial engagement by services with those families targeted at greatest risk (Social Exclusion Taskforce 2008). Thus, both practitioners and services are presented as failing, not only in engaging high risk families, but also failing to engage with the *whole* family. Morris and Burford's research (2007) provides empirical evidence that working with family networks is valuable and effective. However professional practice appears resistant to models of family engagement (Morris *et al.* 2008). Further, the Social Exclusion Taskforce (2008) suggest that:

To understand this resistance it would seem that research must go beyond evaluating particular approaches and move towards understanding the values and conceptual frameworks which are held so strongly by professionals about family networks, and which appear so resistant to change.

(Morris *et al.* 2008, p. 16)

This study bridges that gap in the research. It is these professional values and conceptual frameworks about family networks that will be explored in chapters 7 and 8.

The New Labour shift in focus to 'think family' in England and the 15 *Think Family pathfinder projects* were short lived. With the arrival of the Coalition government the

emphasis moved back to those families that were perceived to be anti-social, or troublesome. A new wave of government funded intensive projects were created targeted at the 120,000 ‘troubled families’ who were troublesome to their neighbours and took up significant state resources (Department for Communities and Local Government 2012, 2013).

As noted in Section 2.3 New Labour situated child welfare and child protection within a social exclusion framework which was futures-orientated in looking to break intergenerational cycles of deprivation and anti-social behaviour in order to create economically and socially productive citizens of the next generation of children to become parents. This framework also looked to the present to maintain these same children safely within their own families and was thus also concerned with the quality of childhood and child welfare more broadly. Thus the ‘think family’ policy had multiple aims of safeguarding children, breaking intergenerational cycles of deprivation and poor parenting, reducing reliance on state services, reducing anti-social behaviour and the concomitant costs of state intervention in terms of both care and control. .

Whilst there are a variety of models and theoretical approaches for working with families such as systemic family therapy there is no clear articulation within policy, or practice, as to what a ‘whole family approach’ entails in terms of the practice process. Similarly there is a limited amount of academic literature on a whole family approach. However, there is a bewildering array of terminology used in relation to, what could broadly be termed, whole family approaches, such as, family intervention, family-focussed, family-centred, and (intensive) family preservation services. In this review of the literature on whole family approaches some attention will be given to family-centred practice and treatment, in addition to considering the more recent resurgence of whole family approaches in the UK, and specifically in Wales.

3.3. The Whole Family Approach as a Therapeutic Process

Whole family approaches (WFA) constitute a constellation of psycho-social therapeutic interventions variously termed family-centred, family-focussed, family-based social work or family involvement. However, whole family approaches are frequently embedded within models of intervention that comprise of a number of

theoretical approaches and models, such as family group conferencing, Strengthening Families (SFP – 10-13), and the Integrated Family Support Services² (IFSS). Thus, there is limited articulation of what a whole family approach is that is independent of the model within which it is located. The origins of whole family approaches reside within Family Service Units in the 1950s and 1960s in the UK (Thoburn 2013) and intensive family preservation services, e.g. Homebuilders in the USA (Kinney *et al.* 1991). However, as is evident from this review of the literature the more recent resurgence of a whole family approach in the UK locates such practice within a social exclusion framework.

Family-centred practice is akin to a whole family approach in taking the unit of analysis or intervention as the family itself, rather than working with individuals within the family. The use of the term ‘family-centred practice’ itself lacks clarity (Allen and Petr 1996). In an attempt to gain greater clarity Allen and Petr (1996) undertook a content analysis of 28 definitions in more than 120 peer reviewed articles across social work, health and education. From this they derived the following definition:

Family-centred service delivery, across disciplines and settings, views the family as the unit of attention. This model organizes assistance in a collaborative fashion and in accordance with each individual family’s wishes, strengths, and needs.

(Allen and Petr 1996, p. 64)

From the content review Allen and Petr (1996) identify six key elements of family-centred practice which are provided below in order of their prevalence within the literature, the percentage weighting of each is provided in brackets:

- 1) **Family as unit of attention** (100%), i.e. a recognition that children’s needs cannot be adequately served without considering the needs of the family as a whole.
- 2) **Family Choice** (29%), i.e. the organization and provision of services in accordance with the families’ choice.
- 3) **Family Strengths** (25%), i.e. acknowledging, incorporating and building on family strengths, this being associated with empowerment.

² **Integrated Family Support Services.** This broader term encompasses both the core Integrated Family Support Team and wider family support services such as family support workers, nursery provision, etc.

- 4) **Family-Professional Relationship** (36%), i.e. partnership working within a philosophical framework of equality, mutuality and team working.
- 5) **Family Needs** (32%), i.e. a holistic view of the family in terms of its 'circumstances, concerns, and resources' (p.65) and the availability of services to all family members.
- 6) **Individualized Services** (32%), i.e. individually tailored assessment, goal setting, and interventions which are matched to the needs of each family.

A decade later Epley *et al.* (2010) conducted a similar review in order to examine whether there was a commonly held definition of family-centred practice and whether the conceptualization of family-centred practice had changed in the interim since Allen and Petr's content analysis. Epley *et al.* identified 63 articles and used Allen and Petr's typology for comparison purposes. Whereas the key characteristics of family-centred practice remained consistent there had been a shift in emphasis with the element of family as the unit of attention having decreased whilst family choice, family strengths, and family relationships had increased and family services had stayed approximately the same.

Goldfarb *et al.* (2010), whilst acknowledging the lack of conceptual clarity regarding family-centred practice approaches, such as family-driven, and family-focussed approaches, identify what they consider to be the key features of such approaches:

Regardless of the name all of these concepts share the same core principle that professionals intentionally partner with families: seeking family input, viewing the family as the primary expert on the child, and responding to family concerns in a strengths-based manner that incorporates the philosophical, cultural, and unique needs of the family and individual.

(Goldfarb *et al.* 2010, p. 92)

From the perspective of families, Goldfarb *et al.* (2010) identify similarly overlapping characteristics of family-centred practice as Allen and Petr (1996) whilst placing a greater, central emphasis on the relationship between families and professionals as the key characteristic. This entails: full and involved partnerships with families, a willingness on the part of professionals to listen and learn, individualized planning and approaches, professionals who are sensitive to and considerate of the 'different places,

different journeys' that families are on in terms of their understanding, experience and engagement with professionals and the issues they face as a family, and finally, that professionals are mindful of the differing cultural needs that families may have.

Painter (2010) provides a definitive overview of family-centred treatment (FCT) in the context of in-home family preservation services. Painter outlines the four components of the model of family-centred treatment as being – '*Joining and Assessment*', '*Restructuring*', '*Value Change*', and '*Generalization*'. Eco-Structural Family Therapy and Emotionally Focused Therapy provide the primary theoretical frameworks from which FCT has developed. Eco-structural family therapy is based on three principles. Firstly, that there is a belief in the family as system, i.e. family members' as interdependent. Secondly, that the patterns of interaction in the family influence the behaviour of each family member. Third, that the patterns of interaction are defined as the sequential behaviours among family members that become habitual and are repetitive over time. Finally, that intervention is designed to carefully target and provide practical ways to change those patterns of interaction.

Morris (2012) suggests that 'the evidence from the reviews of family-minded practice indicates that practitioners may have very limited actual engagement with families. Instead, the evidence suggests that parents, children or vulnerable adults will be targeted' (p. 913). This would seem to suggest that family-minded practice could be considered a more diluted form of family-centred practice. A strong form of family-centred practice, or indeed of a whole family approach, of necessity requires engagement with the *whole* of the family system in its entirety and the patterns of interaction integral to it, rather than simply relationships between specific individual family members, for instance mother and child, or between adult parents, as the key dyadic familial relationship. Further, by logical extension, such patterns of interaction are likely to be learned and inter-generational, thus re-structuring will also entail breaking inter-generational cycles of deprivation, poor parenting and entry into the care system.

Furlong (2001) highlights the challenge to practitioners to work relationally with whole families in the context of organisational and professional cultures which tend to narrow the focus of the practitioner's attention solely upon single patients/clients/service users.

Whereas a relational approach turns the spotlight of attention on ‘the quality of interdependence that individuals have in relation to their location within an ecology of “significant other” relationships rather than viewing the service user as a purely autonomous self’ (p232). As such, Furlong goes on to suggest:

Thinking well of, and working well with, families is therefore constrained by a discourse that valorizes the primacy of ‘the individual’.
(Furlong 2001, p. 233)

Such a culture is antithetical to a whole family approach in which individuals are embedded within an ecological network of systems and interdependencies, or as Furlong suggests ‘families as evolving and interdependent entities’ (p232) that are locally negotiated, dynamic and fluid in their relational construction rather than fixed and static. It is the relational quality of these significant other relationships that determines their designation as ‘familial’.

3.4. Gender and Child Protection

This section provides an overview of the key arguments in relation to the marginalisation of men and over-scrutiny of women in the child protection system. There has been an increasing policy and practice interest in engaging men in welfare services more broadly, and specifically in child welfare. In the UK, ‘Fatherhood [is] on the agenda as never before’ (Burgess and Ruxton 1996). Further, the

. . . absence of men from family support services and the need to make services more accessible and acceptable to fathers has become an area of growing concern for policy makers and practitioners alike.
(Ghate *et al.* 2000a, p. 2)

Ferguson and Hogan (2004) found a failure to engage men in assessments relating to safeguarding children and a lack of father inclusive practice within childcare social work practice. Whilst the rhetoric is of ‘*whole*’ family approaches a conceptualisation of family which presumes the primacy of mother (Perälä-Littunen 2007), and a gatekeeping role for mothers (Allen and Hawkins 1999) may at best render fathers

marginalised, or at worst invisible or absent. This would leave fathers as an untapped resource in parenting and thereby in strengthening families i.e. minimising risk factors and increasing protective factors to improve family resilience.

In England and Wales the highest percentage of registrations in child protection work relates to neglect (Cawson *et al.* 2000; Department for Education and Skills 2004; May-Chahal and Cawson 2005). There is a particular concern regarding the relationship between child neglect and parental substance misuse (Advisory Council on the Misuse of Drugs 2003). Research, policy and practice in the area of child neglect is predicated on gender assumptions, in short, that child neglect is constructed as a failure of mothering, as mothering is presumed to provide nurturing and therefore that child neglect is a consequence of a breakdown in that nurturing relationship (Daniel and Taylor 2006). In relation to child neglect this can impact on practice in three main ways: (1) the invisibility of men both as potential sources of risk and (2) also as possible sources of resource but also (3) in failing to recognize structural pressures on women as mothers, for instance, in terms of greater risk of poverty, social isolation, and so forth. Father inclusivity in child protection practice is significant by its absence (Daniel and Taylor 2006).

Roskill's (2008) research on fathers' engagement in the child protection system in two local authorities found some stark results. Basic information such as contact details or legal status on fathers was absent from some files, for example 20% of files audited did not have the biological father named within the file, with the figure even higher at 31% for looked after children. 80% of fathers were non-resident which has implications for workers in engaging them within the family, for instance, maternal gatekeeping, the nature of the relationship between mother and father, and between father and child. Almost a quarter of children had another significant father figure other than their biological father noted on the file, raising difficult choices about which fathers to involve and how, and the nature of their relationships both with the child, mother and each other. Some 54% of children were living with a single parent and only 12% with both their biological or adoptive parents.

There is evidence that the process of child protection registration is gender biased toward placing blame and responsibility for safeguarding children on biological mothers

(Farmer and Owen 1998). Child protection registrations suggest equal numbers of fathers and mothers being regarded as the perpetrator. The majority of sexual abuse is committed by fathers, or father figures, with step/social fathers being more likely to be perpetrators than biological fathers (Farmer and Owen 1998). In cases of physical abuse mothers are as likely as fathers to be perpetrators, however, in relation to neglect it is most often the mother that is seen as holding responsibility (Ashley *et al.* 2006).

Cawson *et al.* (2000) highlight a number of significant issues in relation to child neglect where gender is a factor, including the correlation between low socio-economic status and referral for child neglect. Lone parenthood is also associated with child poverty and households where the woman is the main earner are more likely to be low income families. It could also be argued that the social, cultural and structural factors that impact on not only mothers, but also on the fathering role, should also be given recognition within policy and practice.

From research into gender and occupational culture within a statutory child protection social work team Scourfield (2003) found the dominant constructions in social workers accounts were that of men as 'threat' and 'no use'. Bellamy (2009) summarises the current literature on male members of families involved with child welfare services as being organized around three themes: 'absence', 'unimportance' and 'dangerousness'. In her empirical study using a representative sample from the US child welfare system she found that far from men being absent in these families, the majority had male involvement and this took a variety of forms. The quality of the relationship between father and child was more important to child welfare outcomes than the whether the father was resident in the household or his legal or biological status to the child (Amato and Gilbreth 1999; Connell and Goodman 2002; Jackson 1999). In relation to male involvement being unimportant Bellamy (2009) found a significant reduction in the likelihood of the child being placed in out-of-home care where there was involvement with a non-custodial parent, most often a biological father. Finally, whilst caseworkers perceived non-parental males as a risk there was no association between a resident non-parental male and re-referral. Duggan *et al.* (2004) found that caseworkers were less confident in working with males and had limited information regarding males, including their sources of income, marital status or education (O'Donnell 1999). The perception of

risk therefore may be heightened by the lack of confidence and lack of information regarding these men.

In an ethnographic study based on the examination of over 100 case files White (2003) describes a hierarchy of accounts as to who is most likely to be believed by social workers: firstly the child, then other professionals, followed by mothers, fathers living in the household and finally estranged fathers and other male care-takers such as step fathers. The value and credibility placed by social workers on men as fathers (regardless of the form of father, or quality of the fathering practices) is self-evidently diminished by practitioners and this must surely be felt by the men involved which would further exacerbate engagement.

The primacy of mothering in childcare has resulted in mothers being the focus of intervention in relation to child welfare and child protection. Whilst there is a dominant rhetoric of gender equality in the division of labour within family life, and indeed within social work practice with its discourse of anti-discriminatory, anti-oppressive practice, the reality is palpably different in both family practices and social work practices rendering men invisible either as sources of risk or as assets to child welfare (Daniel 1999). The majority of social work literature presents this as being oppressive to women rather than as marginalising men or denying fathers' rights. However, the two positions are not incommensurable and reflect the same hegemonic gender stereotypes that are oppressive and discriminatory both to men and women. This militates against gender equity and the diversity and fluidity of family forms.

The over-scrutiny of mothers and 'mother-blaming' is well documented (Scourfield 2010). A range of reasons have been proposed to account for this: that the predominantly female social care workforce gravitate towards building their professional relationships with other women, or due to fear of the threat of violence from men, that men themselves do not want to engage with services, particularly those men who are suspected of being perpetrators, a service deficit model that blames services, and the predominantly female workers within them for marginalising men (Ashley 2011; Ashley *et al.* 2006; Roskill *et al.* 2008).

Mothers are perceived as being responsible for the care and protection of their child, with the focus of intervention on supporting the woman to fulfil this role rather than on engaging with the perpetrator, with consequent ‘mother blaming’ in terms of ‘failure to protect’. This presumes that the mother’s needs and desires, for instance her relationship with the perpetrator who may be a friend or partner, should be sacrificed for the good of her child. The focus on mothers tends to assume and burden mothers with being responsible for tackling and resolving family problems and as being pivotal in changing entrenched, chronic family problems (Scourfield 2003).

Daniel (1999) argues that whilst there are clearly defined societal gender roles and expectations in terms of mothering, the role of fathering is less clear and this poses challenges for practitioners in engaging men in family life. Mothering is synonymous with nurturing and care giving, including domestic tasks and the ‘worry’ and ‘manage’ aspects of parenting (Clarke and Popay 1998). When men are perceived as ‘threat’ or ‘risk’ (Scourfield 2003) practitioners may avoid these men and focus on women as the point of intervention rather than work directly with the men involved. However, even in situations where the man may be a potential resource, the lack of inclusion of men in the assessment process limits the extent to which men can be assessed as a risk or resource.

Daniel (1999) urges practitioners to be gender inclusive in their assessments and in the identification of significant men within the social network, to be clear and specific about the role of the man in terms of fathering, and the aims of engaging him. She sets out four potential fathering roles – ‘partnership’, ‘alternative mother’, ‘luxury’, and ‘unique fathering role’. The partnership role for fathering follows the traditional model of complementary but differentiated gender roles between mother and father who work in partnership: the fathering role is that of breadwinner and disciplinarian, whilst mothers provide nurturing and are responsible for household tasks. The fathering role could also take the form of being an alternative, or substitute, for the mother and undertaking the same roles, tasks, and functions as expected in mothering. The role of fathers as ‘luxury’ refers to a discourse that suggests that fathering supplements the work of the mother in parenting but does not replicate or supplant it. The father provides added value, or additional support for the mother in parenting the children but the mother still has primacy with regard to the carrying out and management of childcare. Daniel (1999)

argues that whichever of these roles fathers undertake within a specific family the context needs to be negotiated and clearly specified so that the role of the father and aims of involvement are made clear and meaningful.

The Family Rights Group commissioned the *Fathers Matter* project to investigate the involvement of fathers in social care services. A number of potential factors that act as barriers and enablers to engaging fathers in social care services were identified (Ryan 2006). The attitudes of practitioners themselves, such as their own values regarding the role of fathers, including discourses of risk and threat in relation to men (Scourfield 2003) and the fear or actual threat of violence (O'Hagan and Dillenburg 1995; Ryan 2000) can act as barriers to practitioners engaging with men. Another attitudinal factor was awareness of the potential impact on women service users and their children, particularly those who had experienced abuse or domestic violence (Ghate *et al.* 2000b). Secondly, the attitudes of fathers and mothers themselves may be prohibitive of involvement, for instance, the view that childcare is exclusively, or at least primarily, the mother's responsibility. Often the environment of service delivery is highly feminized and the presence of men is considered as intrusive, invasive or sexually inappropriate (both by the men and the women) or activities are not orientated to the interests of men (Ghate *et al.* 2000b). Parental (or indeed practitioner) views that the mother has a management role in childcare and that father involvement should be mediated by mothers, i.e. maternal gatekeeping, or enabling, can also serve to marginalise men (Allen and Hawkins 1999; Gaunt 2008; McBride *et al.* 2005). Thirdly, the gendered approach taken to service provision, e.g. gendered nature of activities and orientation of provision such as parenting programmes that focus on talking rather than doing which can be less appealing to men (Ghate *et al.* 2000b).

Ryan (2006) also highlights enablers in overcoming the barriers to father engagement. These include the pivotal role of practitioners reflecting on their practice and, with the support of management, the use of supervision and training (Ghate *et al.* 2000b). Good quality thorough assessments are also important to establish the nature of involvement that men have in the lives of the children and families being assessed, particularly the role of fathers, resident and non-resident, including their needs as well as the risks and resources they may present to the child and mother (Daniel and Taylor 2001; Ryan 2000). Consideration should be given to the timing of social work visits so they are not

all within office hours and to how this impacts on accessibility of services to fathers (or indeed any man or woman in full time employment). Also, it is important to consider the degree to which services and interventions are gendered and whether appropriate modifications could be made to encourage gender inclusivity. Indeed, some interventions and approaches appear to be more gender inclusive than others, e.g. family group conferencing (Holland *et al.* 2005).

Featherstone and White (2006) found in their research with fathers that whilst children were characterised in fathers' talk as essentially 'good' and deserving of love, the women/mothers were 'bad' and perceived as powerful in determining father involvement or preventing it. In short, the fathers in their study perceived children to be vulnerable and in need of protecting from their mothers and from social services. Featherstone and White (2006) conclude that what is needed is a model of education for practitioners in which:

Professionals need to be able to engage with fathers' versions of events in an open and exploratory way, i.e. to adopt a position of 'respectful uncertainty' and 'not knowing' avoiding premature foreclosure and precipitous categorisations, as well as acknowledging the complex discursive terrain in which contemporary fatherhood is situated.

(Featherstone and White 2006, p. 81)

This presents a challenge for practitioners working in family support, but perhaps an even greater challenge if the lack of gender awareness creates an obstacle to gender inclusivity and in ensuring that the *whole* family, including fathers, are engaged within a *whole* family approach.

Daniel *et al.* (2005) argue that child welfare policy should recognise that policy can impact on people differently according to their gender. They highlight the lack of gender analysis in policy such as *Every Child Matters* (2003) and the detrimental effect this has in tackling child abuse and in failing to recognise the differential impact the policy will have on mothers and fathers and boys and girls. Whilst acknowledging that the Green Paper does recognise the need to include fathers in service delivery they draw attention to the obstacles to father inclusion, such as female practitioners' fear of violent

men, a lack of capacity to explore the fears and anxieties that can be engendered by such work, contested conceptions of what being a 'good' father means, differing value systems in agencies and across user groups, and the impact of social structures and particularly employment patterns (Daniel *et al.* 2005). Daniel *et al.* (2005) specifically highlight the struggle for practitioners in determining whether to approach father inclusion by providing specialist, targeted services or a more inclusive, mainstreaming approach that may alienate, detract or intimidate the predominantly female service users. The use of language and the discourses used within policy that are translated into practice can be highly significant in rendering gender issues invisible.

The gender essentialist view frequently adopted with regard to mothering or fathering practices and indeed, the seemingly gender neutral approach of using terms such as 'parent' to provide a veneer of gender equity, only serve to mask that while there may indeed be gender differences with regard to the differing parenting practices of mothers and fathers these are not essentially attributed to gender but arise from the social construction of such practices. Regardless of the gender of the parent, all parenting essentially involves caring for a child and it is the relational quality of that care that should form the basis of assessing good enough parenting rather than the gender of the parent determining what the nature and type of the parenting practices are and measuring the quality of a mother's or father's parenting by these normative gendered standards. If the focus of policy and practice is on improving child welfare outcomes then the quality of the care for the child, rather than the gender of the carer, is what is of primary importance. Similarly, assessing who should be included as constituting the 'family' within the whole family approach needs to be based on who can, and does, provide care to the child to ensure that the child's needs are met, rather than the gendered construction of the family practices and normative roles and responsibilities.

3.5. The Ethic of Care

There is little evidence of an ethic of care in child welfare policy and practice (Holland 2009) and this is similarly evident in debates regarding father inclusion which are usually predicated on an ethic of justice deriving from fathers' rights or children's' rights. However, there has been some discussion regarding the contribution that an ethic of care might make to social work practice generally (Clifford 2002; Orme 2002; Parton

2003); in relation to older adults (Lloyd 2006); and to practice with children - those who are looked after (Holland 2010); or those children and young people who use advocacy services (Barnes 2007). Both Barnes (2007) and Holland (2010) argue that the traits associated with an ethic of justice – autonomy, universality, rights - tend to dominate both policy and practice in the UK in relation to looked after children. This observation could, however, be extended to include much of child welfare policy and practice. Held (2006, p. 15) explains that an ethic of care approach focuses on ‘attentiveness, trust, responsiveness to need, narrative nuance and cultivating caring relations. This contrasts with an ethic of justice approach in which the emphasis is on the consistent application of fairness, equality, individual rights, and abstract principles’.

The debates regarding an ethic of care originate from Gilligan’s (1982) social psychological critique of Kohlberg’s (1981) work on moral development as being gendered. Gilligan argues for the need for a relational ethic of care within the ethic of justice in Kohlberg’s hierarchy. Subsequently some authors have in turn critiqued Gilligan’s analysis as promoting an essentialist view of gender that roots an ethic of care as essentially female and an ethic of justice as essentially male. Tronto (1993) argues that an ethic of care should apply to both men and women.

Care is both a practical activity and an ethical framework (Sevenhuijsen 2000). Some conceptualisations of the ethic of care emphasize positive interdependency between individuals rather than a passive receipt of care by one individual from another or (generally the female) self- sacrificing one’s own good for another. The ethic of care also recognizes the universalism that we are all care givers and care receivers. It thereby normalises care and to some extent de-stigmatizes caring relationships by acknowledging mutual autonomy and the equality of carer and cared for, rather than a dependency model in which the cared for is a passive recipient of care. Further, there is the suggestion that an integrated ethic of care and ethic of justice can breakdown (false) dichotomies between the public and private spheres.

The ethic of care is predicated on the notion of a relational self and thus implies being open to others and attributes importance to communication, interpretation and dialogue. The positive interdependence between carer and cared for means that the recipient of

care is not some distant object to be known but rather both carer and cared for enter into a dialogic and social process of mutual understanding. The ethic of care

. . . in recognizing that humans are relational, interdependent beings, serves as a political concept to prescribe an ideal for a more democratic, more pluralistic politics and form of professional practice.

(Parton 2003, p. 14)

This is particularly pertinent to professional practice within a whole family as it reinforces the focus on interrelationships and relational working, rather than on the protection of individual rights and a construction of competing needs. Instead the relational ontology of an ethic of care stresses the interconnectedness of needs and resources. In other words, with the recognition of mutual interdependence and reciprocity comes a greater desire for collective action in ensuring everyone's care needs are met, i.e. pro-social behaviour and social cohesion benefits everyone in society not just those who are deemed 'vulnerable', 'failing' or 'socially excluded' (Wilkinson and Pickett 2009).

The ethic of care is particularly pertinent in relation to family policy as applied to families where there is parental substance misuse and child protection concerns as such families can be viewed in terms of 'otherness' and as living outside of socially accepted norms by dint of their substance misuse, and within the realms of criminality where the substances are deemed illegal. This 'otherness' is further extended to the family as failing to fulfil its function in protecting the vulnerable family members within it, in this instance failing to protect children. This frames these particular families within a deficit model of 'failing to protect' and of 'otherness' rather than a discourse of difference and multiplicity of family forms and parenting practices. An ethic of care in which parenting is situated within a complex web of social interconnections and positive interdependencies enables the child to be considered as an active agent within this social web, de-stigmatises some of the otherness and negative deficit model of dependence as a failing on the person needing care, and/or the care giver, and shifts the focus from gendered mothering and fathering practices to the identification and meeting of care needs from within a social network that is more open to a multiplicity of constructions of family form and care practices.

The autonomy of the individual and freedom ‘from’ is given highest value within policy, whilst ‘care’ is given only very limited value within the public domain of policy. This is in inverse proportion to the value placed on care within the private sphere with its emphasis on obligations and responsibilities and freedom ‘to’. However, it is care and the relational responsibilities and obligations inherent within that care that form the building blocks of social cohesion. In philosophically conservative constructions of the family these obligations become rights that in postmodern society are re-instated via policy and legislation based on rights and biological relationship. The combining of an ethic of care and justice holds the potential to create greater congruence in autonomy, rights and importantly choice or self-determination regarding who is in your *family* or relationship network and how caring responsibilities roles and responsibilities are negotiated as non-gendered, positive interdependencies. Within such a combined framework gender equity is not about treating men and women the same and giving fathers and mothers the same rights and access to services but enables dialogue about gender differences that are not predicated on gender essentialism, nor fixed gender roles, nor a return to a (mythical, idealization) of family life which is based on gender stereotypes enshrined in policy if never fully actualized in actual family life and practices.

This also re-orientates policy to be rooted in empirical evidence on actual lived experiences and family practices rather than on ideal constructions of a family archetype of fathering practices being orientated toward being a financial provider and mothering practices as being primarily orientated toward nurturing and caring. This enables greater fluidity and negotiation regarding roles and responsibilities whilst safeguarding the care needs of the child or care receiver.

In order to promote greater social cohesion based on democratic, participatory principles of equality and justice, an ethic of care balanced with an ethic of justice provides a framework within which to navigate the moral tensions inherent in balancing the needs of care and protection between the individual and society that is not predicated on gender assumptions. It enables individuals to determine freely their responsibilities in relation to care of themselves and others without care-taking, or being cared-for, resulting in a devaluing of worth to society, or voice in public life.

We are living in a period of change that could perhaps best be characterized as a transition from modernist forms of care politics, based on familial care, to a politics that is better attuned to postmodern caring practices situated in different social domains and in diversity of lifestyles. A notion of 'political conservatism' does not suit this situation since it frames these politics too much in a backward-looking way. It would be better to question how social policies can adapt to 'postmodern kinship practices' and to the need for caring to be integrated into democratic agency at different social locations. This provides a solid starting point for further substantiating the notion of caring as a democratic practice. It thus opens a crucial political window on 'caring' in a third way'.

(Sevenhuijsen 2000, p. 30)

Orme (2002) highlights that care is perceived to be essentially feminine, and predominantly (certainly in the private sphere) as being inherently virtuous and altruistic. Yet caring can limit the individual's right to self-determination or at least limit the choices available both for the carer and the care receiver, and as such can involve control or surveillance, or be narcissistic or sacrificial. Elements of such traits are certainly present within social work and much of the ethical tensions that arise within social work practice relate to managing the tensions between an ethic of justice in terms of rights, equality and universalism and caring aspects that can result in control or surveillance. For instance, in protecting the rights of the child to have their basic needs met e.g. of protection, the social worker may have to monitor and control parental behaviours. As Orme (2002) states:

Social work, while seeming to operate at the level of the public also intervenes at the core of personal relations, and in doing so has to demonstrate care but operate within some notion of justice.

(Orme 2002, p. 807)

3.6. Conclusion

The literature reviewed in this chapter demonstrates the intimate relationship between policy and social work practice. Policy informs and constructs the philosophical and ideological framework for social work practice with children and families determining who the clients of such services are, what interventions are to be used and for what purposes. Within policy and legislation there has been a refocusing from immediate presenting risks in relation to child protection to a more futures-orientated concern for safeguarding children and the longer term outcomes for these children as adults, citizens, and future parents, situating practice within a social exclusion framework. This results in greater attention being given to risks related to social exclusion and building social capital and family resilience. In order to *think family* a paradigmatic shift needs to occur away from traditional social work practices based on individual needs to a whole family orientation that works with the interrelationships between family members. This presents a number of challenges for service delivery and for professional practice.

Traditional service delivery is organisationally structured as child, or adult orientated services with specialisms developed around specific user groups within those groupings, such as drugs, or alcohol, or mental health. A whole family approach requires a shift in service structure and culture away from such organisational boundaries and practice specialisms toward person or citizen-centred services. It also refocuses service delivery from the reactive immediacy of child protection to a preventative, future orientated social investment approach to safeguarding children in need. For practitioners working within a whole family approach this can present challenges in defining who the client is, in identifying social networks and family relationships in constructing the family that is the target of intervention, and in identifying the models, methods and approaches in working with the interrelationships between family members rather than with individuals with specific needs such as drug or alcohol misuse. In combination, these issues may also present a challenge to professional identities and concomitant roles and relationships as an integrated approach to working with whole families requires the deconstruction of current organisational structures and cultures and the certainty of knowledge gained from working within a specific specialism as bounded expertise. As services become more joined up and flexible to meet the complex interrelated needs of members within families the boundaries of practitioner roles and responsibilities also becomes more fluid and uncertain.

As noted in this review of the literature there maybe similarities in the practice process entailed in the constellation of family practice models. However, a whole family approach is distinctive from other approaches to family working in being located within a social exclusion framework and its focus on generating social capital as the global goal. However, it is an assumption on the part of policy makers that strengthening families results in the generation of social capital and less reliance on the state. As highlighted in this chapter the lack of available evidence regarding the therapeutic practice process entailed within a whole family approach is a significant gap in the literature. As such this review has primarily focussed on related approaches such as family-centred and family-focussed practice as providing models of family working. The use of the word ‘whole’ has an implication of (gender) inclusivity whilst not necessarily having conceptual clarity as to how the ‘whole’ is determined and what that relates to in terms of familial relationships and/or such things as gender.

Whilst there has been an increasing attention given to engaging fathers, and father inclusivity, in policy and practice, there exists a substantial body of literature highlighting mother-blaming and the marginalisation of men in child protection practice. This chapter has provided a summary of the key arguments in that literature in order to identify some of the challenges for gender inclusivity within a whole family approach if it is not to merely replicate the over-scrutiny of mothering and the failure to engage with fathers which exist within traditional child protection casework.

The use of an ethic of care as a conceptual moral framework re-frames the construction and embodiment of care, and care practices within a relational ontology that reflects the refocusing of policy and practice to a whole family approach that attends to interrelationships. The ethic of care propounds a contextual, relativist, and pragmatic approach to ethics that acknowledges that both care-giver and care-receiver are in a mutual, multi-directional, dynamic, fluid and interdependent relational process from which both parties give and receive benefits. Consequently, this generates a more egalitarian or democratic power relationship than that in more traditional constructions of care-receiving/care-giving. Both within family policy and practice the impact of gender on parenting care practices, in terms of mothering and fathering, requires greater examination. The ethic of care would suggest that practitioners should go beyond gender to look at situated care practices and interrelationships. There is a tension in

doing so that practitioners should also be mindful of gendered social constructions of care and of parenting, as pertinent to understanding the gender effects on mothering and fathering care practices and the impact this can have on the assessment of parenting capacity.

4. Chapter Four – Research Design and Methods

4.1. Introduction

This chapter describes the research design and the methods used in data collection and data analysis techniques. The research design and methods were determined in order to achieve the aims and objectives noted in chapter 1, namely:

- How is the whole family approach enacted in Welsh policy and legislation?
- What is the Integrated Family Support Team (IFST) model of practice?
- What is ‘a whole family approach’ as embodied in IFST practice?
- How is family co-constructed by practitioners and parents in practice?
- What is the impact of gender on practitioner and parental normative constructions of mothering and fathering as care practices?

This chapter will consider the conceptual frameworks applied to the research design in terms of epistemology and ontology before discussing the use of a case study approach to the research design. The data gathered were drawn from legislative, policy and practice documentary sources and archive records, i.e. client case files, and practitioner interviews. The identification of sources and means of data collection will be discussed before proceeding to the modes of data analysis. Lastly, ethical issues and dilemmas encountered will be examined.

4.2. Epistemology and Ontology: Social Constructionism and ‘effects made by gender’

The epistemological view taken within this study is that of social constructionism (Burr 2003; Edley 2001; Gergen 2009). This is because the focus of the study is the meaning made by practitioners in relation to the construction of ‘family’ and of a ‘whole family approach’. Social constructionism suggests that human beings are not passive recipients of knowledge that exists out there, external to us waiting to be discovered, rather, human beings are active in co-constructing and creating knowledge by making sense, or meaning, from our lived experience. Such meaning-making is situated within the social, historical and cultural context of the meaning-maker. The primary tool for meaning-making is language, thus language is the tool through which the process of the

construction of meaning can be understood. In other words, it is the process by which meaning is made through language that is the focus of study. As such the data sources are primarily in textual formats such as documentary sources and verbatim transcripts. Social constructionism is based on the belief that knowledge does not exist outside of the political, disinterested, affective, and embodied aspects of human experience but is always in some sense value-based, ideological, and political.

Social constructionism emphasizes the rhetorical nature of language as not just representing, or reflecting, a given external reality but as persuasive in constructing how we perceive reality. Through the rhetorical use of talk, narrative and language we use in dialogue with others, and in negotiating our relationships with others and our own sense of self, we ‘construct’ or make sense of our lived experience. Talk thus becomes a process of action that constructs our perception of the external world and has an effect on that world. This can be related to postmodernist perspectives. Language is not merely a representational tool to describe some single, fixed, universal and immutable truth that can be objectively and scientifically known outside of our selves. Rather there are multiple, relational truths to be known that are situated and specific in their historical, social and local environments which are open to negotiation, not only to be deconstructed but potentially reconstructed. This approach emphasizes the *processes* by which people define themselves (their identities) and their environments. This transformative, participatory action is conducted through our interactions with others and the meanings we assign to differing aspects of our experience. One of the strengths of such an approach is that it affords the opportunity to reconstruct meaning in ways that are chosen, and socially negotiated, thus recognizing the importance of interdependence and the relational quality of our social and political cultures. Clearly this opens new possibilities for the re-construction of gendered identities such as mothering and fathering and the practices and obligations associated with such identities.

The consequence of adopting a social constructionist perspective for the purposes of this research means that concepts such as ‘family’ and ‘gender’ and the practices and performativity associated with those concepts as embodied in lived experience are viewed as socially constructed. Similarly, the gendered normative parenting practices of mothers and fathers, i.e. that what men and women ‘do’ as parents, are constructed by

social norms and expectations. Thus, from this perspective a non-essentialist view is taken of gender in that the practices of mothers or fathers are not derived simply from inherent traits based on biological sex but may still be the consequence of 'effects made by gender' (Henwood *et al.* 2008). Rather than an essentialist, 'gender differences' approach Henwood *et al.* call for an 'effects made by gender' approach to provide substantive theoretical explanations. Gender effects are the consequence of a complex interplay of gender codes and categories which elicit gender similarities and differences but are temporally and spatially fluid and carry highly varied meanings within a wide range of interpersonal and group interactions, institutional contexts and social practices. These gender effects become inscribed and inexplicable from our sense of self and our social practices.

The shift away from using the 'gender difference' framework to one investigating the 'effects made by gender' is a critical one in terms of expanding theoretical interest in gender, and in terms of making the complexities, tensions and paradoxes of gender and its measure or perceived associations more researchable and intelligible.

(Henwood *et al.* 2008, p. 7)

A gender difference framework reinforces an essentialist, fixed and dichotomised approach to gender that leaves no room for complexity and contradiction to gendered norms. A gender effects approach integrates subject and performance in the socio-cultural and historical context as gender is internalised and inscribed in social practices and embodied thereby opening up the possibility of problematising and theorising (Henwood *et al.* 2008). For instance, whilst pregnancy is clearly biologically an inherently female task that biological fact does not, in and of itself, mean that women should continue to have primary responsibility for childcare following birth. Such expectations are socially constructed and situated within the cultural, historical and social context. Correspondingly, the normative expectation that men as fathers should be the main providers for their families is not considered within this framework as being an essential attribute inherent in being male but rather an effect made by gender within a specific socio-cultural, geographical and historical context. As such effects made by gender are situated social constructions (Henwood *et al.* 2008).

4.3. Research Design

The research design selected is that of a case study, using mainly qualitative mixed methods. As the concern of the study is the subjective meaning-making and co-construction of family, whole family approach and the gendering of parenting, qualitative methods were used to obtain rich, thick descriptive data. Helen Simons (2009) defines a case study thus:

Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life' context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic (as in a thesis), programme, policy, institution or system to generate knowledge and/or inform policy development, professional practice and civil or community action.

(Simons 2009, p. 21)

Thus in this case study, a single case of a whole family approach from policy into practice is critically examined in the real world context of its implementation in order to undertake an in-depth exploration from multiple perspectives and to understand its complexity and richness – the how and the why of a whole family approach - and the construction of family in policy and practice. The purpose of this exploration is to generate knowledge, and inform policy development and professional practice. As such a case study design is ideally suited to this purpose. The case study design is not a method in itself but rather a frame to focus on a specific instance or single case. A case comprises of two parts – a subject and an object or analytical frame (Thomas 2011). In this instance the subject is the IFST model of practice and the analytical frame or object is a whole family approach.

Yin (2009) suggests that a case study design is particularly well suited to exploring how and why questions. This study poses just such how and why a question regarding how a whole family approach is implemented in practice. He further goes on to suggest that a case study design is ideal when exploring contemporary, as opposed to historical events, for instance the implementation of policy in contemporary professional practice.

The case study is preferred in examining contemporary events, but when the relevant behaviours cannot be manipulated. The case study relies on many of the same techniques as a history, but it adds two sources of evidence not usually included in the historian's repertoire: direct observations of the events being studied and interviews of the persons involved in events. Again although case studies and histories can overlap, the case study's unique strength is its ability to deal with a full variety of evidence – documents, artefacts, interviews, and observations-beyond what might be available in a conventional historical study.

(Yin 2009, p. 11)

Dodd and Epstein (2012) argue that qualitative case study research is more useful for practitioners and for practitioner-based research than research designs such as randomised controlled trials which are privileged within the 'hierarchy of knowledge' as the pinnacle of evidence-based practice, and instead suggest that in actuality:

. . . qualitative 'case studies' of individual clients, client groups or programs are often legitimately and effectively used in social work training and supervision. In addition, many peer-reviewed practice journals rely heavily on evidence drawn from case studies in passing on valuable knowledge to their social work readership.

(Dodd and Epstein 2012, p. 16)

A case study approach has therefore been adopted in order to provide evidence for policy and professional practice by studying the interrelationships between phenomena within the circumscribed organisational boundary of an Integrated Family Support Team as the single case being studied. A single location was identified as the research site with the intention of providing an illustration of how policy was being put into practice in relation to a whole family approach.

The pioneering of Integrated Family Support Teams was identified as an ideal context in which to explore these issues as it had a clear policy and legislative basis and was delivered by professional practitioners including social workers within a specific, newly developed, 'consultant' social worker role (Welsh Assembly Government 2008). At the

outset of the research there were only three IFST pioneer locations. Due to the distance of the location, one of the pioneer sites was pragmatically unfeasible for a part-time researcher. Thus, it was decided to approach one of the two remaining locations. As the first of the two local authorities approached was receptive to participating in the research there was no need to contact the remaining site.

Whilst it is evident that a case study approach to the research design has significant strengths there are also limitations to its application within this context. Firstly, the focussing on one single IFST team limits the generalisability of the therapeutic practice as this could be the result of local variations of the IFST model of practice. Secondly, there is also limited generalisability with regard to the use of a whole family approach within the IFST model of practice. It should be noted that this is an examination of one IFS team's articulation of the IFST model and of the use of a whole family approach within that. However, the benefit of focussing on a single IFST case is the ability to provide greater richness and depth than would have been feasible for a lone PhD researcher in the context of a set of a broad range of research questions. In order to overcome these limitations future research could conduct comparative data collection and analysis across IFS teams; and/or the focus of this study could have been much narrower, for example, an entire study could have been constructed around any one of the stakeholder perspectives or any one of the research questions identified. I decided to retain a broad focus in terms of research questions within a depth of analysis provided by a single team case study as a means of exploring interrelationships between policy, practice and parental perspectives.

Finally, also relevant to the generalisability of a case study design is the decision to select a service that works specifically with families where there is co-existing parental substance misuse and child protection concerns as the site for exploring the therapeutic process of a whole family approach. Whilst it may be argued that this is a somewhat specific, and potentially higher risk/need client group than some other vulnerable families, it should be noted from the literature review the high prevalence of parental substance in the majority of child protection/need cases and therefore there may be some potential for the study's generalisability within the child protection/safeguarding field in parental substance misuse is prevalent. Further, the ethos of a whole family approach (as identified within the findings of this study and elsewhere, such as policy

statements discussed in the literature review) is that it is the interrelationships between the family members that are the focus of a whole family approach to intervention. Thus a whole family approach is family-focussed not problem-focussed. As such the nature of the ‘problem’ or ‘concern’ is secondary to a systems and strengths-based approach to working with, and through, the interrelationships between family members. Thus, it could be argued that to some extent the focus of this aspect is the therapeutic process entailed within a whole family approach and that this should not be substantially different in its process with this constituent group of target families than with any other group of families. Indeed, it is more likely that aspects of the IFST model itself may be more tailored to parental substance misuse, for instance the use of motivational interviewing and the use of the change model rather than impacting on a whole family approach. On which basis there is some validity in considering the resultant findings regarding the generalisability of the whole family approach in practice as robust within the limitations of a single case. However, a larger study that was solely focussed on this research question would no doubt benefit from comparative cases with different constituent family groupings.

Following receipt of ethical approval from the University’s School of Social Sciences Ethics Panel (Appendix A – Ethical Approval) I contacted the Director of one of the IFST locations requesting a meeting and forwarding the research proposal. Following the meeting the Director provided a letter detailing the access agreed (Appendix B). I then met with the Head of Children’s Services, then subsequently with the Head of Service, and then the IFST team manager and Business Support Manager. Anecdotally there is reported a high turnover of team managers in social services, particularly in frontline child protection teams such as Intake and Assessment. Indeed, during the course of the research there were four changes of team manager, three of which were in the first eighteen months of operation. At each change of manager I arranged a meeting with the new incumbent to discuss on-going research site access and expected outcomes of the research. The nature of the team structure meant that some practitioners were on temporary secondment so it was to be expected that there would be some changes of personnel within the team. However, this was further compounded by long term sickness and relatively high staff turnover, predominantly as a consequence of staff obtaining employment elsewhere or requesting a transfer from the IFST into other service areas. In order to ensure that all team members (both original and new) were

aware of the research and the reason for my presence at the team offices I attended several team meetings and provided update briefings throughout the research process. At the point where fieldwork ended only two of the original IFST members were still in post.

4.4. Data Collection

Following the discussion regarding the conceptual frameworks applied within the research and the case study research design, there will now be a discussion of the principal methods of data collection, namely, documentary sources and practitioner interviews.

Yin (2009) identifies six sources of evidence most commonly used in case studies: direct observations, participant-observation, physical artefacts, archival records, interviews and documentation. Further, he suggests that, ‘documentary information is likely to be relevant to every case study topic’ (p.101). Within social research Prior (2003) stresses that documents should be examined not only for what they contain or their content, but also their manufacture, e.g. role, purpose, authorship, target audience, etc. and how they function, e.g. the use of argument, rhetoric, and so forth. The study of documents is not merely a matter of considering what is present in the content but also what is not present or absent. As Rapley (2007, p. 111) states:

Exploring a text often depends as much on focusing on what is said – and how a specific idea argument, idea or concept is developed – as well as focusing on what is not said-the silences, gaps or omissions.

(Rapley 2007, p. 111)

Rapley (2007) supports the idea that documents can be useful in studying contemporary phenomena as they provide ‘the history of our present’, in other words ‘some work with texts specifically focuses on how ideas, practices and identities emerge, transform, mutate and become the relatively stable things that we have today’ (p.119). The documentary sources identified and collected for this research have been used in order to map how the concept of a whole family approach and exhortations in policy for

practitioners to ‘think family’ have been transformed into action in professional practice.

A brief overview of the documentary sources identified as relevant for this study can be found below, however, a more thorough chart outlining the author, title, purpose, target audience and comments can be found in Appendix C. The chart at Appendix C is chronological and thus also provides a time line of the development of IFST from policy into practice.

Figure 4-1 Summary Overview of Documents Analysed

| Evaluation & On-going Monitoring of Practice and Service Delivery | | |
|--|---|--|
| Date | Authors(s) | Title |
| 2007 | Forrester, D., Pokhrel, S., Mc Donald, L., Copello, A., Binnie, C., Jensch, G., Waissbein, C., Giannou, D | Evaluation of Option 2 – Final Report |
| 2008 | Forrester, D., Goodman, K., Cocker, C., Binnie, C., Jensch, G. | What is the impact of care on children’s welfare? A focussed review of the literature |
| Legislation & Policy | | |
| Date | Author(s) | Title |
| 2008 | Welsh Government; NHS Wales | Stronger families - Supporting Vulnerable Children and families through a new approach to Integrated Family Support Services |
| 2008 | Welsh Government | Taking Action on Child Poverty |
| March 2009 | Dr Brian Gibbons, Minister for Social Justice and Local Government | Legislative Statement on the Children and Families (Wales) Measure |
| June 2009 | Welsh Government: Legislation Committee 2 | Proposed Children and Families (Wales) Measure. Stage 1 Committee Report |
| Feb 2010 | Welsh Government | Children and Families (Wales) Measure 2010 |
| Nov 2009 | Jointly prepared by the Department for Social Justice and Local Government, the Department for Children Education, Lifelong Learning and Skills and the Department for Health and Social Services | Children and Families (Wales) Measure 2010 Explanatory Memorandum & Children and Families (Wales) Measure 2010 Explanatory Notes |
| June 2010 | Welsh Government | Children and Families (Wales) Measure 2010 (Commencement) Order 2010 |
| June 2010 | Welsh Government | Integrated Family Support Teams (Composition of Teams & Board Functions) (Wales) Regulations 2010 |
| June 2010 | Welsh Government | Integrated Family Support Teams (Family Support Functions) (Wales) Regulations 2010 |
| June 2010 | Welsh Government | Integrated Family Support Teams (Review of Cases) (Wales) Regulations 2010 |
| Statutory Guidance and Regulations; Practice Toolkits | | |
| Date | Author(s) | Title |
| 2010 | Welsh Government’s Depts. of Social Justice and Local Government, Dept. of Children Education and Lifelong Learning and Skills, Dept. of Health and Social Services, | Integrated Family Support Services: Statutory Guidance and Regulations |
| Version 2; August 2010 | Rhoda Emlyn-Jones OBE & Dr. Amanda Bemble, IFST | Integrated Family Support Services: Supporting the Pioneer Areas in Wales Practice Manual |
| January 2010 | Prof. Donald Forrester | Evidence Based Interventions and “Stronger Families”: <i>Recommendations and Lessons from a Review of the Evidence</i> |
| February 2010 | Prof. Donald Forrester | Integrated and Inter-professional Working: <i>A Review of the Evidence</i> |
| April 2010 | Prof. Donald Forrester | Evaluation and On-going Monitoring: A Practical Guide for IFST Teams |
| May 2010 | Prof. Donald Forrester. | Motivational Interviewing for Working with Parental Substance Misuse: A Guide to support the IFS Team |
| May 2010 | Prof. Donald Forrester, & Anne Williams, Cardiff University | The “Option 2” Model and Homebuilders: A Guide to support the IFS Teams |
| July 2010 | Prof. Donald Forrester, & Sarah Wadd | Social Behaviour and Network Therapy and Parental Substance Misuse: A Practical Guide for IFST Teams |

These documents were selected as they comprise the documentary evidence of the journey from policy into practice. As such, they provide a map of the development of IFST from its inception in policy as a result of an evaluative report on Option 2 (Forrester *et al.* 2007) through to the development of policy *Stronger Families* (Welsh Assembly Government 2008) and the proposal of primary and secondary legislation and its passage through to Royal Assent as documented in legislative committee minutes. Statutory guidance, practice manuals and specifically commissioned practice toolkits were also critically examined. Thus the documents identified as data chart an iterative and recursive process of practice (*Evaluation of Option 2* (Forrester *et al.* 2007) into policy, and back into practice – with further evaluation of IFST being the basis for future implementation of policy and legislation. These documentary sources are public documents and freely accessible on the internet in relation to policy and legislation documents, the proceedings of the Welsh Government and its Committees.

In addition to the naturally occurring documentary data noted above, archival records in the form of case files were identified as a second source of naturally occurring documentary data. As a newly operational service, local team administrative systems and practices were in development and thus files varied greatly in the content and richness of the available information held. I met with the Business Support and Development Manager and explored some of the IFST case files (which are held on a shared drive and are split between an administrative folder (not shared with clients), a ‘family file’ (of materials which are shared with the family in the form of hardcopies) and some of the related case files held on the Integrated Children’s Services’ (ICS) electronic file system. From this meeting it became apparent that much of the data that I had anticipated being readily available on the ICS system, particularly as it related to childhood of parents, such as parental in-care history, or cross-referencing to adult file systems in relation to, for instance, parental substance misuse, or adult mental health were not present. As the aim was to generate qualitative data about practice processes as they relate to the construction of family and a whole family approach, rather than statistically valid generalisable data, it was decided to focus on the local case files rather than the corporate recording in the Integrated Children’s System (ICS).

The Welsh Government target for each pioneer area was to provide a service for 100 families a year, yet at the research site location only 56 referrals were dealt with in the

first 11 months. All recorded referrals for the first eleven months of operation (1st September 2010 to 31st July 2011) were examined. This convenience sample consisted of 56 files, of which:

- 5 were absent,
- 7 were empty,
- 8 had limited information regarding family structure, and
- a further 2 had only recently been referred and had very limited information.

The remaining 34 files were examined. The purpose of the preferred futures accounts and values card-sort statements within the practice model and their use as data is explained later in this chapter.

Case files were identified as being able to provide several types of data:

- 1) Information about family structure and household composition as constructed by practitioners in their case recording.
- 2) Information regarding the practice process, family engagement and goals.
- 3) Information regarding parental views of ideal family life.
- 4) Information about parental values.

I created two standardised instruments, or data collection sheets, to collect data from client files in relation to (1) and (2) above:

- The first provided a broad overview of family structure and composition and the nature of presenting risks and the gender of the perceived person presenting as a risk to the child(ren's) welfare.
- The second provided greater detail on global goals at referral, family members' engagement in the process and subsequent family goals.

Appendix D contains the templates for both standardised case file data collection tools, the instructions and coding used to complete them, as well as illustrative examples of the completed data collection sheets. The data collection sheets enabled the extraction of data from case files in-situ with no identifiable information being removed from the

research site. All of the families' names were replaced by a numerical key code and no names of service users were identifiable in any of the data collected. Before accessing files I was required to undertake the local authority's in-house online training in order to ensure that I understood the requirements in relation to data protection. Similarly, the encrypted data drive had to be obtained via the local authority and to their specifications.

One of the strengths of the first data collection tool was that it provided a broad overview of how practitioners have constructed family structure and household composition of the families referred to IFST. Thus the main purpose of case file data collection tool 1 is to provide an analytical tool to examine practitioners' construction of 'family' and to reveal any underlying models, e.g. family as biological relationships, or household composition, or emotional proximity, or families of choice, etc.

Case file data collection tool 2 was developed in order to collect data regarding family goals and any discernible patterns in the type and level of parental engagement by gender by end of Phase 1 of the intervention. Phase 1 is the initial action planning stage that follows the referral and drawing up the safety plan (please see chapter 6 for further information about the IFST model of practice and diagrammatic illustrations Figure 6.1, 6.2 and 6.3). From the case files of families examined in order to complete case file data collection tool 1, ten families were identified who had completed to at least the end of Phase 1 of the intervention and therefore lent themselves to more in-depth analysis using the second data collection sheet. The focus of this second data collection sheet was on the whole family approach and any discernible effects made by gender in terms of parental engagement.

The IFST model of practice utilises brief solution-focussed therapy (de Shazer *et al.* 2007). Parents are asked to envisage, in as much detail as possible, what their lives would be like if a preferred future occurred overnight and they woke to find everything was how they would want it to be. This is the 'miracle question' which leads to developing the 'preferred futures accounts'. These accounts are then written up by practitioners and given back to parents and are referred to as 'preferred futures accounts' in this thesis. These accounts are contained within the case files and provide an ideal opportunity to examine normative parental constructions of family life, and

mothering and fathering practices. All the available family responses to the miracle question responses recorded as preferred futures accounts were anonymised and recorded verbatim as data as these provide a written description of how parents articulate what an ideal day in family life would look like for them as individuals. As such, inherent within the accounts is how the parent envisages idealised family life. The original research protocol included narrative interviews with parents in order to obtain parental perspectives on the construction of parenting and the gendering of parenting practices (Please see Appendix G – Parental Information Leaflet and Consent Form (Draft) and Appendix H- Parental Interview Schedule (Draft)). The original intention to include parental narrative interviews is an acknowledgement of the importance of family voices in providing a 360-degree stakeholder account of the experience of a whole family approach and of the IFST therapeutic model. In particular it would have added greater clarity as to the extent of validity of the practitioner-mediated preferred futures accounts and practitioners' espoused articulation of the therapeutic practice, in addition to that of the practitioner-perceived co-construction of family.

Whilst it would have been challenging to gain access to this particularly vulnerable group of children it would also have been constructive to include children (of all ages) within the pool of family voices so as to fully represent the views and perceptions of all family members and in acknowledging children's agency and the validity of their unique perspective and experiences. However, as the following discussion highlights accessing parental voices proved to be unfeasible and thereby accessing those of children via parental consent may have been even more problematic.

At the time of data collection very few of the families had completed the active intensive intervention phase which meant there was a very limited pool from which to draw any form of sample and the resulting sample would of necessity have been a convenience sample of limited generalisability. Following discussion with IFST practitioners the practitioners agreed to contact families whose cases were now closed and to provide the information leaflet about the research to parents. This in itself was problematic given the high turnover of staff which meant that most of the practitioners contacting parents were not known to the families they were contacting and had not been the spearhead worker involved in their case. From the practitioner attempt to

engage parents in the research only one mother said that she would be willing for me to contact her to discuss the possibility of participation.

In addition to this challenge SQW who were conducting the National Evaluation of IFST were also in the process of contacting parents in order to conduct interviews and my understanding was that they were offering payment to interviewees in recognition of their time in participation, so it may have been that families were already suffering from research fatigue and/or would prefer payment for their time that this study could not offer. In addition to attempted engagement with parents via practitioners I also attended the newly set-up service user reference group for the local service. The service user group itself was struggling to engage parents' participation and only one parent (mother) was in attendance at the meeting that I attended. Despite the efforts made only two parents (both mothers) expressed an interest in being contacted regarding the possibility of being interviewed. Whilst the lack of inclusion of unmediated parental voices within the research is a limitation on the study a largely pragmatic decision was taken that this was an insufficient sample and widening the sample was neither practicable, nor realistic within available time and resource constraints. The use of parental preferred futures accounts and parental card sorts provides a parental perspective, although it should be noted that these are mediated accounts as these are recorded by practitioners rather than by parents themselves. It should also be noted that these are intended as therapeutic activities and as such have an implicit therapeutic agenda that would not have been the case within narrative interviews.

All the parental preferred futures accounts and recording of the card values sort undertaken were anonymised in situ before being stored on encrypted data pen to be analysed. Whilst the accounts are written up by the IFST practitioners, copies are given to the people whose accounts they are in order to confirm that they are an accurate reflection of the accounts given. To this extent they can be considered valid and reliable (third party) accounts of parental views. Table 4-2 outlines the role and gender of the service users' accounts that were collected.

Table 4-2 Preferred Futures' Accounts Collected

| | | | | | |
|--------------------------------|---|--------------------------------------|----|-------------------------|---|
| Biological Fathers | 4 | Biological Mothers | 16 | Adult sons | 2 |
| Social Fathers | 2 | Identified as lone biological mother | 3 | Adult daughters | 1 |
| Identified as mothers' partner | 1 | | | Adult girlfriend of son | 1 |

The overwhelming majority of accounts taken by practitioners were in relation to biological mothers – 19 in total, three of whom were also identified by practitioners within the case file as a 'lone' (biological) mother. There were substantially fewer fathers' accounts in the case files, four of which were from biological fathers, two of whom were social fathers and a single account identified within the file as a non-resident partner to the biological mother. There were no accounts from children under 18 years written up by practitioners in the case files. The only accounts by children were those taken from adult children. In order to focus on parental views and any effects made by gender, only the mothers' and fathers' accounts were analysed.

The preferred futures question is a tool for eliciting cognitive dissonance in individuals in order to motivate change. As such, it is perhaps not surprising that this is a tool that would appear to be less frequently used with children. In addition to the preferred futures question, another lever to move parents from pre-contemplation to contemplation within the behavioural change cycle (Prochaska and DiClemente 1983) is for parents to undertake a variety of card-sorting activities which, like the preferred futures question, are also intended to generate cognitive dissonance, or a 'grit of discomfort', between actual behaviours and one's own aspirations, ideals and values. The practitioner records of the values card-sort were also collected as providing naturally occurring data regarding parental values. Both from the data analysis of the practitioner interviews and from the researchers' own fieldnotes and memos based on being present for significant periods of time within the IFST office whilst collecting data and liaising with the IFST team it would seem that practitioners perceive themselves as undertaking more preferred futures accounts and values card sort activities with more individual family members (particularly with children) than are recorded within case files. There are clearly some limitations on the use of the local family files as a source of accurate and representative records of family engagement, particularly at this formative stage of the service's development.

Having considered the case file data collection, the construction of the interview schedule and approach taken to the practitioner interviews will be considered next. Yin (2009, p. 108) states that:

. . . interviews are an essential source of case study evidence because most case studies are about human affairs or behavioural events. Well-informed interviewees can provide important insights into such affairs or events. The interviewees also can provide shortcuts to the prior history of such situations, helping you to identify other relevant sources of evidence.

It was specifically this type of insider knowledge or first-hand account alluded to by Yin that the practitioner interviews were intended to elicit, in relation to the development and use of the IFST model, and specifically the use of a whole family approach. The purpose of interviewing IFST practitioners was to explore with the practitioners their understanding and use of a whole family approach within the IFST model of practice, their construction of ‘family’ as used in practice and any gender effect made in relation to normative expectations of mothering and fathering practices.

It is to be noted that the views expressed in interviews are practitioners’ espoused perceptions or ‘self-reporting’, i.e. what they *believe* they do in practice, rather than what they *actually* do. This potentially presents limitations on their validity as reliable evidence when compared with that of direct evidence from the observation of practice. The use of direct observations of practice was explored with the IFST manager but proved to be untenable. There was an understandable reluctance by the team manager and practitioners to have a researcher present during interventions, particularly in terms of potential impact on the intervention itself. Alternate forms of ‘direct observation’, such as via audio recordings or simulated practice audio recordings used in the training and accreditation of practice were also explored but the researcher was unable to gain access to these.

Within a case study research design Yin (2009) suggests that interviews are more like ‘guided conversations rather than structured queries’. Within these guided conversations Yin outlines the two tasks that the interviewer has as being to consistently follow the line of enquiry within the case study as set out in the research protocol, whilst also

asking actual (conversational) questions in a fluid and unbiased manner. An in-depth, semi-structured interview guide was developed (Appendix E) around three topic areas for the interview: the personal and professional background of the respondent including their involvement with IFST, the whole family approach, and the gendering of parenting. Whilst aiming for a fluid, conversational style that would make practitioners feel at ease and able to reflect on their practices I also wanted to achieve some consistency in the topic areas and questions asked so as to enable comparison of responses within the data analysis.

I attended a team meeting to discuss the research being undertaken and the intention to conduct practitioner interviews. Practitioners were given information and consent leaflets (Appendix F) along with stamped addressed envelopes for returning consent forms to me. This enabled practitioners to have time to consider whether they wanted to participate, or not, without any undue pressure or coercion by virtue of my presence or that of their colleagues. This approach also meant that none of the practitioners would necessarily know who had agreed to participate and who had not, thereby aiding anonymity.

The approach taken to undertaking the interviews was predicated on social constructionism and as such, that the interview process is inter-subjective and co-participatory. Social constructionism makes no claims as to an objectivist theory of meaning-making. Both researcher and research participants are active in constructing and interpreting lived experience throughout the data collection and data analysis process. The researcher is an active participant in creating meaning rather than passively collecting, or 'extracting' data from participants. As Mason (2002, p. 64) stresses, accounts generated in interviews are 'not a direct reflection of understandings "already existing" outside the interview interaction'. Both the subject of research and the researcher are themselves interpreting their lived experience - the researcher is not merely re-counting or describing the interpretation of the research participants. Reflexivity can provide some transparency regarding the inter-subjectivity of the interview process by identifying the impact of self on the research process.

Prior to undertaking interviews with IFST practitioners from the research site I conducted a pilot interview with an IFST practitioner from a different IFST team.

Following the interview the IFST practitioner and I reflected on the process of the interview and the construction of the questions. On the basis of this discussion some aspects of the schedule were revised in terms of the phrasing of some questions. The finalised interview guide used in the interviews can be found in Appendix E.

Within the case study research site a total of eight interviews were undertaken. Five female practitioners were interviewed and three male practitioners. Interviewees were given the option of choosing the location of the interview. For pragmatic reasons three of the interviewees opted to be interviewed at a University location whereas the remaining participants were interviewed at the IFST offices. The age range of professionals was between 28 years old and 50 years old with the average age being 38 years old. The professional backgrounds of the IFST practitioners interviewed were predominantly as social work professionals (5), two of whom also had experience in probation. There was also one probation qualified worker and two with a background in nursing (1 Community Psychiatric Nurse (CPN) and 1 from substance misuse services). Only one worker was unqualified and their experience was entirely drawn from the voluntary sector. The range of post-qualifying experience was between 4 years and 18 years. Only one practitioner was not a parent themselves. This information is drawn from the earlier part of the interviews in which practitioners were asked about their personal and professional backgrounds and as such the responses and information provided were variable and not easily amenable to comparison but do give an indication of the age, professional backgrounds and levels of practice experience of the IFST practitioners interviewed.

All the interviews were digitally recorded and transcribed (Davidson 2009; Edwards 2007; Hepburn and Potter 2009; O'Connell and Kowal 1995; Oliver *et al.* 2005). Reflected in the research journal entries during the interview process and in subsequent transcription and data analysis is an awareness of the way in which knowledge and theorising was co-constructed between the IFST practitioners and the researcher. Whilst I am not an IFST practitioner I understand from the feedback from the practitioners interviewed that they experienced the interviews as collegiate, non-threatening and exploratory, with several practitioners stating in the interviews that the interview process itself had provided a reflective space to consider their practice (Chew-Graham *et al.* 2002; Cooper 2010).

4.5. Data Analysis

As noted above, there were three primary data sources— policy documents, client case files and practitioner interviews. This section outlines the data analysis approaches used in relation to these three sources of evidence. The two case file data collection tools enabled some data to be collated on a numerical basis, for instance in relation to the structure and composition of families (please see Figures 8.1, 8.2 and 8.3) and gender and risk (please see Figures 9.1 and 9.2). However, the majority of the data was subject to qualitative data analysis in order to obtain more finely grained, rich insights. The main strategy for the analysis of documentary sources, preferred futures accounts and transcribed interview texts was that of a constant comparative method informed by grounded theory. This was used to develop themes so as to generate an analytical framework with which to map out the terrain of this exploratory case study research. In addition to this approach legislative and policy documents were also scrutinised via *Trace* methodology (Sevenhuijsen 2003). Thus, in this section of the chapter the use of a constant comparative thematic analysis informed by grounded theory and *Trace* methodology will be considered. Then the use of content analysis to collate the data gathered via the client case file data collection tools and values card-sort accounts will be discussed.

The general approach taken to data analysis is that of grounded theory as this approach is particularly useful as an inductive approach to theory generation in an area that is currently little researched. Glaser and Strauss (1967) suggest that a grounded theory approach is a tool for eliciting and analysing qualitative data to identify important categories in the data, in order to generate ideas and theory ‘grounded’ in the data itself. Grounded theory approach is recursive and iterative which facilitates reflexivity, thereby rendering the researcher’s own meaning-making more transparent.

Grounded theory involves a line-by-line coding of the written text in order to identify descriptive categories which are constantly compared for similarities and differences. These are then clustered, or merged, in order to construct researcher categories at a more conceptual, or interpretative, level. These categories are then used to re-examine the data to further elaborate the concepts analysed. Throughout the analysis the researcher writes memos to clarify any creative leaps made when linking, merging or splitting categories and to record emerging theoretical reflections, which help make and

keep the process of the analysis transparent and maintains the self-reflexive stance. One of the advantages of grounded theory is that it enables researchers to conduct contextually sensitive research (Pidgeon and Henwood 1997). Thus a constant comparative method was used in data analysis combined with theoretical sampling to achieve theoretical saturation.

Henwood and Pidgeon (1996) and Charmaz (2006) argue that the researcher will always have implicit hypotheses and theoretical interests, therefore, it is important for the researcher to make explicit their own hypotheses which will often have been developed from personal and professional experience. A research diary and memo writing were maintained throughout the research process as tools to support researcher reflexivity. I used Nvivo 9 (then subsequently Nvivo 10) software as a means of project management and data storage (Bazeley 2007). The software also assisted in data analysis as it is possible within Nvivo to highlight extracts of text in order to label or code the extract with a descriptive category. It is also possible to link extracts of texts to memos in order to build relationships, or hierarchies between categories. By constantly comparing labels and categories it was possible to build a hierarchy of relationships within and across data sets and to aggregate these around the original research questions. Thus the initial coding was open, followed by axial coding and then selective coding to reduce the coding to core categories which could be related to the central topics of the study.

Whilst the approach to data analysis was similar across textual data sets the management and organisation of the data varied and this affected the process. The policy and guidance documents were grouped as in Appendix C, namely, evaluation and on-going monitoring, legislation and policy, and statutory guidance, regulations and practice toolkits. Thus, each document was individually subjected to constant comparative analysis, then each document within each of the three categories was thematically compared and finally, any differences or similarities in themes across all three categories were identified. The analysis of the practitioner interviews was concurrent with conducting the interviews and transcription. As such, the researcher's relationship with the data was immersive and recursive as themes within and across interviews emerged.

The preferred futures accounts and values card-sort statements were grouped by gender of the parent and the nature of their relationship with the child, e.g. biological or social. This grouping was done in order to facilitate the identification of any similarities or differences, absences or presences, within and across these categories in relation to any effects made by gender. As such, the accounts were collated and thematically analysed by gender of parent, i.e. mothers' accounts were analysed for recurring themes, as were fathers' accounts. Finally, the themes in mothers' and fathers' accounts were compared for similarities and differences, particularly where these highlighted any gendered normative expectations of mothering and fathering care practices.

In addition to the constant comparative approach informed by grounded theory described above, the analysis of the legislative and policy documents was also influenced by *Trace* methodology. I decided to use this approach specifically with the policy and legislative documents as it provided a useful analytic framework in order to examine these documents in terms of any gender effects and any (gendered) normative constructions of parental care. Sevenhuijsen (2004) provides a detailed guide to the use and application of *Trace* to analyse text. *Trace* takes the feminist ethic of care as its main point of reference in order to evaluate the normative frameworks of policy documents that deal in one way or another with care. Normative paradigms are more than just value statements, they are recurrent ways of speaking and judging that construct how problems are defined.

By preferring certain narrative conventions and modes of communication, policy documents encapsulate power: They confer power upon certain speaking positions and vocabularies, and are thereby instrumental in producing hegemonic discourses, in including and excluding certain modes of speaking. It is precisely the aim of *Trace* to enhance insights into how this happens. (Sevenhuijsen 2004, p. 15)

Trace methodology involves four steps: 'Tracing', 'Evaluation', 'Renewal with the Ethic of Care', and 'Concretizing'. The goal of the first step –Tracing– is to establish which normative frameworks are actually at work in the text (Sevenhuijsen 2004, p. 24). This includes examining how the text was produced, how the problem is defined, what the leading values are, what the conceptualisation of human nature is, how care is

defined and elaborated, what consideration is given to gender, what the role of the state is, and the use that is made of rhetoric. The second step involves evaluation and clusters around three questions:

- a. What political philosophy underpins the text in question?
- b. The adequacy of the text in terms of:
 - i. Definition of the problem,
 - ii. Social knowledge,
 - iii. Power relations,
 - iv. Structural axes of power and inequality: those of class, gender and ethnicity.
- c. How does the text address care as a social and moral practice?

Sevenhuijsen (2004) locates the third step of renewal with the ethic of care within Tronto's definition of care, and the four phases of caring plus the addition of a fifth by Sevenhuijsen, of trust. Care is defined by Fisher and Tronto (1990) as

. . . a species activity that includes everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. This world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life sustaining web.
(Fisher and Tronto 1990, p. 40)

Fisher and Tronto (1990) conceptualise the caring process as having four phases or dimensions and a concomitant underlying value. Firstly, 'caring about', i.e. establishing what care is needed (corresponding value - attentiveness). Secondly, 'caring for', i.e. initiating care needs being met (corresponding value – responsibility). Thirdly, 'taking care of', i.e. carrying out the care needed (corresponding value – competence). Finally, 'care- receiving', which includes a dialogue between cared for and carer regarding the quality of care (corresponding value – responsiveness). They also stress the importance of reflecting on the image of human nature which informs the ethic of care, and to reflect on what difference that would make to the policy domain under scrutiny. Finally, the aim of the last step – concretizing - is to move the analysis back from the more philosophical to the concrete level and also to compare the insights of step 3 with those of the first step. It thus becomes possible to more concretely formulate which

alternative perspectives the ethic of care can bring to the policy debate in question. The methodology of *Trace* holds a distinct value position in relation to the ethic of care and does not claim to be value free or neutral. When considered from a social constructionist point of view this self-reflexive subjectivity whilst without being unproblematic has internal validity.

As noted above, the exception to the main approach of constant comparative thematic analysis informed by grounded theory was the analysis of the case file data collection tools. The analysis of the data obtained via these tools was primarily content analysis and quantitative in that items noted in the data collection sheets were counted. In terms of case file data collection tool 1, I was particularly mindful to be aware of any patterns (differences or similarities) between families in terms of structure, nature of substance misuse, nature of child concern, and so forth. Also, in terms of kinship ties/biological relationships and social familial relationships, and in relation to gender within the family – whether households were predominantly female, or headed by lone mothers, what male involvement (type and level) was visible within family life. In addition to further explore gender, e.g. whether men were characterised as risk, resource, absent, useless or neutral, what gender were the primary carer(s), and how mothers were characterised.

In terms of client case file data collection tool 2 the analytical focus was on exploring, firstly, the relationship between policy and practice, e.g. how do the family goals constructed with practitioners conceptually align with policy intentions? Secondly, the tool was used to identify any effects made by gender of the parent and/or IFST worker on the construction of family, and levels of engagement with family members according to their gender.

Having developed analytic thematic hierarchies within each dataset I then triangulated the data by looking for similarities and differences across data sets in relation to each of the research questions. This enabled me to compare and contrast differing stakeholder perspectives, namely: policy, practice and parental lived experience, in relation to a whole family approach, construction of family and any effects made by gender.

4.6. Ethical Issues: consent, access and participants' protection

This section deals with ethics, issues of access and consent specifically in relation to documentary sources and human participants as they apply to the study. Ethical issues are present throughout the research process, not only in negotiating access and participation and data collection, but also in data analysis and dissemination of findings. This was particularly apparent in the thematic coding process and I was very aware of my own use of judgement in the identification of themes and subsequent theory generation. The awareness of grounded theory assisted the research in attempting to remain grounded in the data.

Investigation was undertaken as to whether NHS ethical approval would be needed. The local NHS ethics panel determined that ethical approval would not be required from them. There is no equivalent procedure for social care ethical approval in Wales. That is, for research in statutory social care services there is no single, standardised formal procedure for ethical approval. Similarly, there is no one single entry point or standardised procedure for negotiating access arrangements. Ethical Approval was granted by the School of Social Sciences Research Ethics Committee on 11th June 2010 (Appendix A) and monitored by the panel on a twelve monthly basis, as well as being a standing agenda item during supervision.

The intention was to use naturally occurring data wherever possible, i.e. documents and other sources that were already in existence so as to cause minimal burden to participants and minimal impact on families, and particularly to avoid any potential interference in the intervention work with families. As such the least intrusive means of collecting data were identified in order to cause the least harm to participants.

As noted above, access to the IFST case files and practitioners required negotiation with the Corporate Director, Head of Children's Services and Head of Service. In addition support from the Team leader(s) of the IFST and informed consent of practitioners within the IFST was also obtained. There are limitations on the ability to protect the identification of the local authority in that there were only three pioneer sites at the start of the research. However, within the data collection and subsequent findings individual contributions are not identifiable by name although there may be some limitations in relation to roles as a means of narrowing down the identification of individuals.

All data collected was anonymised prior to removal from the research site and stored digitally on an encrypted data pen for transferral on to my own laptop. All access to data and data retrieval, were compliant with both University procedures and the local authority's own requirements. Much deliberation was undertaken regarding the need to obtain consent from parents to access case files, however, due to the pioneering nature of the IFST all parents sign a consent form at the outset of their involvement with IFST regarding the use of case file information for research purposes and involvement as participants in research. This was deemed by the University and the local authority as sufficient consent by parents for the researcher to access case files. Aside from case files, the documentary sources in relation to policy and legislation and the proceedings of the Welsh Government and its Committees are public documents and freely accessible on the internet.

I am a qualified, registered social worker subject to regular Disclosing and Barring Service (D.B.S.) checks and have professional experience of working with vulnerable children and adults and responding to challenging and/or distressed individuals. Also, as a registered social worker I must abide by the Care Council of Wales' Code of Conduct for Social Care Workers (2004). Consideration was given to ensuring that all interview participants understood the nature and purpose of the research and were able to provide written informed consent via standardised information leaflets and consent forms. The information and consent statements make it clear that all participants have the option to withdraw at any time and without having to provide any reason or justification for withdrawal (Appendix F).

I did not anticipate any distress or emotional harm to professional participants involved as the focus of study is neither personal, nor sensitive to professionals. It was made clear to participants that the study was not an evaluation of individual practice or of the IFST itself. However practitioners were made aware that any issues of poor practice that raised serious concerns in relation to harm to themselves or others would have to be reported using the local authorities' own whistle-blowing procedures and in accordance with the researcher's own professional responsibility to abide by the Care Council for Wales' Code of Conduct (2004).

Participants were offered the opportunity to conduct their participation via the medium of Welsh if that was their preferred language and practicable, although this may have presented resource implications as this would have necessitated the use of a Welsh speaking interviewer/translator, transcription by a Welsh speaking audio typist and translation of the transcript into English for the purposes of coding by the English speaking researcher.

Participants were offered the opportunity to receive a summary of the findings of the completed study and to attend a dissemination event of the findings. The benefits to practitioner participants also include a conceptual model for practice of a whole family approach when working with families where there are issues of parental substance misuse and child protection concerns.

4.7. Conclusion

In summary, the research design utilises a case study approach within which primarily qualitative methods were used for data collection and analysis. A range of data sources and methods have been used in order to cross triangulate data in order to strengthen the validity of findings and provide a comparison between differing stakeholder perspectives. Three sources were used for data collection – policy and practice guidance documents, archived records, i.e. client case files, and practitioner interviews. I developed two standardised instruments for the retrieval of case file data: the first focussed on construction of family and the second on the process of practice and engagement of family members according to gender. Preferred futures accounts and values card-sort statements were also collected and anonymised in-situ. Constant comparative analysis, influenced by grounded theory, was used in order to ensure that findings were generated from, and grounded in, the data. Grounded theory also facilitated transparency of the researcher's role in constructing knowledge. Reflexivity regarding the impact the researcher's own professional knowledge and experience had on the design, data collection and analysis is important in order to understand how this informed the project and ultimately the theorising resultant from findings. A reflexive approach and use of memos and fieldwork journals were used to assist in making the researcher's effect in knowledge creation transparent. An integral part of reflexivity was the mindfulness of any potential ethical issues and dilemmas presented by the research.

This study is an exploratory piece of qualitative research that maps out the terrain in relation to the construction of family, the practice processes involved in a whole family approach and a thematic examination of the effects made by gender on these constructions. The research does not attempt to evaluate the effectiveness of IFSTs nor of a whole family approach. Whilst the research does not endeavour to provide a process evaluation, the research does articulate what a whole family approach entails in this practice context and to explore the relationship between, and translation of, policy into practice. There are limitations on the generalisability of the data, however, the theory generated does have potential for greater generalizability and the testing of validity and reliability with the replication of methods in differing contexts where a whole family approach is utilised as part of the intervention. As such, this research provides an analytical framework for further research on a whole family approach in practice.

5. Chapter Five – The Whole Family Approach as Enacted in Welsh Policy and Legislation

5.1. Introduction

Since the Government of Wales Act (GOWA) 1998, which established the National Assembly for Wales, almost all public policy that relates to children and young people in Wales has been created in Wales. Thus, the English *Quality Protects* (Department of Health 1998) agenda and its successor, *Every Child Matters* (Department for Health 2003) do not apply in Wales. Similarly, the Children Act 2004 has distinct sections that relate to Wales and others that do not. For instance, Part 3 of the Children Act 2004 applies exclusively to Wales and provides for a new statutory framework for planning and delivery of services at a local level within Wales to meet local needs that are consistent with national policy objectives. Unlike England there is no requirement in Wales to radically reconfigure children's services, nor any provision for children's trusts. Rather, the model is that of local partnerships of statutory and other relevant bodies with power to pool budgets and other non-financial resources (Children Act, 2004, S.25). There is a distinctively different approach by the Welsh Government to children's policy, and as stated by Butler (2007, p. 165) 'an unambiguous and explicit commitment to a rights based agenda'.

In Wales, the Welsh Assembly explicitly based the seven core aims for children on the United Nations Convention on the Rights of the Child (UNCRC):

Over the last ten years [the UNCRC] has helped to establish an internationally accepted framework for the treatment of all children, encouraged a positive and optimistic image of children and young people as active holders of rights and stimulated a greater global commitment to safeguarding those rights. The Assembly believes that the Convention should provide a foundation of principle for dealings with children.

(National Assembly for Wales 2010, p. 10)

On the basis of the UNCRC Welsh Government (WG) developed seven core aims for children which are discussed in depth *Children and Young People: Rights to Action*

(National Assembly for Wales 2004). Thus the Welsh policy and legislative approach to child welfare is explicitly a rights based agenda reflecting an ethic of justice.

As highlighted in chapter 1 this study investigates via a case study approach the social processes by which ‘family’ and a ‘whole family approach’ are constructed in policy and practice. To some extent policy and family life are co-constructed, and for policy intervention to be effective it must reflect the diversity and actual, lived experience of family life for the families it intends to serve. This chapter draws on the findings of the *Trace* analysis conducted on *Stronger Families* (Welsh Assembly Government 2008) and the *Children and Families (Wales) Measure 2010*, and an analysis of supporting documentation, namely the *Statutory Guidance and Regulations* (Welsh Assembly Government's Departments of Social Justice and Local Government *et al.* 2010b) and legislative committee minutes, ministerial announcements and consultation feedback to the Welsh Government. The documentary analysis findings discussed in this chapter start by examining the *Evaluation Report of Option 2* (2007) which provided the spur to *Stronger Families* (2008) and the subsequent legislation - *Children and Families (Wales) Measure 2010*.

The analysis of these documents maps the enactment of a whole family approach within the Welsh context of policy and legislation. In addition, the use of *Trace* enables an interrogation of the ethics and ideology underpinning these documents in the policy construction of this target group of families and the cognisance taken of the impact of gender on family life.

5.2. Policy Drivers: Documentary Analysis of the Evaluation of Option 2 Report

This section, 5.2, explores the drivers that define the problem(s) that the policy is intended to tackle and the proposed policy solution(s). The *Evaluation of Option 2* (Forrester *et al.* 2007), and subsequent focused literature review on the impact of care on looked after children (Forrester *et al.* 2008b) informed the development of the *Stronger Families* (2008) consultation document which was the key policy document in the formation of IFSTs. Option 2 was an intensive support service to families in Cardiff and the Vale of Glamorgan where there are issues of parental substance misuse and high risk of admission of the child(ren) into care. The primary aim was child welfare and the

prevention of children entering into the care system, i.e. family preservation. The service was modelled on Homebuilders (Kinney *et al.* 1991) which is delivered in the United States. The Homebuilders model has an evidence base for effectiveness in preventing admission to care and/or limiting the time spent in care (Fraser *et al.* 1996; Walton 1998).

Forrester, *et al.* (2007) conducted an evaluation of Option 2 for the Welsh Government. The evaluation methodology consisted of a literature review of intensive family preservation services, a quantitative follow up of Option 2 children and comparison group in relation to the impact of the service on care entry and associated cost savings, a qualitative study of the views of parents and children who accessed the service in 2006 and questionnaires to social workers in Cardiff and the Vale of Glamorgan. The literature review within the evaluation highlights the underpinning beliefs in relation to preventing children going into care as being: ‘families are better for children’, the poor outcomes for children that enter care and the significant cost to the state in receiving children into care (Forrester *et al.* 2007). Both Homestart and Sure Start are identified by Forrester *et al.* (2007) as failing to engage those families at highest risk in the community, and further that improving circumstances for the wider community may actually further disadvantage high risk families.

Forrester (2008) states that the evaluation of Option 2 ‘is the first demonstration in the UK that investment in preventative services for ‘high risk’ children can result in net cost savings’ (p. 416) and that there is some indication that the intervention can impact on longer term child welfare outcomes given that 68% of Option 2 children were at home at follow up, compared with only 56% of the comparison group.

The then Minister for Social Justice and Local Government, Dr. Brian Gibbons, and the then Deputy Minister for Social Services, Gwenda Thomas, in their paper to the Cabinet Committee on Children and Young People which presented the evaluation of Option 2 highlighted the high rate of looked after children in Wales as being 72 per 10,000 compared to 55 in England, a rise of 34% since 2000 in Wales compared to 6% in England (Gibbons 2009). Furthermore, Wales ranked amongst the top 5 internationally for the highest rates of children in care and also has a lower spend per capita on family support services when compared with other European countries, the

United States of America, Canada and Japan. Thus suggesting that there was too much an emphasis on child protection and a greater need for refocusing services more toward children in need and family support, whilst acknowledging that for some children entry into care may be a positive option and improve child outcomes. However, the evaluation was commissioned to consider the impact of entry into care rather than broader child welfare outcomes of the intervention so there is limited discussion on this topic.

The *Evaluation of Option 2* report indicates around a third of all childcare social work cases involve parental substance misuse and that paternal substance misuse is an issue for around 60% of children subject to parent orders, whilst acknowledging that other problems may also be present, such as mental health, domestic violence and significantly including lone parenting within this list of ‘problems’. Option 2 is applauded as a model of service to families where substance misuse is present and that it is evidence-based, efficient and effective. Whilst Option 2 did not reduce the number of children entering care, the service did significantly reduce the time spent in care and the concomitant cost. The service is noted as being particularly effective with lone parent families where the parent is misusing alcohol. Most notably the report sees one of the greatest achievements of Option 2 as being in the engagement of families, and the building of positive relationships with families that other services had failed to engage.

The *Evaluation of Option 2* report compared families who accessed Option 2 with a comparison group of families who were families referred to the service but unable to access it due to lack of availability of a therapist. On examination of the family structures it is notable that there is some variation between two parent families (43% in the comparison group and 48% in Option 2 group), but greater variation in terms of gender in relation to lone parents, with 21% mother only in the comparison group but 39% in the Option 2 group, and 35% of father only families in the comparison group with just 4% in the lone father group receiving the Option 2 service (Forrester *et al.* 2007, p. 34). There is little discussion within the evaluation of this gender anomaly but it may suggest that whilst lone father families are being referred to the service they gain access to the service less frequently than lone mothers. The reasons for this are not explored.

The *Statutory Guidance and Regulations* (2010b) states that the use of evidence-based interventions (EBIs) is central to the delivery of IFST and defines EBIs as ‘ways of working with people that have been rigorously evaluated, using experimental research designs’ (p17). The guidance highlights Motivational Interviewing (MI) as an EBI in which practitioners will be trained, in addition to others such as Brief Solution Focussed Therapy (BSFT) and Cognitive Behavioural Therapy (CBT).

The IFST model is whole and complete in itself. It has been built on intensively researched models and skills. It is important for the success of the intervention that each of its core elements is adhered to: the sense of family crisis, the intensity of the intervention, the relationship between worker and family, the skilled workers, the tools, the structure, the clear goals and the attention to maintenance in the Family Plan. Each element locks into place to create the opportunity for personal transformation.
(Emlyn-Jones and Bremble 2010, p. 5)

This statement emphasizes model fidelity and implies by extrapolation that as many of the elements of the model are evidence-based interventions that the IFST model in its entirety is evidence-based. However, there is very limited evidence of the effectiveness of the IFST model (Forrester *et al.* 2007). Indeed, Forrester (2010) in reviewing evidence-based interventions for creating stronger families states that the review is ‘highly selective and that there is not a well-established evidence base of direct relevance’ (p2) and further, that ‘there is no strong evidence base on what works with families affected by serious parental substance misuse’ (p13). Subsequent research by Forrester *et al.* (2014) provides stronger evidence for the effectiveness of the Option 2 model in working with parental substance misuse and co-existing child protection concerns.

Forrester and Williams (2010) conclude their review of *Option 2 and Homebuilders* by stating that:

.... evaluation of interventions such as Option 2 are at a comparatively early stage and the evidence we currently have is not strong. However, on balance the evidence for Option 2 and similar intensive family

preservation interventions is stronger than that for any other intervention we know of aimed at families affected by serious parental substance misuse. Option 2 or carefully developed adaptations of it (such as Families First) therefore appear to be the best place to start building ways of working effectively with families affected by such issues.
(Forrester and Williams 2010, p. 6) (Emphasis in original)

On which basis Forrester (2010b) includes Option 2 in his identification of five interventions considered best suited to informing the IFST model:

- 1) Intensive family interventions, such as Option 2,
- 2) Motivational Interviewing,
- 3) Cognitive Behavioural Therapy,
- 4) Social and Behavioural Network Therapy, and
- 5) Task Centred Casework or variations.

However, Forrester adds a significant caveat to the use of EBIs:

The enthusiasm, energy, belief and dedication that is put into a project (i.e. the way that you do it) may be just as important as the characteristics of the service or methods used as described in evaluation (i.e. what you do).
(Forrester 2010, p. 18)

This emphasis on the way that you do things, rather than what you do, suggests that the practice process and use of self, are both important factors in the effectiveness of the intervention. In other words, how practitioners embody the model of intervention is a significant variable in its effectiveness. As such, an intervention that has a strong evidence base of effectiveness may be advantageous in improving the likelihood of effectiveness, but in and of itself, it does not guarantee efficacy.

The following section, 5.3, discusses the findings from a documentary analysis of *Stronger Families* (Welsh Assembly Government 2008) which was a pivotal policy document in the development of IFSTs and in the enactment of a whole family approach in the Welsh context.

5.3. Problem Definition and Solution: Stronger Families (Welsh Assembly Government 2008)

Stronger Families (2008) was selected as a text for analysis using *Trace* as it meets Sevenhuijensen's (2004) twofold criteria of being both a key text and having sufficient discursive space for an analysis according to the ethic of care, i.e. care and the values underpinning it are central to the discussion. As noted in chapter 4, Prior (2003) stresses that documents should be examined not only for what they contain but also their manufacture, e.g. role, purpose, authorship, target audience, and so forth and how they function, e.g. the use of argument and rhetoric.

Stronger Families originated from the Children's Health and Social Care Directorate within the Welsh Government (WG). Although a range of health, social and criminal justice services are listed as the target audience the document was open to public consultation and therefore comments were also invited from any person or group. Notable in its absence within the target audience is any service user representation groups – either representing adults or children, or mothers, fathers or families. The window for consultation ran from 8th August 2008 to 3rd October 2008. The primary stated aim of the consultation was the establishment of a legal framework to require local authorities and their health partners to provide Integrated Family Support Teams rather than a consultation in relation to the establishment of the teams themselves or their role and function. Thus Welsh Government can be considered as seeking a mandate to introduce legislative powers to require local authorities, health authorities, and the professionals within them, to implement IFSTs rather than as opening a dialogue regarding problem definition or problem solution.

The problem was repeatedly defined within the document by the WG as being that of families, services and professionals 'failing' to meet the needs of children within families where substance misuse, mental health difficulties, learning disability and/or domestic violence are present. The problem solution is defined in terms of improving or 'strengthening' the families themselves, reconfiguring services and improving and refocussing professionals' knowledge and skills.

WG identified four levels, or tiers, of need (Welsh Assembly Government 2007, p. 41) which are reiterated and re-formulated in relation to families within *Stronger Families* (Welsh Assembly Government 2008, p. 7) :

- Tier 1 – Universal services accessible to 100% of the population.
- Tier 2- Focussed on early intervention for vulnerable individuals and families requiring remedial support targeted at 20% of the population.
- Tier 3 – Relates to more complex support and care needs and is targeted at avoiding escalation, restoration and safeguarding and relates to 15% of the population.
- Tier 4 – Deals with acute or restorative issues where a child may have become looked after or accommodated in a social or health care setting and relates to 5% of the population. This is the most invasive, costly and intensive area of service provision.

The principle of the triangle is that at each tier people have access to all the services in the tiers below and additional services relevant to that tier. The risk of social exclusion increases as people progress up the tiers. The aim of services should be to help people move back down the tiers towards inclusion.

(Welsh Assembly Government 2007, p. 41)

As presented in *Stronger Families*, the role of the state appears to be to minimize intervention and the dependence of individuals on state provision. Following an ethic of justice, the citizen is portrayed as being someone who should be self-sufficient for their care and support needs through accessing universal services. The aim of more targeted intervention is to return individuals to mainstream universal services. IFST is targeted at tiers 3 and 4 with the intention of returning families to lower levels of need. The assumption seems to be that there is a linear progression, both up and down, the tiers of need/levels of service provision and an implicit assumption that early intervention equates to age and stage in the life cycle of the child, i.e. preventative services such as

Flying Start and Cymorth³ supporting families with pre-school children are tier 1 universal services. It is suggested that for a minority of families

.....who struggle to break the cycle of disadvantage, more specialist support is required through targeted services. Tackling the complex and entrenched social exclusion of these groups requires a more focused and integrated approach that is sustained over a period of time. This consultation therefore sets out proposals to refocus systems and support on the complex needs of these families.

(Welsh Assembly Government 2008, p. 8)

There is a clear acknowledgement of the cycle of disadvantage that leads to social exclusion and of the future orientated thinking in breaking this cycle, however there is also a tension in intervention being ‘sustained’ via a service that is brief and intensive such as IFST. Whilst there is an acknowledgement that there is little evidence in relation to the effectiveness of whole family approaches the thrust of the document is on the need for evidence-based approaches and the intention to not only evaluate service provision in terms of outcomes but also to provide practitioners with an ‘approved’ list of evidence-based approaches for use in practice. The focus is on a rationalist, technicist approach to practice based on scientific rigour and the standardisation of practice. The stated aim of the IFST is ‘systemic change in the delivery of services’ rather than improving quality of life, family relationships and outcomes for children. IFST could be viewed as a means to reconfigure services and refocus practitioners to create cultural change. This appears as a service led, top down change implemented via legislation with little evidence presented on what the families that are the focus of these targeted interventions see as their needs, or concerns, and little discussion regarding the lived experience of these families.

In achieving the stated aim, four interrelated priorities are suggested:

1. Developing new multi-agency teams (Integrated Family Support Service). IFST’s to deliver services for services where children are

³ **Flying Start and Cymorth** are national initiatives delivered in areas of local deprivation and intended to provide pre-school children with a head start in order to counteract economic and social disadvantages.

at risk of developing long term difficulties or experiencing significant discontinuity in their upbringing that may result in the child entering care. IFST will also support the reunification of children who are voluntarily accommodated;

2. The focus will be on the delivery of evidence-based interventions, that are thoroughly evaluated and recognized by the Welsh Government;
3. The models of intervention will need to be part of a coherent and consistent model for service delivery across the area as a whole and the teams will have a role in providing training supervision for all other agencies in the area; and
4. Thorough evaluation will be built-in as an on-going feature of the proposals, to enable all elements of the system to have on-going feedback on their performance.

(Welsh Assembly Government 2008, p. 9)

Point 1 re-affirms that children should be cared for within their families and where separation has occurred reunification should be a goal, thereby endorsing traditional family ideology that children are best cared for within their own families. There is also evident a concern with longer term difficulties, or the safeguarding of the child⁴ rather than solely immediate child protection concerns. The second point affirms the centralization and government sanctioning of which interventions are (and are not) effective at a service and practice level on a national basis, with geographical areas having a responsibility for ensuring coherence and consistency within their localities and thereby minimizing any ‘postcode lottery’ effect. A scientific, rationalist approach to the model of feedback is suggested with little reference to co-production or any participative approach to the development, management and evaluation of the service by those who the service is targeting. The IFST’s are clearly intended to be catalysts of cultural change within service delivery and practice to break down organizational and professional barriers and to implement a more centrally prescriptive approach to both service delivery and practice approaches, indeed the ‘teams will act as engines for

⁴ **Safeguarding Children** extends beyond child protection to include the additional aims of preventing the impairment of children’s health and development, ensuring children are growing up in circumstances consistent with the provision of safe and effective care, as well as protecting children from maltreatment.

system change’ (p.10). The IFST will become ‘a core service function within each local authority area’ (p11).

IFST practitioners are expected to have high levels of expertise in order to deliver individually tailored ‘person-centred’ packages of support and to develop partnerships that breakdown interagency barriers. The use by the multi-disciplinary team of a common suite of evidence-based interventions is intended to create a common language and promote inter-disciplinary practice and trans-disciplinary working. The WG considers the key to delivery of evidence-based interventions to be a ‘sustained commitment to excellence in developing highly skilled practitioners’ (p13) who have accessed extensive training and on-going professional supervision. The WG proposes within this document a career progression framework from newly qualified social worker through to consultant social worker linked to training that enables a pathway to career progression as an advanced practitioner. Previously career progression was often reliant on progression through management roles and thereby re-directing more experienced practitioners into management rather than advancing their professional expertise. Coupled with this is a greater emphasis on practitioner involvement in direct work with service users.

The IFST would be focused on professional excellence to achieve change through greater emphasis on direct work with children and families through relationship-based activity.

(Welsh Assembly Government 2008, p. 21)

Thus, whilst plainly an ethic of justice is apparent and coherent with WG’s rights-based policy agenda there is scope for integrating an ethic of care in a relational approach to service provision and practice. Strengths and resilience can be promoted through the interrelationships between individuals that are integral to the practice process of a whole family approach. Indeed the whole family approach itself acknowledges human beings as being reliant on positive inter-dependencies rather than the autonomous, rationalist, self-sufficient beings within the ontology of an ethic of justice.

Whilst the document is keen to emphasize inter-agency and inter-professional working, social work is given particular attention, and appears to be held particularly responsible

in failing to support these families to care for their children and prevent admission into care. The lack of a route to advanced practitioner status and the development of expertise are particularly highlighted as presenting a number of interrelated problems:

- The career structure draws many able practitioners away from direct work with clients at a comparatively early stage in their careers;
- Limits the incentive for social workers to become highly skilled practitioners;
- Contributes to the high turnover and poor retention of child welfare staff; and
- Contributes to the systemic difficulties in providing high quality placements, practice teaching and assessment for students.

(Welsh Assembly Government 2008, p. 23)

Annex 1 of the document provides a broad outline of what the model of such a career progression pathway might look like. The pioneer areas are intended to test the model both in effecting change in relation to integration of services and better professional working relationships and in improved outcomes for children and families.

5.4. Documentary Analysis of Welsh Legislation: Children and Families (Wales) Measure 2010

In order to implement the proposals suggested within *Stronger Families*, the *Children in Wales Measure (2010)* was brought into being and provided a new statutory framework for the delivery of IFSTs. The Measure was passed by the National Assembly on 10th November 2009 and approved by Her Majesty in Council on 10 February 2010. To support this legislative framework *Statutory Guidance and Regulations* (Welsh Assembly Government's Departments of Social Justice and Local Government *et al.* 2010b) were also provided along with what are termed 'a suite of practice tools' to assist the pioneer Integrated Family Support Services. These were:

- Evidence-based interventions and 'Stronger Families': Recommendations and Lessons from a Review of the Evidence - January 2010

- Integrated and Inter-professional working: A review of the evidence - February 2010
- Evaluation and On-going Monitoring: A Practical Guide for IFST Teams - April 2010

Three further guides were commissioned by the Welsh Government to inform the practice of the IFSTs:

- Motivational Interviewing for Working with Parental Substance Misuse: A guide to support the IFST Teams May 2010
- The ‘Option 2’ Model and Homebuilders: A guide to support IFS Teams May 2010
- Social Behaviour and Network Therapy and Parental Substance Misuse: A Practical Guide for IFST Teams July 2010

In addition, the Welsh Government (WG) commissioned a National Practice Manual (Emlyn-Jones and Bremble 2010). (For more detailed information about each of these documents please see Appendix C).

Assembly Measures pass through the National Assembly for Wales in five stages:

- Stage 1: Consideration and agreement of the general principles of the Measure.
- Stage 2: Detailed consideration of the Measure and any amendments tabled by a committee of Assembly Members.
- Stage 3: Detailed consideration in plenary of the Measure and any selected amendments.
- Stage 4: Passing the final text of the Measure by the National Assembly and Her Majesty at Privy Council.
- Stage 5: Measure comes into force.

The proposed Children and Families (Wales) Measure was introduced into the National Assembly for Wales on 2nd March 2009. The Measure provided the legislation to take forward the Welsh Government’s child poverty commitment and to give greater support to families where children may be at risk. As Part 3 relates to Integrated Family Support

Teams it is this section which will be the focus of analysis. However, that the central legislative focus of the Measure is on eradicating child poverty and intergenerational transmission of disadvantage is significant in setting the context for the introduction of a new model of Integrated Family Support Services. In relation to progress of the Measure to its final version attention will be given to Stage One as it is this stage which endeavours to determine the general principles of the proposed Measure and is helpful in illuminating the rationale and value base of the proposed Measure.

The Legislation Committee comprised of Assembly Ministers with cross party representation produced a Stage 1 Committee Report in June 2009. An open call for evidence was made and over 40 organisations and individuals submitted evidence. The report highlights:

. . . that the proposed Measure is the most substantial to be introduced to date and is ambitious in terms of scope, cutting across three ministerial portfolios – Social Justice and Local Government; Children, Education, Lifelong Learning and Skills; and Health and Social Services.

(National Assembly for Wales Legislation Committee No. 2 June 2009, p. 17)

The scope of the Committee was to consider:

- The need for the proposed Measure in order to deliver the stated objectives;
- Whether the proposed Measure achieves those stated objectives;
- The key provisions the proposed Measure set out and whether they were appropriate for achieving stated objectives;
- Whether the proposed Measure took account of potential barriers to implementation;
- The views of stakeholders who would be working within the proposed arrangements.

In terms of the general principles of the proposed Measure and the need for the legislation the ‘majority of the evidence’ was ‘very positive’ (p.22). However, there is only one reference in this section to the setting up of IFSTs which is a contribution from

Children in Wales⁵ regarding the potential for IFSTs to promote greater integrated working across agencies and across adult and children's services. The rest of the evidence relates to the eradication of child poverty rather than the creation of IFSTs. Yet on this basis the Committee concludes that there is a 'general consensus' and 'broad support amongst stakeholders for the general principles' (p.25).

When focusing on IFSTs the discussion as presented in committee meeting minutes revolves around the role of the third or voluntary sector within the development, with the 'evidence' coming from the voluntary sector that they should be more centrally involved, e.g. that they are constituent members of Integrated Family Support Boards rather than Boards merely having the option to co-opt voluntary sector partners. The response from the Deputy Minister, whilst acknowledging the 'crucial role' of the voluntary sector, describes IFSTs as 'a statutory vehicle' to promote better assessment and regulation of care.

There is some discussion regarding the involvement of General Practitioners and schools, particularly in identifying the children that are the target of Integrated Family Support Services, however, the Care and Social Services Inspectorate's (CSSIW) response is that 'there is no difficulty in identifying the children' who would be well known to Social Services. There is also a similar discussion regarding the involvement of the Police and Youth Justice. Thus the focus of the evidence presented relates to power relationships between key stakeholders with Social Services as the lead agency working in partnerships with Local Health Boards and co-opting involvement from the Voluntary Sector, Education, and Criminal Justice as and when needed. The Deputy Minister perceives the changes as about driving up standards of assessment via integration of health and social services and raising professional practice benchmarks.

The definition of the term 'abuse' as used in the proposed Measure is questioned, however clarification is made that the use of the word abuse as defined in the Measure is in relation to adult abuse:

⁵ Children in Wales is a charitable organisation whose core activities are training and consultancy; forums, networks and campaigns; conferences and meetings; and influencing policy.

We are talking about the abuse of adults through domestic violence or through their own substance misuse, and how that can affect the child within a family. So we are talking about abuse in regard to adults.

(National Assembly for Wales Legislation Committee No. 2 June 2009, p. 70)

The Welsh Local Government Agency (WLGA) stated that they would not support the IFST section of the Measure without safeguards that if the teams were found to be ineffective that the legislation would not be enacted. The Deputy Minister's response indicates the high levels of confidence and expectations with regard to the IFST despite this being based on rather limited evidence from one study, i.e. the *Evaluation of Option 2*. This is apparently sufficient evidence for the Deputy Minister to consider the Option 2 model of practice to be a 'proven model'. It is also worth noting that this limited evidence of efficacy relates to the Option 2 model rather than the IFST model of practice which is largely, but not entirely, based on the Option 2 model. Whilst the Deputy Minister stresses her 'confidence' that IFSTs will be successful there is some caveat that this part of the proposed Measure could be repealed or lie dormant if the pioneer services did not prove to be effective.

Phase 1 of the Integrated Family Support Services (IFST) became operational on 1st September 2010 in the three pioneer areas: Newport; Rhondda Cynon Taff and Merthyr; and Wrexham. The word 'pioneer' is significant as it is indicative of a vanguard rather than a trial or testing 'pilot'. In *Stronger Families* (Welsh Assembly Government 2008) the term 'pilot' was used but during the course of the Measure's journey into law this became 'pioneer' indicating an increasing level of confidence from initial proposal to statute.

Whilst the pioneer services are subject to inbuilt local and national evaluation, the findings of those evaluations will not be concluded until *after* the roll out of the services across Wales which has now (2014) been completed. Thus there is evident a clear WG commitment to providing the service pan-Wales even before the evidence-base for the effectiveness of the model of service has been collected. Indeed, in March 2011 the Welsh Government announced its intention to bring forward the rollout of the service

across Wales. Also, the need for a comparative element to assess the effectiveness of IFST was removed from the National Evaluation tender specification (SQW 2012).

Phase 2 became operational in February/March 2012 in a further two areas: a regional consortium of Hywel Dda University Health Board, Powys Teaching Health Board, and their respective local authorities - Carmarthenshire, Ceredigion, Pembrokeshire and Powys; and a consortium of Cardiff and Vale University Health Board and its respective local authorities - Cardiff and the Vale of Glamorgan. Phase 3 provided the service to Swansea, Neath Port Talbot and Bridgend. Phase 4 completed the roll out to North Wales and Gwent (Welsh Government 2013).

IFSTs operate within a new statutory framework with new key powers which:

- Place a duty on local authorities to establish one or more IFSTs to provide services to adults where there is a benefit to a child who is in need.
- Place duties on the Local Health Board (coterminous with the LA area) to assist the local authority in establishing and resourcing an IFST in order for the local authority to discharge its duties.
- Provide for collaborative working across the local authority boundaries; more than one local authority may establish one or more IFSTs with their Local Health Board.
- Require an IFST Board to be established and for the aims and functions of the Board to be prescribed.
- Provide for the functions, staffing and resourcing of IFST.
- Place a general duty on relevant health and social work professionals to consider the referral of the client's children to social services as children in need where consideration of the adults' needs indicates such.
- Introduce new review arrangements for cases referred to the IFST.
- Retain responsibility for child protection and case management with the child allocated a social worker who will work with the IFST in supporting the child and the family.

Thus unlike the 'no wrong door' approach advocated within Think Family (2008b) there is only one door via which families can access IFST, namely via the statutory

childcare social worker who continues to retain case responsibility. There is a clear emphasis on two separate policy foci – systemic change to integrate services and inter-professional working, and systemic change within the family, with the aim that both combined will improve outcomes for families and the children within them.

In introducing the proposed Measure the then Minister for Social Justice and Local Government, Dr. Brian Gibbons, issued a Legislative Statement by the Welsh Government on 3rd March 2009. The statement makes clear that the proposed Measure is targeted at ‘our most disadvantaged children and families’:

It is the launch of a national mission to give all our children the best start in life and to break the vicious circle of cross-generational deprivation and disadvantage that blights too many individuals, families and communities throughout our country.

(Gibbons 2009, p. 1)

This statement locates the proposed Measure within an ethic of social justice context that aims at tackling social exclusion through a universal right for all children to have ‘the best start in life’ unhampered by cross generational structural inequities and disadvantage such as child poverty. This is situated within a context of social cohesion as important for the ‘nation’. The rhetoric re-iterates the view that the family is the building block or unit of social cohesion within society and that this is an issue of universalism, rights and social equality further strengthened in terms of the stated need for the proposed legislation to ‘create a sense of unified national purpose’. It could be argued that whilst the legislative and policy intent is underpinned by an ethic of justice, the goal of social justice is to be achieved through a relational ontology underpinned by an ethic of care, i.e. the strengthening of relational bonds within families in order to generate social capital and social inclusion. As such this integrates an ethic of justice with an ethic of care.

Specifically in terms of the content of the proposed Measure that relates to IFSTs there is a re-iteration that families are where children’s needs are best met and that the reform of children’s services systems is vital

. . . to provide earlier intervention to manage and support children and families to live at home and to flourish in that environment. The integrated family support teams will play an integral role in addressing the diverse needs of children who are in need or in care, so that they can be safely reunited to live with their families or be allowed to continue to do so. It will also identify earlier those children who are considered to be high risk and whose needs can only be met by more arrangements outside the family home.

(Gibbons 2009, p. 4)

Thus whilst the driver is to maintain, or re-unite, children safely within the family environment there is an acknowledgement that the family is not always the universally best place for children's needs to be met and that for some children remaining within the family environment can present unacceptable risks. There is a lack of clarity in this statement as to who or what is high 'risk', and to whom or what the risk is presented, in that the statement seems to suggest that it may be the children themselves who are considered to be 'high risk' and/or the families themselves presenting high risks to the child in terms of an inability to adequately meet the child's needs and their parental obligations. Thus the policy construction of family contains inherent tensions and contradictions not unlike those identified in the literature review in relation to UK family policy more broadly.

The Minister's subsequent statement seems to expand on this:

Family structures and the social fabric of today's society mean that a radical rethink and adjustment are required so that services can be more responsive, particularly for struggling families that face multiple disadvantages, in which parental alcohol or drug misuse and mental illness is the norm. This new approach seeks to address the complex interplay of these problems and to change behaviour and place greater focus on supportive family values so that parents can better prioritise their children's welfare.

(Gibbons 2009)

Thus the rhetoric is that of a society that is disintegrating as a consequence of the diversity of family forms and decay of the traditional nuclear family which was both unit of social cohesion and most capable of fulfilling its obligations for child rearing and care of the vulnerable. This is a discourse of family ‘breakdown’ and consequent ‘atomisation’, i.e. moral degradation, over-reliance on the state and social disintegration requiring a return to ‘traditional family values’ of responsibility and obligation (Gillies 2003). These families are identified as being faced with multiple disadvantages and are at the fringes of social exclusion and their circumstances are exacerbated by their own use of alcohol or drugs (referred to as a ‘self-abusive act’ in the evidence provided in Stage One by the Deputy Minister) and/or as a consequence of mental illness. Whilst Parts 1 and 2 of the proposed Measure deal with structural inequalities and disadvantage as a consequence of child poverty the foci of IFST intervention is on ‘family values’ and parental behaviour change in order to promote family cohesion and parental obligations to adequately meet their child’s needs within the family environment with minimal state intervention. The construct of family as presented in Welsh policy thus seems to uphold a traditional model of family ideology and minimal state interference in the private realm of the family, other than when families ‘fail’ in their responsibilities in relation to child welfare and the production of the next generation of citizens/parents.

The *Children and Families (Wales) Measure 2010* provides a definition of family for the purposes of local authority referrals to IFSTs as being:

- (a) a child in need (or looked after child), the parents of the child and, if the authority thinks it is appropriate, any other individual connected with the child or the parents;
- (b) individuals who are about to become the parents of a child in circumstances where subsection (8) applies and, if the local authority thinks it is appropriate, any other individual connected with the individuals who are about to become the parents of that child.

Children and Families (Wales) Measure 2010 Part 3 Section 58(7)

Thus whilst endorsing and seeking to affirm traditional family values WG also acknowledges the diversity of family forms and structures. The inclusion of ‘any other individual connected with the child or the parents’ facilitates local authorities, i.e.

practitioners acting with delegated authority, to consider ‘family’ as relatively unboundaried and inclusive and provides a great deal of latitude for professionals in constructing family. This also provides scope for family membership to be co-constructed between practitioners and the child and/or the parents. Within such a construction of ‘family’ there is sufficient latitude to encompass fluidity of form and for family composition to be self-determined, i.e. to be ‘families of choice’ (Pahl and Spencer 2004). There is no definition given regarding the nature or type of connection between the adult/parent, or child – biological, social, legal or other, such as regular care of the child or quality of the relationship between adult and child.

It is notable that ‘family’ is identified as such both pre and post-natally. This further affirms the suggestion that this is intended to be preventative early intervention refocusing on safeguarding rather than child protection following an incident. It also affirms a supposition that certain parents are deemed as less likely to meet their parental obligations even before the birth of their child or of having had any opportunity to parent.

The integration of services and higher skill levels of the professionals within those teams brought about by IFSTs are considered as ‘engines for change’ and ‘that this can only result in better outcomes for children and their families.’ Whilst there is some reference to ‘*parents*’ there is no use of the terms ‘mother’ or ‘father’ and gender is not acknowledged either in this statement, nor in the proposed legislation to which it refers. There is very little consideration given to gender within these proposals and the differing impact such proposals might have on mothers and fathers: the focus that is given to rights and equality is in terms of the child’s rights and child poverty.

Part 3 of the Measure requires local authorities to establish Integrated Family Support Teams (IFSTs). The intention is that these teams will provide services to families where there are children in need or ‘looked after’. A local authority will be able to refer a family to an Integrated Family Support Team if it reasonably believes or suspects that a parent of a child in that family, or a prospective parent, is dependent on alcohol or drugs or is a victim of domestic violence or abusive behaviour, or has a mental disorder. The teams are intended to bring social workers, family workers, substance misuse professionals, nurses and health visitors together to

work with families. The practitioners' role is to deliver evidence-based interventions direct to families where children are at risk of developing long term difficulties or experiencing '*significant discontinuity*' in their upbringing that may result in the child entering care.

From the outset, and re-iterated within the *Stronger Families* policy document is that:

There is a broad agreement that as far as is consistent with their welfare, children should be supported to remain with their families.

(Welsh Assembly Government 2008, p. 3)

Families are thus constructed as the best place for the care of children and indeed that a primary function of families is the care of children. Thus family preservation, as an ideology, is to the fore. No evidence is provided for this and it is presented as a self-evident truth. Article 7 of the Rights of the Child (UNRC) and the Children Act 1989 are cited as 'traditionally' reflecting the importance of families as the assumed natural location for rearing children. The use of the UNRC and UK legislation firmly locates this as a child's legal right and evidences an ethic of justice approach of universality as the right to 'know and be cared for' by ones parent.

This policy responds to concerns that services are not sufficiently meeting the needs of some children whose families have complex problems such as substance misuse and/or mental health problems or mental illness, learning disabilities and domestic abuse.

(Welsh Assembly Government 2008, p. 3)

Where this concern emanates from, or in what way services are failing these families is not identified:

For these families there is an increased likelihood that the child's physical, social and emotional development will be impaired and for some children there will be repeated or long term episodes of being looked after by the Local authority.

(Welsh Assembly Government 2008, p. 3)

Whilst it is suggested that there is an increased likelihood and therefore greater risks factors within these families the evidence to support this assertion is not presented within this document. However,

the children of parents with substance misuse problems are identified as a priority group with specific needs that would benefit from targeted intervention by both children's and adult's services.

(Welsh Assembly Government 2008, p. 6)

Thus the concern is that services do not meet the needs of these families to care for their children resulting in the children being received into looked after services and that in order to strengthen families services need to be improved as does the knowledge and skills of practitioners, particularly those of social workers.

The families that are the focus of this service are presented as posing risks to positive outcomes for their children, and in effect, are failing to care for their children adequately. This characterises these families within a deficit model. Whilst the prevalence of alcohol and drug usage is indicated and deemed the initial priority for targeted intervention by IFSTs this is not discussed in relation to the prevalence and impact of other parental problems and any cumulative effects. The risks as presented seem to be as much from the discontinuity in care and recurrent reception into looked after services as that of any presenting risks from parental behaviours.

The use of the term parent is conflated with that of family. The gendered nature of parenting practices is not acknowledged and only the gender neutral term 'parent' is used with no distinction in relation to any differing needs of mothers or fathers. The only reference made to gendered parenting is in relation to the 'more problematic drinking and drug taking by mothers' being 'identified as a key factor in the increase in numbers of children subject to care proceedings since the inception of the Children Act' (Welsh Assembly Government 2008) perpetuating the mother blaming discourse evident in much family policy and practice, as noted in chapter 3, section 4.

The configuration of families or presenting risk factors as cumulative is not discussed. The family is considered to be a 'unit' in need of strengthening, thus implying that

families, or certainly the families that are the target of this intervention, are either weak or not strong enough to successfully carry out their obligations in relation to child rearing. These families are variously described as ‘vulnerable’, ‘complex’, or as having ‘complex needs’ and that what is required is a ‘step change’ via the introduction of legislation to require the various agencies and professionals to improve the outcomes for the children in these families. The suggestion being that strengthening the legal framework to reconfigure and refocus services and the professionals that deliver them will in turn strengthen these families:

This consultation identifies the need for a step change in the resources, workforce and skills needed to respond effectively to children who are at risk of long term difficulties and separation from the family. The emphasis is to reconfigure services to deliver person-centred services for the whole family which will enable children to remain safely with their families, where it is in their best interests to do so.

(Welsh Assembly Government 2008, p. 4)

The philosophy reflects the refocusing agenda of futures thinking and longer term outcomes of safeguarding rather than immediate risks of child protection, and yet again reinforces the ideology that family is the best place for children with separation from parents being considered a presenting risk rather than a positive option. There seems an inherent contradiction in both stating that services should be person-centred and for the whole family. The goal of intervention seems clearly to be to safely maintain children within their families with little discussion regarding the interrelatedness or interdependency within caring relationships. Keeping families together appears to be the paramount concern combined with a drive to reduce the numbers of children who are looked after at great expense to the state and which results in relatively poor outcomes for the child. Further, that the family is the right and proper site for the care of individuals ‘across the life course’ (p4).

Whilst there is some reference regarding the impact differing family members’ use of substances can have on other family members the central focus is clearly the impact of parental substance misuse on children. There is some reference to a relational ontology in terms of building resilience through effective support for individuals, families and

communities. The role of the state seems to be to provide legislation to ensure that services keep families together in order to improve child outcomes and prevent costly reliance on state care and reception into looked after services. Throughout the document it is constantly re-iterated that these are the ‘most vulnerable families in Wales’. There is a recognition that the needs of the child, and their parents or carers, are interrelated and that rather than assessments being undertaken on individuals that the assessment process should be integrated, holistic and provide an overview of the whole family in terms of their strengths, risks, needs and relationships.

Too often families experience un-coordinated services which do not work effectively together in the best interest of the child and his/her family.

(Welsh Assembly Government 2008, p. 11)

Thus it is services that are portrayed as failing to meet the needs of the child and their family and that ‘practitioners are not making good use of the range of assessment and intervention tools which have been developed’ (p11) that this targeted legislation is aimed at addressing. The picture portrayed is that of families failing to meet the needs of their children and of services and practitioners failing these families.

5.6. Conclusion

The problem as defined in policy is the ever increasing numbers of children in Wales being received into looked after care and the concomitant cost to the public purse. Further, that the majority of these children come from a relatively small minority of families with complex needs that are interrelated and cumulative, such as parental substance misuse and/or mental health and/or learning disabilities and/or domestic violence. Further, that these interrelated issues are a consequence of inter-generational cycles of deprivation, social exclusion, poverty and abuse.

Both services and the professionals providing services are presented as ‘failing’ to engage successfully with these families despite them being well known to social services. The policy solution is a cultural transformation of service provision and professional practice through the introduction of IFSTs. The policy intention of IFSTs is

to act as a catalyst or '*step change*' in the use of EBIs in professional practice and in the integration of services.

Both UK and Welsh governments locate the use of a whole family approach within a social exclusion framework, however, there is less explicit emphasis on 'social capital' as a construct within Welsh policy than is evident in UK policy. Welsh policy and legislation does echo UK family policy and legislation in foregrounding family preservation, and presenting a construction of 'family' as being the ideal context for childrearing whilst simultaneously identifying some families as failing in this endeavour. Within Welsh legislation and policy there is an ostensibly sympathetic construction of these families that focuses on vulnerability and complex needs rather than on anti-social behaviour. The construction of family is one in which these families with '*complex needs*' are failing to adequately parent and provide for their children, and that the state therefore is morally obligated to intervene in order to safeguard the children within these families. The legislative construction of family acknowledges the diversity of family forms and emphasizes 'connection' as the signifier of family membership. In addition to the parent and child as constituting the family the definition is broadened to encompass individuals with a 'connection' to the parent or the child. This addition facilitates a degree of latitude in judgement on behalf of the local authority to co-construct with families themselves family composition as relatively fluid and unboundaried. However, the parent and child dyad is presented as being at the core of the construction of family with other extended family members being 'invited in' to the family by dint of their 'connection' with either parents or child(ren).

Parents are defined as those having a legal parental responsibility. The construction of parenting is pathologised as one in which individual failings of substance misuse, and/or domestic violence, and/or a history of abusive behaviour, and/or mental health problems are deemed to be adversely impacting on family functioning in the rearing of children. Services and the professionals within those services are deemed to have also failed – both in terms of engaging these families and in safeguarding the children within them, resulting in an increased admission of children into looked after care. Thus a deficit model is presented, both of families themselves and the services that are intended to support them.

It is stated that assessment and intervention should be child-focused: aimed at protection and promoting positive child welfare outcomes, however, there is little attention given to the child's agency and strengths. Rather the portrayal is that of 'vulnerable' children at risk within 'fragile' families that are unable to neither meet their needs nor break free from a cycle of disadvantage that may have been transmitted inter-generationally for several generations so as to become entrenched. Further to this, the services and professionals tasked with supporting these families are perceived to be failing, hence the need for new legislative powers to **require** localities to reconfigure services and to work in partnership in order to ensure that local implementation follows national directives. A career framework and approved list of evidence-based approaches are also proposed to improve the quality of practice.

Several themes are apparent within these documents. There is evident a technical, rationalist empiricist approach to epistemology that emphasizes scientific remedies to social problems and the use of evidence-based approaches to service delivery and to practice. There is also an ideological view of the family as the 'correct' and 'natural' home for child rearing. There is also a gender neutral use of language in terms of 'parents', with no acknowledgement of any gender differentiation in either parenting practices, or needs. Similarly, there is a conflation of terms such as 'parent', and at some points 'carers', with 'family'. There are several areas that are given very limited consideration: the structural inequalities of gender and class as they impact on these families; the structure, or composition, of these families, e.g. the proportion of lone mother headed households; and the inter-play and cumulative nature of risk factors in relation to social exclusion. Instead the target families are determined on the basis of parental risk behaviours such as substance misuse. This identification may compound effects of stigma and disenfranchisement experienced by such families. The broad construction of these families as presented within these policy and legislative documents is as weak, needy, or failing, and characterized as 'fragile', 'vulnerable' and having 'complex needs' with limited discussion of strengths and the ability to build resilience and social capital within these families.

There are also some tensions and contradictions apparent. Whilst the WG has a self-professed rights based policy agenda and stresses the rights and participation of children

and young people this seems noticeable by its absence within this document with its stress on the dependence and vulnerability of the children and young people concerned. Similarly, whilst containing a strong ideological view of the family as the best place for children and the avoidance of reception into care, the document also presents these particular families as failing their children and as a source of risk and vulnerability.

In revisiting this policy and legislation through an ethic of care lens greater emphasis would be placed on strengths and positive inter-dependencies between family members, on gender within the family and the lived experience, and a participative voice for these families within the development, management and evaluation of this new service and legislative framework.

Having considered the Welsh enactment of a whole family approach ideology in policy and legislation the next chapter will explore the model of IFST practice as espoused in the *Statutory Guidance and Regulations (Welsh Assembly Government's Departments of Social Justice and Local Government et al. 2010b)* and *Practice Manual* (Emlyn-Jones and Bremble 2010) and its embodiment in practice as described in practitioner interviews.

6. Chapter Six – The IFST Model of Practice

6.1. Introduction

The practice model as presented within this chapter is derived from analysis of policy and legislative documentation, operational and other service documentation and IFST practitioner interview data alongside data drawn from the case file analysis and memos from fieldwork. As noted in chapter 4, section 4, there are limitations on the extent to which findings in relation to the IFST model of practice are generalisable, given that the data were obtained from one single instance of an IFST. The model of practice discussed within this chapter, and the illustrative diagrams used to support that discussion, have been constructed by the researcher and are not officially sanctioned descriptions of the model of practice as espoused in, for instance, the practice manual or similar single sources. Therefore, the articulations of the practice model within this chapter are my analytical interpretations based on the data collected.

In addition, this chapter compares and contrasts the articulation provided within the IFST documentation, such as *Statutory Guidance* (Welsh Assembly Government's Departments of Social Justice and Local Government et al. 2010b) and the *Practice Manual* (Emlyn-Jones and Bremble 2010), with the model as applied in practice as articulated by practitioners in interviews. The codification of the practice model within documents such as the *Practice Manual* appears to present the model as a uni-directional, linear series of procedures or tasks, whereas the practice model as articulated by practitioners in interviews appears more fluid, dynamic, multi-layered and multi-directional. This reflects the use of professional discretion and judgement making in integrating and transposing policy into practice when working with the actuality of presenting needs. The penultimate section of this chapter, section 6.4, uses case file analysis to examine the degree of alignment between policy intentions and practice goals.

The *Integrated Family Support Teams (Composition of Teams and Board Functions) (Wales) Regulations 2010* (Social Care Wales National Health Service Wales Children and Young Persons Wales 2010) outlines the composition of IFSTs. Integrated Family Support Teams must comprise of a minimum of five workers with at least one social worker, one nurse and one health visitor. At least one member of the team must be a

Consultant Social Worker (CSW). Thus there is considerable scope for the size and composition of teams to vary between different local authorities. At the time of data collection the research location team comprised of an IFST Manager (CSW), four CSW's, one Health Visitor, one Community Psychiatric Nurse (CPN) and three workers seconded from the voluntary sector and probation.

6.2. The IFST Model of Practice

Within this section I will outline the procedural model of practice as codified within various documentation such as the *Statutory Guidance and Regulations* (Welsh Assembly Government's Departments of Social Justice and Local Government *et al.* 2010b) and *Practice Manual* (Emlyn-Jones and Bremble 2010), followed in section 6.3 by an articulation of the model derived from the practitioner interviews of the model as applied in their own practice.

The stated aim of the Integrated Family Support Teams (IFSTs) is to provide a 'whole family' response to families with complex needs, through a multi-agency team of practitioners, utilising evidence-based interventions (Welsh Assembly Government 2008). The intended outcome is to retain children safely within their families for as long as possible and prevent or minimise entry into looked after care provision. Thus, the overriding aim of Integrated Family Support Services (IFSS) is 'family preservation', i.e. that wherever possible child(ren) are maintained within their family.

In order for a referral to be accepted all of the following referral criteria must be met:

- One or both parents/carers have a dependence upon drugs or alcohol as a result of their substance misuse;
- Children are in need in of protection, at risk of losing accommodation or are Looked After Children who cannot return home;
- There is an expectant mother where one, or both, parents has a substance misuse problem that is likely to give rise to the child being in need of protection;
- The family must be at a point of crisis; and that,
- The family know and agree to a referral being made.

Only childcare social workers can refer families to an IFST and the referring social worker retains case responsibility. If after the discussion the referral is considered appropriate, and the IFST has capacity, the team will pick up the referral and visit the family. As the IFST uses a crisis intervention model (Roberts 1990) and the service needs to be delivered at a critical time for the family IFSTs do not hold waiting lists. Where the referral is not accepted by the IFST consultancy and signposting to other services are offered instead. Within 72 hours of the referral being made, an assessment is written up by the IFST practitioner to ascertain whether the family are able to work with the IFST. If the work can progress a safety plan is drawn up and the assessment and plan will be shared with the family and the referrer.

One IFST practitioner is allocated to each family (*'spearhead worker'*) and applies the IFST model as the therapeutic intervention. This trans-disciplinary model of practice is in addition to the multi-disciplinary working in which several different professionals may contribute their expertise in supporting the service user/family via the spearhead worker. In the trans-disciplinary model the expectation is that there is a level of inter-professional learning and cross-germination of knowledge, skills and values amongst team members but the family has only one point of contact, one key relationship.

In addition to the policy-prescribed referral criteria, the key judgement made by IFST practitioners in accepting a referral is determining whether the family are in crisis. Crisis intervention theory (Roberts 1990) suggests that at points of crisis an opportunity opens for change, in that there is a perception that things cannot continue as they have been and that things must change in order to change the direction of travel and outcomes that the current behaviours will lead to. The heightened risk of a child being placed onto the child protection register, or into local authority care, could inherently be perceived as a cause for crisis within families. However, for a family that has had frequent involvement with social services and similar recurrent experiences of risk of entry onto the child protection register, or entry into care, this can become normalised as routine (if unwanted) intrusion into family life. Thus, practitioners both in the field notes for this research and the *Interim Evaluation Report* (SQW 2012) stress that it is the family's perception of whether they are in crisis that is pivotal in this being an opportune time for change and acceptance of the referral.

In order for a family to meet the eligibility criteria for IFST involvement there must be a co-existence of parental substance misuse and child welfare concerns, however, the majority of families also have other co-existing and interrelated issues such as poverty, debt, homelessness, learning disability, mental health issues, and domestic violence. These issues are chronic and interrelated, so whilst the current eligibility criteria focus is on parental substance misuse as impacting on parenting capacity, there is evidently potential for these interrelated issues to have a cumulative detrimental impact on parenting capacity and also to be chronic, on-going and intergenerational. What distinguishes families accepted by IFST from those declined is the presence of the family 'perceiving themselves' to be in crisis (Emlyn-Jones and Bremble 2010).

Whilst professionals may perceive the family to have reached a crisis point, if the families themselves do not perceive themselves to be in crisis then there is no dissonance between current behaviours and desired behaviours in order to facilitate change. In short, if the family themselves do not perceive a crisis and the need for change then the context is not one in which behaviour is considered as being amenable to change. For example, children may be considered as being in a revolving door in which they recurrently enter and exit public care and that this is a 'normal' part of family life for these families, rather than a crisis requiring change in how the family functions. However, for some other families just the threat of having the child's name placed on the child protection register may generate a feeling of crisis and the desired motivation to change. Thus 'crisis' is a subjective, relative concept and has to be individually assessed within the specific familial context rather than one that can be codified in a practice manual, or determined by a set threshold, or eligibility criteria. It is the knowledge and skill of the individual practitioner which informs this judgement. This judgement forms part of the tacit or unwritten, but essential, part of the assessment process.

The trigger for referral is thus crisis orientated and is also therefore frequently incident driven. Much of social work practice in statutory child protection practice has been shown to be incident driven as evidenced in the preceding literature review (chapters 2 and 3) and hence intervention in relation to the identification of neglect which can often be on-going and chronic, and whose effects are often only more evident in the longer term can be challenging (Cawson *et al.* 2000). From analysing the case files referrals to

the IFST site that is the focus of this case study referrals are frequently triggered following an incident. However, what is notable about the use of crisis theory within the IFST practice model is that this 'incident' can either be an act of commission, i.e. something done or happening within the family, such as a child found wandering unattended or witnessing domestic violence; or an act of omission, in that 'normal' family life for that family has continued and it is this very perception of lack of change, or complacency, and/or non-compliance, and/or non-engagement that has motivated professionals to escalate proceedings. The case files suggest that this can be confusing to parents who do not understand why there should be an escalation when nothing has changed in the family circumstances or family functioning, whereas for practitioners it is this very absence of change that escalates the anxieties and concerns of risk, particularly in relation to on-going neglect. It is this escalation in professionals' perception of risk that can serve to act as a crisis for the family which creates a 'tipping point' and motivator for change. Thus, it is professionals' perception of increased risk, rather than necessarily any actual increase in risk, or change within the family circumstances, or family functioning, that can trigger a crisis for the family.

A safety plan is put in place within 72 hours of the referral being accepted in order to maintain the child(ren) safely in the current situation. Within the interviews practitioners presented this as providing some stability and reassurance, both for the family and also for the referring childcare social worker, which thereby creates a safe space in which to begin therapeutic work. The IFST practitioner works with only one family at a time, and is available to that family 24 hours a day, seven days a week.

The diagram below (Figure 6.1) has been constructed by the researcher from the *Practice Manual* (Emlyn-Jones and Bremble 2010) and field notes. The diagram below outlines the procedures followed from referral to exit. The diagram also incorporates the tools that can be used at each stage.

Figure 6-1 IFST Procedural Timeline constructed by the researcher from the IFST practice manual (Emlyn-Jones and Bremble 2010)

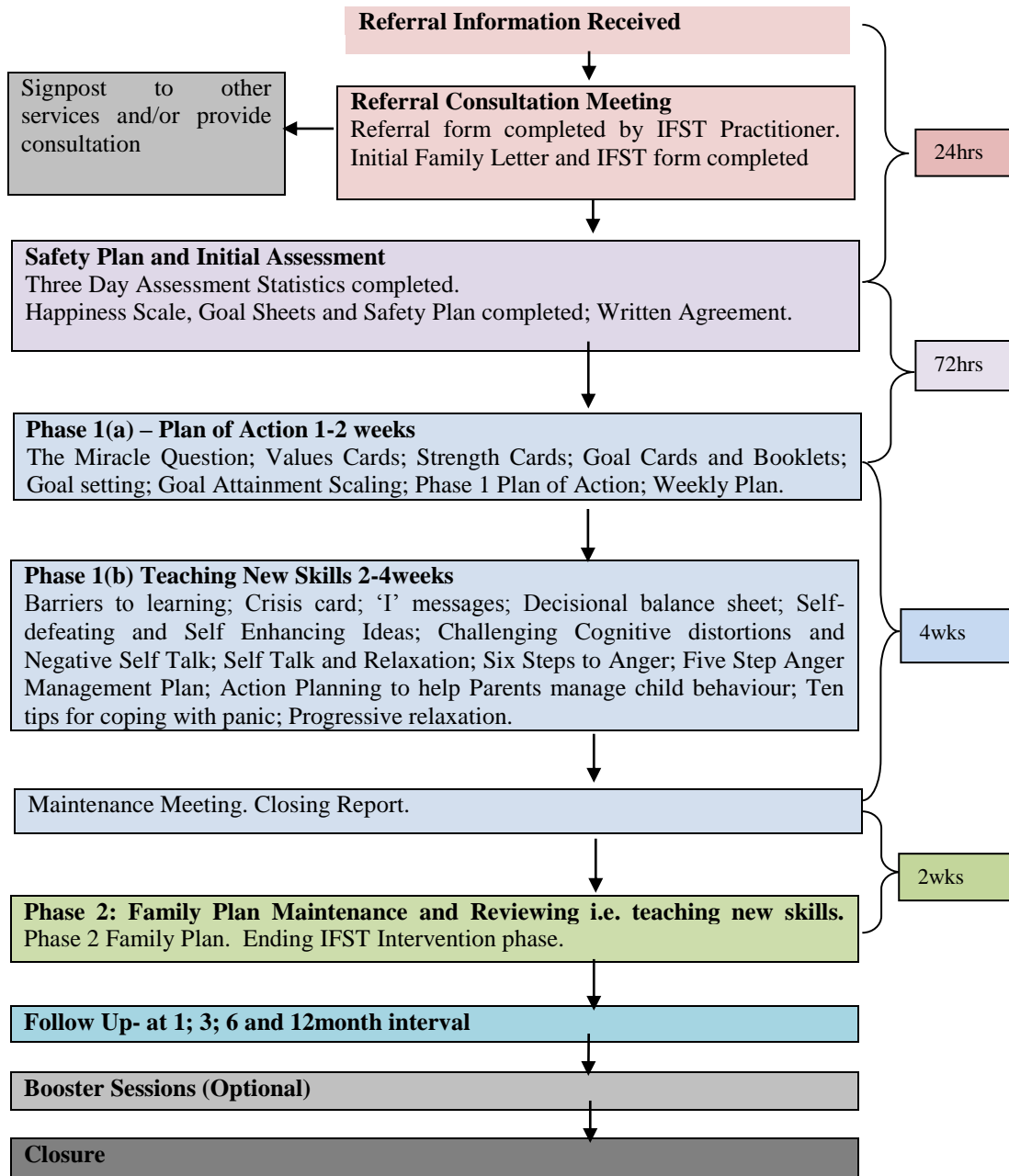


Figure 6.1 was devised by the researcher to summarise and illustrate the description provided in the *Practice Manual* of the IFST model (Emlyn-Jones and Bremble 2010). The description provided in the *Practice Manual* suggests a straightforward linear series of tasks and activities undertaken by practitioners with family members that need only be repeated with each family member individually or collectively. From the description in the practice manual it appears as though the spearhead worker need only follow the procedure as outlined in the flowchart in Figure 6.1 in order to generate the intended outcomes of the intervention. As a codified articulation of the practice process it is, perhaps necessarily, somewhat simplistic and reductionist and lacking in the rich detail of the process as embodied in practice. The interviews with practitioners suggest that practitioners need to use a great deal of skill and judgement in order to determine which tools to use with which family member at any given point in the process, this decision has to be weighed up against where each of the other family members are within their own cycle of behavioural change. This judgement making is dependent on the practitioner's assessment of the individual's own needs and strengths alongside the nature of the interrelationships between family members and what effect individual change is having on the family system as a whole. As such, the practice process moves recursively from individual to whole system and back in on itself again. Individual change impacts on the whole system, and whole system change impacts on the individual. This dynamism and fluidity would seem to be the essence of re-focussing from individuals to interrelationships between individuals, i.e. a re-focussing from subject (individual) to process (relational inter-subjectivities). Further, that the ability to assess, 'hold' and respond to this fluidity and constant flux is an essential skill for practitioners in working within a whole family approach.

The researcher devised Figure 6.2 in order to illustrate this same linear, procedural process in a cyclical diagrammatic form that would serve as the basis of a more detailed diagram incorporating the additional layers of theory and approaches that are integrated within the model in practice. The subsequent Figure 6.3 has the additional layers of theory and approaches integrated into the model as they were described by practitioners within interviews. The increased level of sophistication of the model in its practical application becomes apparent when these additional layers of models, theories and approaches are added. The complexity of the therapeutic work being undertaken becomes even more apparent when it is understood that this model is applied in relation

to each family member and that where each family member is located in their own process of change has to be considered in relation to every other member of the family and their own process of change, in order to consider the impact of change in relation to each member on the family system as a whole. This will be examined further in chapter 7 which will focus specifically on the whole family approach aspect of the IFST model rather than the IFST model of practice in its entirety.

6.3. The Therapeutic Practice Process as articulated by IFST Practitioners

The IFST model of practice is a psycho-social intervention aimed at family preservation through the strengthening of the interrelationships between family members. As is notable in Figure 6.3 the model of practice is multi-layered and integrates a number of approaches, theories and skills:

- Crisis theory in that the family should perceive themselves to be in crisis at the point of referral, thus providing a window of 6-12 weeks where the opportunity for change is more likely.
- Brief solution-focussed therapy.
- Cycle of Change.
- Cognitive-Behavioural Therapy.
- Systems Theory.
- Motivational Interviewing.
- Strengths based Approach.
- Social Behavioural Network Therapy.
- Whole Family Approach.

It is the practitioners' expertise and judgement that enables them to decide who should be involved in the intervention as part of the family, where each family member is in relation to the cycle of change and how that relates to, and impacts on, where other members are in the cycle of change. Thus, whilst procedurally the process appears linear (see procedural timeline above, Figure 6.1) and amenable to a procedural checklist, in reality the practitioners' use of values, skills and knowledge is highly sophisticated. Indeed, the procedural checklist devised for this particular IFST team tended to focus on tasks and administrative bureaucracy rather than the therapeutic activity which is the focus of the *Practice Manual* (Emlyn-Jones and Bremble 2010). It

is this therapeutic activity that is the professional aspect to the work. The complexity and therapeutic nature of the work is acknowledged in the rigour of supervision required.

The complex nature of the IFST work requires high quality supervision of its staff. Each IFS Board will ensure the provision of high quality supervision through a supervision policy. Examples of supervision within the context of IFST may include one-to-one supervision through line managers; peer supervision through peers assigned to support one another and provide reflective practice and peer-led or facilitated group supervision.

(Welsh Assembly Government's Departments of Social Justice and Local Government *et al.* 2010b, p. 12)

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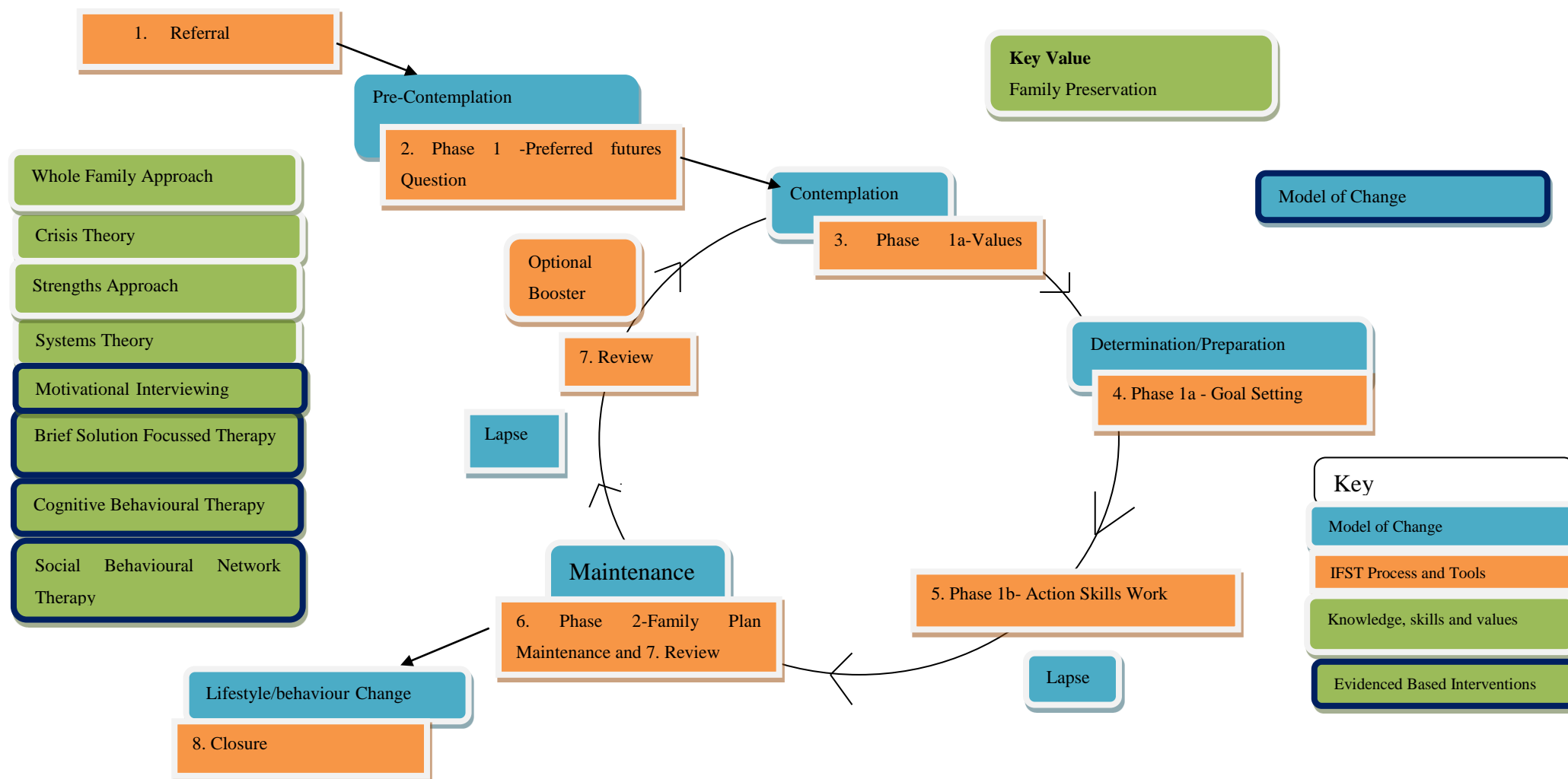
graph TD
    1[1. Referral] --> 2[2. Phase 1 -Preferred futures Question]
    2 --> 3[3. Phase 1a-Values]
    3 --> 4[4. Phase 1a - Goal Setting]
    4 --> 5[5. Phase 1b- Action Skills Work]
    5 --> 6[6. Phase 2 - Family Plan Maintenance, and 7. Review]
    6 --> 8[8. Closure]
    6 --> 7[7. Review]
    7 --> 3
    7 --> 7b[Optional Booster]
    7b --> 3
    
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The flowchart illustrates the IFST process, which consists of the following steps:

1. Referral
2. Phase 1 -Preferred futures Question
3. Phase 1a-Values
4. Phase 1a - Goal Setting
5. Phase 1b- Action Skills Work
6. Phase 2 - Family Plan Maintenance, and 7. Review
7. Review (Optional Booster)
8. Closure

The process flows from step 1 to step 2, then to step 3, and continues through steps 4, 5, and 6. From step 6, the process can either proceed to step 8 (Closure) or loop back to step 7 (Review). From step 7, the process can either loop back to step 3 or proceed to an Optional Booster, which then loops back to step 3. A key indicates that the orange boxes represent the IFST Process and Tools.

Figure 6-3 IFST Practice Model in Practice i.e. with models, theories and approaches embedded within it.



Within the research site a multi-layered approach to supervision was being developed. This comprised of daily reflection on practice with a paired buddy, 'pods' of three or four workers held on a weekly basis led by consultant social workers and formal managerial supervision with the team manager to focus on administrative and procedural tasks, held on a less frequent bi-monthly basis. The main purpose of the buddies and the pods as articulated by practitioners was to provide a 'reflective space' in which to share the challenges and complexities of the work being undertaken with the family and to prevent 'drift', i.e. to stay on track with the goals and intended outcomes, and the use of the model in achieving that:

Then we'll have the pods which is, say it's, it's like a mini reflective space but it's kind of a checkpoint, really, just to keep us all..... stop, stop any drift, you know,..... to keep us on track with, with our cases. I mean it is...it is a reflective space because it gives us the opportunity to think, you know. I mean, for my pod, I've set up like a little, not questionnaire...like a little crib sheet, really, you know, of the key questions of people...so my pods have a copy of that so they're also thinking about that to bring to their pods as well. So it keeps that you know, reflection going all the time. And then we've got the buddy system as well which is daily.

(Female Practitioner 1)

Most of the practitioners acknowledged the emotional labour involved in the nature of intensive working and the importance of frequent and regular supervision to prevent emotional burn out, or clinical fatigue, and in order to avoid 'immersion' or collusion with the family. Whilst working with one family may seem somewhat of a luxury when this is coupled with 24/7 availability this focus on one family can become intense.

I thought, "One case." And everybody goes, "One family? Wow! That's amazing!" You know, when I thought, "Oh, lovely! One family, wow!" But it's, like, all or nothing. And you just got to be conscious all the time what are they saying, re-interpreting that and reflect that back and not telling them what to do. So, there are lots of things going on in your head. It's quite exhausting, actually, keeping it up as well, you know. So, I don't do the eight hour stints anymore. That lesson I learned the hard way.

I can't do that physically, emotionally, and energy-wise. You're just left with nothing, then.

(Female Practitioner 3)

Practitioners thought this feeling of intensity, exhaustion and immersion could also be felt by the families themselves, who did not necessarily want a professional in their home for lengthy periods.

During the intensive phase of the intervention Brief Solution Focussed Therapy (BFST) is used in the form of the 'miracle question' (de Shazer *et al.* 2007) in order for the family member to identify for themselves how they would like things to change and the goals/outcomes they would like to achieve. This also introduces the cycle of change (Prochaska and DiClemente 1983). The miracle question invites the family member to open up possibilities about how they would like things to be different by asking them to visualise, in as much detail and clarity as they can, what life would be like if they woke up the following morning and a miracle had happened overnight and their life was exactly how they would want it to be. This can elicit a pre-contemplation stage to change as alternative possibilities begin to open up.

The use of values cards with the family member then enables the individual to identify their own values and the extent to which in their behaviour they are living to their own values. This can generate a 'grit of discomfort' that motivates the individual to bring their behaviour in alignment with their beliefs and values (contemplation stage) (Prochaska and DiClemente 1983). Strengths can also be explored, and strengths cards can be used as a tool to facilitate this discussion. The use of tools, such as cards, can enable conversation in a less direct, and therefore, less confrontational way. At this point it may be possible for the individual to determine for her/himself a series of goals to achieve that create alignment between values and behaviours (determination/preparation). An educative function is apparent in the teaching of new skills and actions to bring about the changes sought and achieve the goals identified. Goal Attainment Scaling (GAS) is used to monitor and evaluate the progress towards goals and provides a tangible sense of achievement to generate further motivation to continue on the path of change.

During Phase 2 a family plan is devised in order to sustain and maintain change in the longer term. The intensive involvement of the practitioner ends. For the purposes of this research the focus is on Phase 1 as this is the intensive phase of the model and the period during which the thrust of the therapeutic work that encompasses the whole family approach is undertaken.

Phase 1 (4-6 weeks) is considered the intensive period of working. This ‘intensity’ relates to the amount of time relative to the intensity of working, i.e. that whilst 4-6 weeks is a relatively short period of time, within that period the practitioner may spend a substantial amount of time working with the family in the family home. Guidelines recommend a family receives between 16 and 20 hours of contact time a week during the 4-6 week intensive phase, which equates to between 64 and 120 hours. SQW⁶ (2012) found that in 5% of cases this phase was less than 4 weeks; 54% were 4-6 weeks; 35% were 6-10 weeks; and 5% were more than five weeks. These periods are still relatively brief, particularly when compared with the enduring nature of the complex family issues that the intervention seeks to address. SQW found that only 5% of families received less than 16 hours of contact during this phase and 10% 16-30 hours which highlights the intensity of working within relatively short timeframes. The emotional labour and intensity of the relationship between the practitioner and the family is well illustrated by the following extract.

So, whereas we are just...can be just there, that we are “it” for the family, we are their resource, we are the person they cry with, and we are everything to them.

(Female Practitioner 4)

The practitioner interviews suggest that the cumulative effect of time, intensity and presence within the family home also impacts on the relationship between the practitioner and the family. The practitioner becomes both immersed in the family (outside/insider) and as a professional observing (outsider/inside). There are tensions apparent in balancing insider/outsider perspectives in relation to objectivity, and also,

⁶ SQW with Ipsos MORI and Prof. Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick were appointed to undertake the evaluation of the Integrated Family Support Service (IFSS) model in August 2010. This report contains findings about the setting up and early stages of the IFSS model covering the period up to September 2011.

between observation and surveillance. Whereas traditional casework would largely leave the practitioner reliant on verbal accounts, and thereby individual perceptions of the dynamics within the family, the IFST practitioner is enabled to observe directly the nature of family dynamics and the family as the unit of analysis, rather than individual perceptions/accounts by family members. The differing standpoints and relationship dynamics between the traditional casework approach and that within the IFST practice model is neatly contrasted by the following IFST practitioner interview extract:

I was taking the time to listen, to develop a relationship, with a relationship where they can feel they're going to open up and talk. And then, you're obviously seeing the dynamic much more clearly up close than somebody who visits once a week. Because we're working often for two to three, maybe longer, hours a day with our initial four-week period. They may...I suppose in the first few days, they may sort of make their place tidy and you'll see that...but by the time you've established that sense of rapport and relationship then everything seems to go on all around you. You get to see the dynamics around you, the boundary setting the kids, the relationships, you know, the attachment of the adults to their children, what their own personal relationships are like, you see all that stuff and they become very open to talking about that.

(Male practitioner 2)

The importance of working within the family home and the difference this makes to the dynamic of the relationship between practitioner and worker is also apparent in the following extract, as is the contrast between therapeutic work in a clinical setting and therapeutic work undertaken in the families' own home environment:

I think it's because it's more realistic setting, isn't it? I think if, you know, other family therapies are you go to an office, you can take yourself out of that situation and you, are almost like in an interview, in a structured environment. Whereas, when I meet in a family home, you're watching it all go on, all the interactions. I mean, I got a view that you never really know what's going on fully in a family because you're not going to be

there to 24/7 but this model lends itself to know the best that a professional will probably ever know without moving in.

(Female Practitioner 2)

Thus it becomes apparent that the intensive nature of the intervention is a consequence of a cumulative effect of a number of factors: that the intervention occurs in the natural setting of the home environment, the frequency and length of individual visits within a short space of time (4-6weeks), the focus on time bounded goal setting and the intensity of emotions and emotional labour undertaken. The practitioner interviews suggest that emotionality is heightened by the crisis point which was the basis for the referral. The IFST practitioners noted in the interviews that families are aware that change is necessary if their children are not going to be taken into care and this in itself exerts pressure and intensity on the situation.

Yeah, and it's really much easier to develop discrepancies then because people are not, you know, if you've got a whole family in the room, they can't lie. Whereas if they're coming out of their family home, they can tell you what they like really. And in an hour in an interview in an office they could say this is going on. And you've got no evidence to suggest otherwise. If a family member hears something that is not right, they can challenge that and that makes my job so much easier because I don't need to challenge anything really. That's not my role. The family can challenge each other.

(Female Practitioner 2)

For practitioners working with only one family they can become '*immersed*' within that family and have to balance the tension between close relationship and becoming enmeshed, or colluding within the family dynamic, i.e. needing to balance empathy with emotional distance:

The biggest thing about this role is – and the hardest thing, I would say – is that...the biggest thing is, it's because you're there so much, you become immersed in it, you know. But you cannot **not** be, because you're spending so long with people.

(Female Practitioner 4)

In the intensive phase the practitioner can spend several hours at a time within the family home with family life continuing around them. This is very different to the contained setting of a clinical environment where the social rules and power dynamics are very different. Whereas in a clinical or interview setting information is mediated through language and the teller, within the natural setting of the home environment the practitioner can observe and gain direct experience of personal relationships and family life. This more visceral, immediate and direct experience can have a powerful emotional impact on the practitioner. Both the potential for 'enmeshment' and the emotional impact of being in the family home and observing family life was identified by practitioners as a challenge in terms of keeping oneself (emotionally) 'safe' if the emotional impact was not to take a toll on one's well-being.

You hear a lot, and you observe a lot, and just emotionally....We talk about this, like, enmeshment and looking at keeping yourself safe.

(Female Practitioner 4)

IFST practitioners' practice is primarily located within the family environment of the home and this has a significant impact on who is engaged, and how.

Yeah, I think that add...adds a lot, to be honest, because you see people in their real environment. Whereas in the office it is a very clinical setting. People are either....I see a very big differences actually, when I see a family in the home and they can really explain and reflect on where they're at, and then, you know, the child protection needs, you know, something like that. And they just totally come over wrong, and they could go...or they really struggle with that formal setting. So in terms of when you have people in their own setting, they are relaxed; it's their home. I don't know, probably little bit more empowered really.

(Female Practitioner 4)

This is combined with the fact that IFST practitioners do not hold case responsibility, nor statutory powers and thereby there is less power imbalance between parents and

IFST practitioners when compared with statutory childcare social workers. All of the IFST practitioners placed stress on the importance of working within the family environment and the difference that made not only in making assessments of risk, but also in situating learning within a natural context where skills could be learnt and repeated over time. Female practitioner 1 considered working within the home environment as having a ‘massive’ impact:

Oh, massive. Because well, first of all, it’s their space so they could feel comfortable but also, it’s more real because they are acting their own lives in their own location, you know. So if you bring people out of that, you know, it’s not the same, as you know, none of us are the same out, outside as we are in our own home. So, but also, you know, part of the model is always looking for those sort of teachable moments and when they’re in their own home and they’re acting just as they would if I wasn’t there...
(Female Practitioner 1)

As the IFST practitioner is within the family home they can observe interactions and relationships rather than simply rely on individuals’ self-perceptions and personal narratives regarding behaviour and interrelationships. This also provides opportunities for ‘teachable moments’ in which new skills and behaviours can be applied in situ with the support of the worker to make those changes. Further, the presence of other family members means that they can interject and correct false self-perceptions, or false perceptions of others. In discussing his research findings in relation to home visiting and social work child protection practice Ferguson (2009) suggests:

We need to understand much more about how the body and mind of the practitioner moving into the lives and spaces of the other is affected by the visceral experience of doing social work, and how the senses and emotions impact on perception and workers and service users capacities to relate to one another.
(Ferguson 2009, p. 474)

In the practitioner interviews two themes were highlighted in relation to discussion of the practice model – *The Structure of the Model* and *Professionalism* in implementing

the model. Practitioners frequently spoke of the model as ‘a structure’ within which the work with families was framed, however, within the structure practitioners saw themselves as having a degree of autonomy and judgement making that relied on their professionalism.

I personally don't see it as ...you know, I pick up the manual and this is what I do, you know, it's not prescription. But it sort of gives you the foundation, again, really to then use your own personal experience and knowledge and stuff to build it up.

(Female Practitioner 1)

Practitioners considered the practice model as articulated in the *Practice Manual* as the framework, or structure, within which they operated, however, the practitioners felt they had discretion in making judgements regarding the timing and use of tools and even which tools to use and which can be disregarded depending on individual needs and circumstances.

All of the practitioners acknowledged the usefulness of the *Practice Manual*, training and reflection on the application of the model with specific families enabled by supervision. Similarly, all of the practitioners indicated that these were necessary but not sufficient, in implementing the model. Whilst the model provided structure it was not viewed as prescriptive by practitioners but rather as the vehicle for applying one's own personal and professional knowledge and experience.

I see it as an approach as opposed to a prescribed model.....we use like CBT and all that type of stuff. But I don't see, it as you have to use everything in its entirety.

(Female Practitioner 2)

As familiarity with the model through its application grows with the experience of its use so does practitioners' confidence in adapting and changing it to suit individual needs and circumstances. The extract below echoes similar comments made by most of the IFST practitioners.

It's changed now, because I've become more confident with using the model and about assessing which bits go where, and whether you need them or not.

(Female practitioner 3)

Some tension was expressed between model fidelity and application in specific situations and individual family needs.

So I think as a service, I think we were right to try and keep the purity of the model for as long as we could. However, there are families that don't fit the model and historically, we've all adapted what we're doing to be, you know, family or individually-focused and all the rest of it. And the model didn't allow for that. So we have added to the model and I think we were perhaps, overly cautious about adding to it, to me as long we didn't take anything away from the model. Because the family I've just worked with now that we've, we've binned the model pretty much.

(Male practitioner 2)

Thus the families' individual needs and the practitioners' assessment regarding the best fit between these presenting needs and the most effective intervention supersedes a dogmatic application of the IFST model as prescribed and described within the practice manual. Evans (2011) considers the discretion and autonomy of the practitioner to make such judgements as being the 'very hallmark of professionalism'.

6.4. The Alignment of Policy Intentions and Practice Goals

The way in which goals in the case files are framed initially at the referral stage tends to be in negative terms, i.e. that something needs to be stopped or reduced, e.g. drug taking, rather than as a positive desirable outcome to aim for, e.g. that X has more time, and is emotionally available to her children. This deficit approach to negatively framing goals has potential to undermine confidence and disempower parents as it emphasizes for the parents loss rather than achievement. For example, a reduction in substance misuse and thereby the social networks related to this activity can result in is a loss both from the pleasure gained from substance misuse and the associated friendships.

Reframing the goals positively, for instance, in terms of gaining closer family relationships and harmony incentivises the achievement of the goal. From the case file analysis it is possible to group the self-identified goals of families (parents) as recorded by practitioners around three key recurring themes: meeting basic needs, interrelationships between family members, and relationships with services and other professionals.

As previously noted in chapter 5, the IFST initiative is located within policy and legislation aimed at eradicating child poverty. This is frequently embodied in the practice goals in relation to debt, poverty and housing. Whilst a minority of service users are in employment, most are not, and the goals relating to employment are generally about aiming for employment readiness, rather than aimed at obtaining employment, i.e. prior to obtaining and maintaining employment greater emotional stability and resilience is needed within the family environment so as to make this a realistic goal. The impact of substance misuse can result in making the maintaining of tenancies problematic, make permanent accommodation precarious, and create a spartan living environment and mounting debt. Where accommodation is stable and adequate it is frequently noted that environments are not 'homely' suggesting that the physical environment has not been loved and cared for, and that the personality of its occupants is not evident. The cleanliness of the environment is not simply about hygiene but also symbolises love and care not just of the physical environment but of the family that occupies that environment.

Just as poverty is a priority in policy and echoed in practice, similarly the construction of family within the case files is one in which families are perceived to be self-sustaining resources for individual family members. However, what seems evident from the practice data, such as the case files and practitioner interviews, is that individuals cannot meet the needs of others unless their own needs are also met, and it is this multi-directional reciprocity of energy flow which is the source of sustainability. At the crux of the whole family approach as embodied within the IFST model is that all family members are both the givers and receivers of love, care and attention and thus an ethic of care would seem to be operating within familial bonds (Williams 2004).

A further recurrent theme within case files in relation to goals is one which could be broadly encapsulated as generating social capital via the relationship between parents and services, and also with the professionals providing those services, particularly within statutory child protection. Statutory childcare social workers are tasked with safeguarding children which entails the assessment of risk to the child. The families under scrutiny are aware that this assessment of risk could potentially result in the removal of their child(ren) from their care. Thus from the outset there is an adversarial conflict of interest which acts as a disincentive to parents being open and honest regarding their own needs and lifestyle and the potential risks these might pose to their children. From the childcare practitioner's perspective, as noted in the case files, a lack of open, honest information leaves practitioners feeling anxious and uncertain as to the validity and reliability of the risk assessment, and they are therefore more likely to be even more cautious in order to protect the child. This mutual mistrust potentially presents more of a risk to safeguarding children than other presenting risks, as it undermines the ability for building on strengths and collaborative partnership working between parents and service providers which are the essence of generating social capital.

The word 'addressed' is frequently used within global goals at the referral stage which suggests that some acknowledgement is sought on the parent(s)' part that there are difficulties and issues in the family for which the parent(s) is responsible and that they are motivated to change these issues - not necessarily that they achieve change but that they are, at the very least, striving for change. Similarly, there is often evident a concern regarding a lack of honesty on the part of parent(s). However, in the context of child protection concerns it is understandable that parents would not feel safe to share the extent of problems and issues, e.g. extent of substance misuse, with statutory childcare social workers. This perceived lack of reliable, accurate, 'honest and open' information leaves statutory childcare social workers anxious regarding the extent of risk, and how safe the risk assessments they are making are.

The perceived lack of parental honesty, and/or parental understanding of presenting risks can potentially create a gridlock in which both parties are in a confrontational stalemate. By dint of the use of motivational interviewing and a strength-based approach within the IFST model, IFST practitioners do not feel morally obligated to

directly challenge parents regarding presenting risks (and concomitant ‘failings’ on the part of adults as parents to protect and nurture their child(ren) in the same way as their childcare social worker counterparts based on the interview accounts. The emphasis of the statutory childcare social worker on risk and on challenging parents to raise their awareness to the presenting risks to their child simultaneously, and inadvertently, undermines parental self-efficacy that they can care for, and protect, their child. For the parent there is clearly a dissonance between this information and their own knowledge of the extent of love and care they have for their child, therefore encouraging defensiveness and secrecy which is interpreted by professionals as non-compliance and lack of engagement and further heightens professionals’ anxieties and uncertainty regarding the safety of the child. The IFST practitioner has ample opportunity to observe first-hand the family dynamics and presenting risks in a manner that few statutory childcare social workers would have the opportunity to do.

6.5. Conclusion

In summary, the purpose of this chapter was to provide an overview of the IFST model in its entirety as a precursor to locating and differentiating the whole family approach that is utilised within it. In terms of the practice model it was suggested that the very process of codification itself may lead to an apparent proceduralism and cause a sophisticated, multi-directional, multi-layered model of practice to appear as a linear, simple set of procedures or tasks thereby negating, or minimising, the degree of skill, expertise, and use of self, that is required by practitioners in implementing the model. Procedural codification could be considered ‘the outsider looking in’ approach to practice, whereas the applied model as articulated by practitioners themselves is that of ‘the insider looking around’ (Coulshed *et al.* 2006). Further, this could be said to be about the orientation to practice as either one of bureaucratic social work, or one in which the central focus is on therapeutic practice. This emphasis on therapeutic work as the thrust of social work practice, and the concomitant need to up-skill social work practitioners to undertake this type of direct work, is the focus for workforce development and reflects the current professionalization agenda in social work within contemporary policy in Wales (Welsh Assembly Government 2011). There also seems to be a strong alignment between policy intentions and the family goals constructed in practice in terms of eradicating poverty, the family as a sustainable resource and

generating social capital via the interrelationships between family members, and between family members and services and professionals.

What is also evident from this chapter is the significance of working therapeutically within the family home and the impact that this has on the nature and intensity of the therapeutic work. The intensity of the intervention is not only about the frequency and duration of contact within a specified time frame but also the intensity of the therapeutic relationship and emotional labour this entails. There were four notable themes from the practitioner interview extracts regarding therapeutic practice in the home environment discussed within this chapter. Firstly, that learning is contextualised and actualised. Learning and change occurs in the context in which it is intended to take place which makes it more real and actual than simulations in a group work, or a parenting class context. The benefits of change to the family are also experienced directly which acts as a motivator. The presence of the practitioner as a guide and mentor also promotes the self-efficacy and self-confidence of the parent(s) that they can make necessary changes. Secondly, the intimacy of environment promotes openness, honesty and mutual trust. There is 'no place to hide' and daily family practices are openly observed. Rather than a reliance on what families say they do practitioners are able to directly observe what actually happens. This can also facilitate co-option of the practitioner within the family which could also present a danger of immersion, or collusion, with the family. Thirdly, working within the familial home facilitates building of relationships and greater equity in the power balance between practitioner and family, thus enabling greater partnership working. Finally, working within the home environment appears to facilitate a whole family approach to engagement. Presence in the family environment provides access and facilitates engagement, with significant people within the family, i.e. the people who are actually regularly present in the family environment, rather than who is reported as living in the household or biological kin. Physical presence also enables the practitioner to make use of naturally occurring opportunities for working with the interrelationships between individuals, not just individuals in isolation. However, presence within the family home can also constitute surveillance (Parton 2010).

In relation to the use of the IFST model as an evidence-based model of intervention it would seem that there is still an apparent need for the use of practitioner judgement in the application of the model to specific families in their own unique context. Whilst of

necessity guidance and practice manuals codify the tasks to be undertaken there is also a sophisticated use of knowledge, interpersonal skills, use of self, emotional labour, professional discretion and clinical judgement within the framework of the model. Within the chapter there has been some discussion about the tension between the use of evidence-based interventions, model fidelity and the use of professional discretion and judgement which could be said to be a reflection of the difference between effectiveness and efficacy. Whilst an intervention may have an evidence-based that demonstrates its effectiveness in particular circumstances with particular clients, in the real world context of practice, practitioner discretion is required to transpose legislation, policy and evidence-based interventions into practice and apply it to the individual circumstances of the presenting individual and/or family network.

This chapter, 6, has provided an understanding of the IFST model in its entirety, and thereby located a whole family approach within the broader IFST model. Chapter 7 will focus on the use of a whole family approach within this model and how this can develop a more generalisable understanding of a whole family approach as applied in practice.

7. Chapter Seven - The Whole Family Approach as Embodied in IFST Practice

7.1. Introduction

As noted in the literature review chapters, 2 and 3, the key characteristics of a whole family approach as expressed in UK policy are that it builds on family strengths to promote family resilience and social capital, prevents social problems, and that this is more sustainable in the longer term than multiple service interventions which focus on either adult or child, rather than the *interrelationship* of needs and resources within the family and wider community (Morris *et al.* 2008; Social Exclusion Taskforce 2007, 2008). This is also reflected in Welsh policy, and specifically in the introduction of Integrated Family Support Teams (IFSTs) in which the overriding aim is family preservation, i.e. that wherever possible child(ren) are maintained within their family.

This chapter makes use of practitioner interview data to articulate what the practice process of a whole family approach is, as embodied in IFST practice. As such the aim is not simply to describe how a whole family approach is undertaken in practice in terms of tasks but rather to explore the use of self and an articulation of the therapeutic process of such practice as described by the IFST practitioners themselves.

Within the *Practice Manual* (Emlyn-Jones and Bremble 2010) there is very limited coverage of the whole family approach and how it is embodied in practice. The quote below is the fullest definition given of a whole family approach within the *Practice Manual*:

As many family members as possible will be facilitated by the worker to complete each exercise and share the process and detail with their family.
(Emlyn-Jones and Bremble 2010, p. 46)

However, what is made evident from this quotation is that practitioners are to mediate communication between family members. The *Practice Manual* is also clear that:

The whole family is our focus:

- We work with all the family as we engage them. The children need time and special attention as well as the adults. We need the appropriate skills and confidence to work with whole families.

(Emlyn-Jones and Bremble 2010, p. 4)

And that,

We can help the whole family to make changes even if the whole family does not work with us:

- We need to take a Systems Approach. Providing intense interventions enables us to invite family members in when they are ready. Key people can be part of the thinking even though they may not yet be in the room.

(Emlyn-Jones and Bremble 2010, p. 4)

Thus there is very limited articulation in the Practice Manual to guide practitioners in the use of a whole family approach. Similarly, it was noted in the literature review (chapter 3, section 3) that there is a gap in the research literature regarding the therapeutic practice process embodied in a whole family approach. This chapter will articulate an account derived from practitioner interview data of the therapeutic practice process entailed in a whole family approach within the context of the IFST model of practice.

7.2. The Construction of ‘*Family*’ in Whole Family Approach Practice

In traditional case work the client (be that an adult or child) is the central focus and other family members are assessed in relation to the client in terms of their ability to act as a resource to the client, or as a source of risk. However, within a whole family approach it is the family itself that becomes the unit of analysis rather than the individual. This is a significant shift in focus away from the individual and on to the interrelationships between individuals as a unit. Significantly this shift places emphasis on the interconnectedness of strengths and needs of individuals both within the family unit and wider community. This suggests an underlying assumption that as human beings we are interdependent relational beings. This construction of humans as

interdependent relational beings reflects that held within the ethic of care (Gilligan 1982).

In strengthening the family the interview data suggests that practitioners intervene in order to build relational competence so as to strengthen family bonds. This is done in order to increase social capital and available resources to the family whilst minimising presenting risks. Alongside the shift toward the family as a unit, and a focus on the interrelationships between individuals, comes a de-emphasis on problems and individual deficits, i.e. pathologising the client. Instead a strengths approach is used that focuses on family dynamics and interrelationships rather than individual pathology. Thus it is the family that is the focus rather than the problem.

.....it isn't just one person that makes that family, it is a whole, you know. And I just think historically agencies have just gone into one person, and just almost pathologised them, really. Say mum's got a drug problem, okay, she must be the whole issue. And often, it isn't as simple as that, you know, and it is a lot of protective factors, lots of resilience factors, and you've got to look at that for all of the family. And with, you know....So just...just that real, simple...that we work with everybody, whoever's important in that child's life.

(Female Practitioner 4)

The policy approach of focussing on the interdependence of needs and resources between family members could therefore be seen as implicitly reinforcing the conceptualisation of family as the people who are 'there for you' and placing an emphasis on the importance of 'being there'. This concept of 'being there' was a recurrent theme both for practitioners within the interview data and, as we shall see in chapter 8, for the families themselves within the case file data.

The following extracts illustrate this sense of 'being there' as an unconditional safety net, a private place of refuge and sanctuary, and also connects it with a sense of belonging that constructs one's sense of identity by reference to others in the family network, as a personal historical reference point. This underscores the interconnectedness of needs and resources.

I'd see a family as a unit of individuals who rely on each other or *are there for each other* or help each other out in difficult times, who want to stay together,

(Female Practitioner 5)

.....family is the people that when you're in trouble, you go to, to be sort of able to feel safe.... and *we belong together*, you know, because there are these deep emotional things of knowing, understanding, and inter subjective kind of experiences that we've shared...

(Male Practitioner 2)

'Being there' is a brief phrase that encapsulates a complex set of interrelated concepts. It encompasses (unlimited) time, (unconditional) love expressed as both physical and emotional need, and an (unlimited) availability and access of the care giver to the recipient not just in times of crises. As Reid Boyd states:

. . . 'being there' is not singular or particular; it is continual, and constant. It is more than physical. It engenders a sense of not just physical but emotional presence, evoking the colloquial "I'll be there for you" (for support) as well as "I'll be there with you." It implies constancy and indeed constant availability: "being there" means being there always, as well as being on demand, when needed, when called for.

(Reid Boyd 2002, p. 464)

If a perceived characteristic of family relationality is 'being there' and 'belonging together' then inherent in this construction of family is the assumed sustainability of a whole family approach as presented in policy, i.e. that family is an on-going resource and that family members will 'be there' for one another in an on-going and consistent manner not achievable by statutory services or state intervention. As per policy, practitioners when implementing a whole family approach in practice construct the family as a (self) sustainable resource.

Because the family is looked at, really as its own resource, and is about helping the family to move into a position where they actually manage

their own issues then looking into the family is vital to that in terms of the risk and resilience. That's why we're in there. The resilience to cope in the future needs to come from the family.

(Female Practitioner 3)

The longer term goal is to increase the relational capital within the family so that individual needs, particularly those of child(ren) are met without state intervention. In other words, protective factors are enhanced and risks minimised so as to increase self-reliance and sustainability in the longer term without state intervention.

. . . we need the family to work together and...for longer term, because, you know, not to be involved with agencies, because that's what one of our goals is, you know, I see it with the family, is to become self-reliant and have resilience, and developing that really as a family. Because at the end of the day we don't know who's going to *be there* and it is family that has an impact. And it's sort of building up their resources and resilience as well.

(Female Practitioner 4)

Whilst there is an emphasis on risk and resilience the approach taken by practitioners is family-focussed rather than problem-focussed. This foregrounds relationship building and rapport between client and practitioner.

The introductory few sessions is very much about 'Who are you?' not 'What is your problem?' not 'What is this referral about?' but 'Who are you as a family?' You know, 'What do you like doing? Who are you?' . . . you know? So, get to know the people as well and build that sort of rapport with them rather than just focusing on their problem.

(Female Practitioner 1)

7.3. Strengthening Familial Relationships: Relational Practice within a Whole Family Approach

All practitioners placed an emphasis on relationships as the central vehicle to the behavioural change work they were undertaking with families. Indeed, one practitioner stated emphatically that where IFST practice is concerned ‘It’s all about relationships!’ (Male practitioner 2). This view, expressed by a (male) practitioner, was frequently reiterated by IFST practitioners, as noted in the extract below and firmly places the focus of practice on relationships as the vehicle for change.

It just puts a great emphasis on the relationship, which is the thing that changes people. It’s about the relationship. Things improve in terms of the social work relationships of the families and everything else, really.

(Female Practitioner 4)

Relationship-based practice privileges the relationship between practitioner and client as the vehicle for healing and therapeutic change (Furlong 2013). This can be to the detriment of existing and prospective significant relationships within the client’s life. In the child protection arena this can be seen in professional attempts to extricate individuals from relationships or social networks that are considered to be engendering risk or unsupportive of change, e.g. in order to safeguard a child the use of coercion or punitive outcomes if a mother does not disengage from a relationship with a male considered to be a risk to the child. The underlying assumed moral identity of mothering in such approaches being that it entails self-sacrifice of personal needs, such as romantic love, and her identity as a sexual being. Within a whole family approach there is greater opportunity to acknowledge parental needs as adults, e.g. for love and belonging, beyond that of the parental role. The distinction between relationship-based practice and relational practice being that in the latter the therapeutic relationship is not privileged, and the existing network of relationships are utilised in a therapeutic alliance to support healing and behavioural change (Furlong 2013). As such it would be more accurate to term the relationship-based practice within a whole family approach as embodied within the IFST model as relational practice.

Improving the relationships within the family, as well as between the family and professionals, was clearly viewed as a central goal within both the practitioner

interviews and the case file analysis. What is apparent in the data is that it is not simply the therapeutic relationship between the worker and client that is of primary importance but rather that the relationships *between* family members themselves have a therapeutic function in generating change. Further, it could be said that family members are viewed as co-therapists:

Yeah, and it's really much easier to develop discrepancies then because people are not, you know, if you've got a whole family in the room, you can't lie whereas in an hour in an interview in an office they could say this is going on. And you've got no evidence to suggest otherwise. If a family member hears something that is not right, they can challenge that and that makes my job so much easier because I don't need to challenge anything really. That's not my role. The family can challenge each other.

(Male Practitioner 1)

Thus family members are co-opted as therapists in challenging incorrect self-perceptions and generating awareness of the discrepancy between values and behaviours that is intended to illicit behavioural change (Prochaska and DiClemente 1983). This engagement of family members as co-therapists is not restricted to adults. Children as co-therapists can have a powerful impact as motivators for change:

... there is some discomfort in them hearing that their child isn't happy with how things are. You know the stark contrast between how her normal day would be like and how her miracle day would be. You know that that would be the motivating factor for parents to start making those changes.

(Female Practitioner 2)

Children can not only challenge parental beliefs and understandings but advocate for their own needs and desires:

In sharing their preferred futures with each family member it can be so powerful. Especially for parents hearing their children, you know, saying that they just want to sit by the table and eat breakfast every morning. It can be a huge shift.

(Female Practitioner 1)

This provides a platform for self-advocacy and the promotion of the child's rights to involvement in decisions regarding their care, as well as improving communication between parents and child(ren). A strong theme in the data was that the intervention was perceived to be 'child-focussed'. The purpose of work undertaken with adults was focussed on improving child welfare outcomes and this was facilitated by providing children with 'voice and choice'. All of the practitioners stressed the importance of working with the children and not just the adults, within a whole family approach. As child protection is the purpose of the intervention it is perhaps to be expected that practitioners were concerned to understand what the child's experience of family life was like and how it could be improved and to ensure that this was communicated to parents and others.

Children often tell us what's really going on and how it affects them, and that's the goal for us, really: it's for the children to be protected or feel protected, and to hear their voice.From a child, you can see what's really going on, I don't knowit's so hard; when you see through a child's eyes what's really going on, it allows you to understand more about what...where we need to focus the work, really, I think.

(Female Practitioner 4)

Practitioners highlighted that advocating and mediating on behalf of children and young people to other family members could present challenges and dilemmas. One practitioner discussed a seventeen year old who was adamant that they did not want their views shared with other family members. Practitioners also discussed the importance of sensitive handling of family communication and concerns about how the disclosure of feelings might impact negatively on the dynamic of the relationship. For example, in discussing one case illustration the practitioner referred to their concern that once the practitioner 'walked out of the room' the parent might punish or blame, or in some other way, mistreat the child or young person for saying something the parent did not want to hear, or found too painful to hear, such as how the child felt about the parent's behaviour. For instance, the parent may be convinced that they have protected their child(ren) from their substance misuse and that the child is unaware they are a user

and that it has no impact on the child. For a parent to hear directly from their child that they are not only aware of the parents substance misuse but that it also has a direct negative impact on the child can be a difficult thing to hear but once accepted can be a powerful motivator for parents to move from pre-contemplation to contemplation (Prochaska and DiClemente 1983).

Perhaps what moved that mother from pre-contemplation to contemplation, was listening to her daughter say to her that she was, you know, very hyper and stroppy, you know, agitated, until she went out and then came back. And then was like a zombie on the couch for the next couple of hours.

(Male Practitioner 1)

The aim of intervention is family preservation as the perceived best outcome for children. In other words, the outcomes for the welfare of the children are the focus of the intervention, however, a whole family approach recognises the interconnectedness of family members and that addressing and meeting the needs and vulnerabilities of the adults (frequently the parents) can have an indirect benefit on the outcomes for children as the adults are then better placed to meet the welfare needs of the children.

If adults have got needs that remain unmet, it becomes much more difficult for them to be functional parents. So, it's really looking to every member of that family to see what their role is, what their needs are, can they be met in order for them to be better parents.

(Male Practitioner 2)

Practitioners do not see themselves as therapists for individual family members but rather as creating a therapeutic environment within the family itself. Thus, rather than privileging the worker-client relationship as the primary therapeutic relationship the entire network of familial relationships become therapeutic and mutually re-enforcing toward positive change.

Really, we're not there to be therapists for the children. The family has its own co-therapeutic kind of environment, if you like. The main focus is to

give children a voice. And so, for example, we'll do the first part of the miracle question, "What do you want...what's your perfect day?" and the child will be saying, "Oh, I want to go to the beach. And we will be a happy family, et cetera, et cetera." And just having that coming out in terms of the parent's emotion, having that written down, is very empowering for the child and also builds empathy for the parents to see what's going on.

(Male Practitioner 2)

The emphasis for practitioners is in providing a space for the child's voice to be heard. Winter (2010) in her research with children in care aged between 4-7years old notes that '... the act of creating spaces for young children to speak signalled to them that they were being treated as individuals and that their perspectives were important and valued' (Winter 2010, p. 190). Winter urges practitioners to include children's perspectives on family life within assessment and decision making processes in order to better understand the nature of risk and harm within the familial environment. The participation of children is enshrined in Articles 12 and 13 United Nations Convention on the Rights of the Child (1989), it is also a statutory duty and following the Laming Review (2009), a policy priority.

The description provided by practitioners of the whole family approach practice process suggests that it is recursive in that it combines developing individuals' relational competence (ability to communicate feelings, trust, empathy and self-efficacy) whilst simultaneously mediating and improving communication of emotion within and between familial interrelationships in order to strengthen familial bonds via trust and empathy.

The basis of all the work that I've done with all the families regardless of the circumstances, or the referral, you know the issues that the people have had are that the major thing that is problematic for them is issues of confidence and trust. And that underlies everything.

(Female Practitioner 1)

The confidence referred to is in relation to self-efficacy and low self-esteem. Deciding what can be communicated in terms of feelings and how those feelings can be expressed safely entails skill and judgement on the part of the practitioner.

Yeah. It's very much my judgment. Yeah, yeah. I mean, you wouldn't want to like sweep anything under the carpet. You know, as long as it's safe to do so, just lay out that judgment, professional judgment, really, of like, what is safe to talk about, what's appropriate to talk about and stuff like that.

(Female Practitioner 1)

Communicating feelings constructively can be a challenging activity. The use of tools such as values cards can deflect some of the fear and apprehension about sharing feelings and limit the potential for conflict and friction.

A lot of the exercises like, things like the card games and stuff are so non-threatening and take eye-contact away. You know, to get people to open up who find it difficult.

(Female Practitioner 1)

The communication of feelings is therefore used to engender empathy, trust and understanding between individuals and bring them closer together, i.e. increase emotional connection and bonding. This facilitation of empathy may be between parent and child:

I see a mum shouting at her child all the time. So I'll go then and say, "When you were a child, how did it feel? Or if I shout at you now, how would you react?" And try to get empathy through that.

(Female Practitioner 4)

Or between parents and/or other family members:

We're encouraging a culture within a family which is all about openness and about the safe way and strength-based way of sharing honesty....to get parents to connect to each other empathically.

(Male Practitioner 2)

As well as with extended family:

I involved grandmother and great grandmother because they were part of that support system. And just did improving communication there and developing that empathy, both sides, really, in that understanding.

(Female Practitioner 4)

The developing of empathy is not restricted to informal support networks but also formal and professional networks. IFST practitioners both use empathy in building rapport with family members, and also, seek to engender empathy in professionals toward the family they are working with.

We become a broker of other relationships, if you like. We do get to think, "Oh, well, actually, if that was me in that situation," we can understand how that would happen. And when they can understand, you feel that they can feel that empathy which might be the first time they've ever experienced that from a professional anyway instead of being judged or, you know, with the relationships, but also, if they can feel empathy, they can give it elsewhere as well in the system.

(Male Practitioner 2)

The extract above illustrates the strengthening of the formal support networks around the family via empathic bonding between professionals and the family. The greater understanding and empathy of the professionals regarding the family dynamics and situation places them in a better position to make improved judgements based on direct evidence from IFST practitioners observations of family life. This can also potentially improve trust and rapport between the family and the professional. This change in the relationship dynamic itself might lower professionals' perception of risk and increase

trust and the perceived strengths within the family. This, in and of itself, may reduce the likelihood of children being removed into statutory care.

Further into the interview the practitioner refers to the mother's pattern of drinking as a coping mechanism to deal with the bereavement of a parent and that her use of alcohol and thereby her parenting capacity will be improved having received counselling to cope with her bereavement. This deeper understanding of the aetiology of the substance misuse is achieved through building rapport and a more empathic relationship between client and practitioner. This example also illustrates the interconnectedness of family issues: the parents' bereavement is perceived to be the cause of the substance misuse that impacts on parental capacity so that addressing the bereavement issues indirectly improves the child welfare outcomes by increasing parenting capacity whilst reducing substance misuse. This approach to working seems to tackle root, underlying causes at a much deeper level, i.e. the bereavement and parents' relationship with the deceased father, rather than just focussing on the (symptomatic) substance misuse. The presumed increase in parenting capacity as a consequence of tackling this issue is the anticipated indirect impact on the child welfare outcomes.

All of the practitioners indicated that whilst they might work with the entire family in the same room, at the same time, therapeutic work was frequently carried out with individuals then brought back to the family as a whole.

My sessions were predominantly all six of them in the room. We'd be talking about different stuff and then there would be some sessions where I would just work with mum and dad when the kids were at school. And I work some sessions, one on one with the children individually. And then I worked some sessions just with dad and some sessions just with mum. But, but whatever we did separately, we talked about, and like, you know, I would say, "How do you feel about bringing this back into the family?" They would agree. And then the next time we were all together as a family, you know, in my plan, I knew that there would be certain things I'd like to address and would be bringing that up.

(Female Practitioner 1)

The practitioner does not relay what one family member says to other family members but rather facilitates safe disclosure and communication by one individual to another through face to face contact or therapeutic letter.

They go, “Don’t tell them.” And then they’d automatically tell them when you’re in the room because you’re that conduit as well. So another role is that we allow communication to happen through us.

(Female Practitioner 4)

Nor does the practitioner relay information shared by one family member to another about how that person feels about the other. The interview data make it clear that for practitioners that would be a betrayal of the trust that the family member has in the practitioner. The practitioner functions as a ‘conduit’ through which communication is enabled between one family member and another, enabling that communication by increasing the family members’ confidence that they can share feelings with others in their family safely and constructively. The presence of the IFST practitioner creates a safe environment for individuals to share feelings with other family members.

Yeah, yeah so we can keep it safe, yeah absolutely. So they will listen and they won’t just storm out. But it does allow the families to communicate....It’s almost like... we’re the mediator.

(Female practitioner 4)

The mediation of communication is not only in relation to problematic or challenging issues but also on the strengths and positives of family relationships:

Because often, families who are so caught up in there, you know, in their own issues and crises, I suppose, because of what’s going on, they very rarely stop to think about what’s actually going on in their family and what do they actually like about each other and what is the reason that they’re all together as a family anyway. You know, so, giving them that opportunity as well to, to not just focus on what were the problems and what we’re hearing about who’s doing wrong.

(Female Practitioner 1)

The sharing of positive feelings with one another has the potential to strengthen and increase bonds of love and affection both for the person talking and the person listening. Feeling safe in expressing emotions, whether positive or negative, seems to be a key factor in increasing familial bonding and empathy.

Feeling safe...feeling safe to be able to say, I don't know... "I'm really proud of you for doing that." You know. And not feeling stupid or you know, that you're going to have a negative response. So yes, it's about getting them to feel safe to express emotion as well.

(Female Practitioner 1)

Whilst the communication of feelings between family members is often an implicit or tacit goal in terms of the formal goals reviewed in the case files it is clearly a goal practitioners consider to be of great importance in strengthening families:

And to be honest what we find is, in most families people don't necessarily communicate their feelings and that's the biggest thing about this, is it allows people to communicate their feelings when they never could have, or even reflected on that, before.

(Female Practitioner 4)

The mediation of communication is not only with the immediate family but also the extended family and wider community both formal and informal.

Another mum I've worked with in the family, her sister's been very involved. So she'll encourage her to keep appointments and stuff like that when at times, you know, families go through phases, don't they? And getting a good relationship with the sisterIt does help a lot, definitely. And it does keep the family going, and, you know..."Why don't you give [name of sister] a call?"

(Female Practitioner 4)

The following extracts from closing reports in the case file data give an indication of the outcomes from mediating family communication, developing empathy and building better relational competence within the family.

All family members describe themselves as a closer unit now with more working together and less arguments and shouting.

(Extract from IFST Closing Report)

At the end of Phase 1, the family are more calm, relaxed, organised and optimistic for the future. Although the family have always displayed a close and loving bond they are now spending quality time together doing activities as a family.

(Extract from IFST Closing Report)

Each family member currently describes their family situation as being '10 out of 10' and independently claim this is due to less arguing and more working together.

(Extract from IFST Closing Report)

These extracts would seem to suggest that building relational competence is central to a whole family approach and that there is some evidence to support a whole family approach's ability to strengthen familial bonds. Research conducted by Morris (2013) highlighted the failure by practitioners to engage with the wider family network beyond the household which then places an additional burden on family members to mediate communication between professionals and the wider family network and that this communication may be affected by the service user's own vested interests, for instance, in terms of the avoidance of conflict with other family members. From the practitioner accounts provided within this data it would seem that these practitioners do indeed 'think family' in the broader sense of family systems and networks, engaging beyond the immediate family to wider kinship and relational networks.

7.4. Conclusion

The ‘*whole*’ in a whole family approach refers to the whole family system and requires the practitioner to conceptualise the family as the unit of analysis (rather than the individual) and to (re)focus on the interrelationships and interconnectedness of needs and resources between family members rather than focus on specific individuals within the family, be that mother or father or child(ren). This focussing on interrelationships rather than individuals also has a tendency to minimise pathologising individuals in terms of their ‘*problems*’ and instead to concentrate more on strengths i.e. strong relational bonds as protective factors. However, ‘whole’ does not necessitate all family members participating in the intervention for the intervention to impact on *all* the family, nor do all family members need to participate in the therapeutic work together in the same room at the same time for the impact to be felt by the entire family system. Due to the interconnectedness of family relationships a change in behaviour in one person can impact on the entire family system. From the analysis of the practitioner interview data discussed in this chapter it appears that it is not the work with individual family members, nor with combinations of family members collectively that is the key to change in a whole family approach but the mediation and change effected by intervention in the relationships *between* individuals through enhanced relational skills such as trust, communication and empathy. On the basis of the data presented in this chapter it seems that this is achieved through a combination of building relational competence within individuals and the generation of self-efficacy, trust and mutual confidence between individuals. Thus, it has been proposed that relational theory and the skills of relational working may be a useful theoretical framework from which to understand and further develop a whole family approach.

This is a shift in focus away from the individual (whether child or adult) and re-focussing on change in the relationship dynamics between individuals and the system as a whole. In this context ‘whole’ is viewed as the whole family system and family is conceptualised as the network of relationships from which individuals draw resources (and concomitantly meet obligations) in order to get their needs met. Thus what constitutes ‘family’ is neither predicated on legal, biological, or household categories but rather the interconnected network of relationships itself and their capacity to present risks or generate resources (social capital). The practice process of a whole family approach appears to be recursive and to invite a circular questioning approach.

Practitioners develop rapport and relationships both *between* family members and *with* individual family members to engender individual change that will impact on the system as a whole. Thus the practitioner may work individually or collectively with family members whilst simultaneously being mindful of the impact that individual behavioural change may have on the whole family system. Within this process the practitioner needs to maintain forward momentum in terms of change whilst still maintaining sufficient equilibrium within the family system so as to preserve (and where possible enhance) familial bonds and the family as a self-sustaining unit.

Strengthening families entails the minimising of presenting risks and enhancing the capacity for those relationships to provide sustainable resources to meet individual family members' needs. In terms of family preservation in the context of child protection the significant needs are for protection and nurturing in relation to children. Secondary issues that affect parental capacity such as substance misuse, and/or domestic violence and/or learning disabilities and/or mental health issues are not the focus of the intervention but may be impacted by the changes in relational competence and stronger, more cohesive familial relationships based on the limited evidence of the IFST closing reports. This also facilitates a positive strengths based approach, i.e. that rather than focussing on the 'problem' of, for instance, substance misuse, the practitioner is focussing on the strengths in the relationships between individuals, and as relationships strengthen dependency on substances to ameliorate personal problems becomes supplanted by the coping mechanisms and support from strengthened familial relationships.

A critique of a whole family approach is the potential to lose focus on the child, however, all the practitioners that raised this issue were keen to stress the inclusivity of *both* adults *and* child(ren) in direct work and the focus on child welfare outcomes in relation to the work undertaken with adults. Of greater significance is that working with either an adult or child focus denies the reciprocal, multi directional and interdependent nature of love and care between parents as adults and their child(ren). Re-focussing on interrelationships rather than on individuals (be they adults or children) provides a greater opportunity to empower children and young people as having a right to full participation and as having their own social agency. The silo mentality of either child, or adult focus, and thus the tendency to view care as linear and uni-directional tends to

limit the extent to which children are conceptualised as having their own agency in determining and getting their needs met and of the interconnectedness between needs and resources of individual family members (be they child or adult). Within individual casework there is a greater propensity for the child to be conceived as passive and cared for, and the parent as the care giver, i.e. that care is uni-directional from parent to child, rather than multi directional and reciprocal between parent (or friends, or neighbours, or wider community) and child. Working within a whole family approach has the capacity to be more inclusive and to evaluate these dynamics as more fluid rather than fixed, as multi-directional rather than uni-directional and linear.

What is evident from the case files and practitioner interviews is that IFST practitioners work with parents, children and extended family individually and in various combinations, although not necessarily with all family members simultaneously in the same room. However, a considerable focus of the work appears to be on the mothers, whether this is due to the actuality of mothers being primary carers or the (gendered) assumption that this is the case. It would also seem that the focus of the therapeutic work is relational, i.e. it is focussed on improving the relationships between mothers and fathers, between parents and children, between the family and extended family/significant others and inter agency, inter-professional working relationships so as to develop a more cohesive circle of support in order to keep children safe and meet their needs. This seems to very much equate with the policy intention of a whole family approach to develop social capital, the social capital in question being the quality and strength of familial relationships and the wider community to generate resources and resilience.

This chapter has highlighted the family as being the unit of analysis within a whole family approach, and the interconnectedness of needs and resources between family members. The following chapter, 8, examines the co-construction of ‘family’ in practice by practitioners and parents.

8. Chapter Eight – The Co-construction of ‘Family’ in Practice and Parental perspectives on Mothering, Fathering and Family Life

8.1. Introduction

This chapter, 8, draws on data from practitioner interviews, case file recordings of parental preferred futures accounts, and values card-sort statements in order to explore how ‘family’ is co-constructed in practice between parents and practitioners. As noted within Chapter 4, Section 4.4 there are limitations on the validity and reliability of both the practitioner interviews and of the preferred futures accounts. Practitioner interview data are the ‘self-reporting’ of practice rather than direct evidence of *actual* practice, and this is a particularly pertinent consideration in relation to the perceived levels of family engagement held by practitioners. The preferred futures accounts and values card sorts are recorded, and thereby mediated by practitioners, rather than the more direct perceptions of family members which could be provided by interviews or direct observations. It is also worth noting that the preferred futures accounts and values card sorts carry an agenda as a therapeutic tool which may affect the process of selection. However, the preferred futures accounts and card sort recordings do provide a novel and useful approximation of the parental voice in the absence of access to interview data. Both the miracle question and the exploration of values via a card-sorting activity are intended to elicit cognitive dissonance between parents’ actual behaviours and espoused core values so as to motivate participants to bring greater alignment between what they value and how they behave. The sorting of cards is used for the participants to identify at least five of their most important core values. Of the case files examined there were only two accounts of fathers’ value sets and twelve of mothers’ value sets, of which only one was a lone mother’s account. The values cards are created before the activity by the practitioner and/or are co-constructed with the parent as part of the sorting activity. As the values cards are not a standardised set of cards the number of cards used and the wording and choice of available values on the cards vary, however the card pack usually consists of a minimum of thirty cards. Given the number of cards in use, it is significant that many of the same values are shared between participants.

Within the case files there were eighteen biological mothers' preferred futures accounts to the miracle question. Three of these accounts were taken from lone biological mothers and of the remaining fifteen accounts the biological mothers either had a current partner, or were in an intact biological two parent relationship. There were only a total of seven preferred futures accounts taken from fathers' recorded in the case files. Five of these accounts were taken from biological fathers, and two from step-fathers.

As noted in chapter 4, preferred futures accounts are articulations made by parents and written up by practitioners for return to the parents themselves to reflect on and/or amend for accuracy. Thus they are idealised parental constructions of what family life should be, rather than a reflection of how family life currently is. Such 'should' and 'ought' statements are thus moral imperatives and this is further evidenced when the preferred futures accounts are combined with the themes forthcoming from the values card-sort activity. Further, it is potentially the absence of some of these features of family life, such as harmonious relationships, daily routine, family days out, and so forth in the lived experience of family life that may account for them being the focus of attention within these accounts, i.e. areas of family life that parents would like to change. Parental accounts of family life as derived from the preferred futures accounts centre on displays of family (Finch 2007) and appear to be constructed on the dominant discourse of traditional family ideology and differing gendered roles for mothers and fathers.

In comparing the themes evident in mothers' and fathers' preferred futures accounts and underpinning values card-sort statements some features were strikingly similar: the importance of home, daily routine, food and mealtimes, family days out, family cohesion and harmonious households. However, there are some nuanced differences in the way that these are discussed with some gender effects evident in terms of differences of emphasis and how these are discursively constructed in terms of their meaning. In addition, there appears to be a commonly held view amongst parents that mothers and fathers should hold traditional gendered roles of father as 'provider', and mother as (emotional) 'housekeeper'. The accounts not only reveal parental hopes and aspirations for family life but also the normative expectations they have of themselves as mothers and fathers, namely, traditional gendered normative expectations of mothering and fathering care practices. The next section examines *family* in terms of

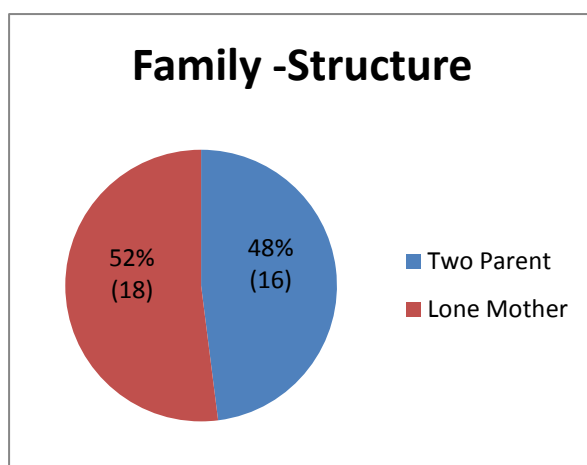
structure and household composition and draws on data from the case file analysis to do this.

8.2. Family as structure and household composition

During practitioner interviews all of the practitioners characterised the families they work with as predominantly lone parent (mother) households. However, the case file analysis present a somewhat different picture in relation to the structure and composition of the families that are the target population actually receiving this intervention as being somewhat diverse in family structure.

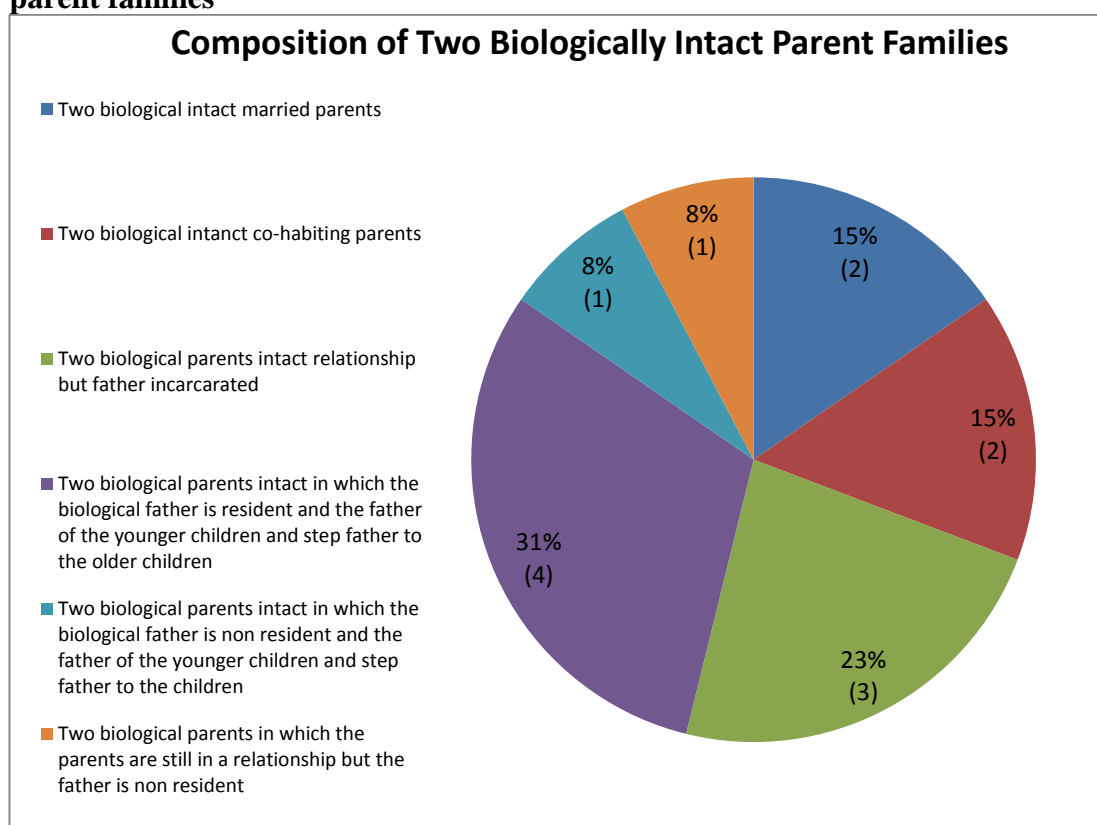
The pie charts below created by the researcher provide diagrammatic illustrations of the family structures as constructed by practitioners from data contained within the case files. What is apparent from these illustrations of the data is the diversity of family forms and structures within the broad categories of two parent biologically intact families and lone mother families. ‘two parent biologically intact parent families’ refers to families in which both parents have a biological relationship with one, or more of the children, whereas, ‘lone mother headed households’ are families in which the biological mother and father are no longer in a romantic relationship.

Figure 8-1 Comparison between two parent intact biological families and lone mother headed households



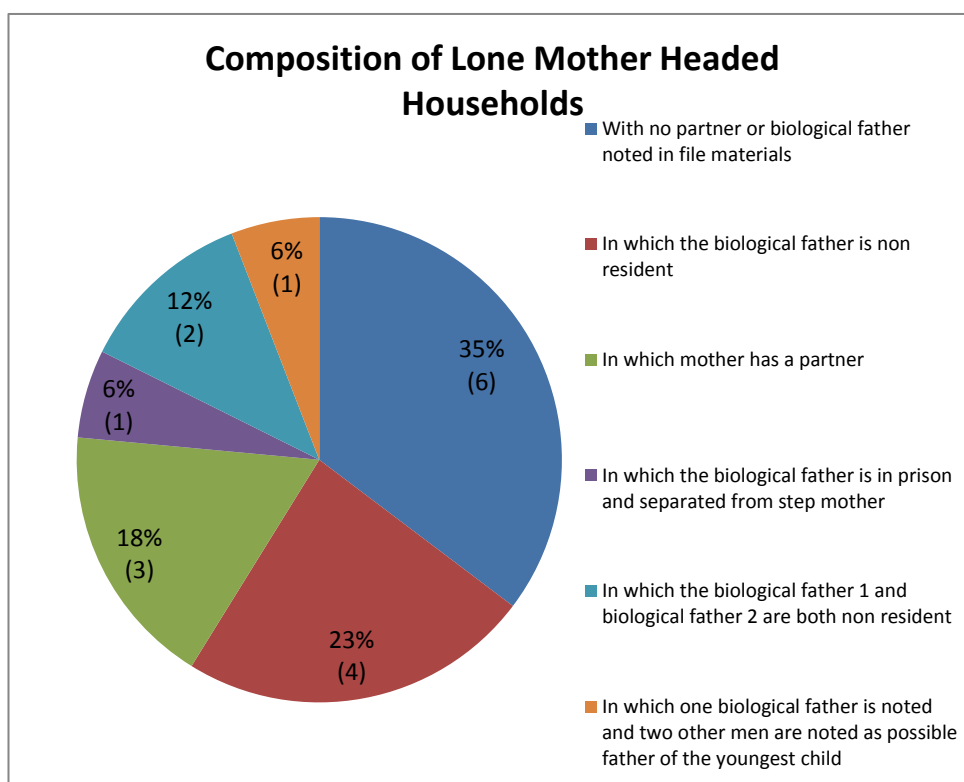
Whilst 18 families classified by practitioners as ‘lone mother headed households’ were identified from within the case files sampled, an almost equal number (16) ‘two parent biologically intact families’ were identified.

Figure 8-2 Diversity of family structure composition within two biologically intact parent families



Even within the broad category of ‘two biologically intact parent families’ there is a diversity and fluidity of relationships. The on-going existence of a romantic relationship between biological parents does not necessarily mean that the biological father is resident, and that may be from (maternal or paternal) choice or by dint of circumstance, e.g. imprisonment.

Figure 8-3 Diversity of family structure composition of lone mother families



Similarly, as is evident from the diagram above, there is significant diversity and fluidity in familial relationships within those families characterised within case files as ‘lone mother headed households’. There is no necessary correlation between biological relationship to the child(ren), residency status, or relationship status with the biological mother that provides an insight into the nature of the relationship with the child(ren) and the extent of fathering practices the man is involved in. In other words, the extent of fathers’ engagement in child welfare cannot be assumed on the basis of physical proximity, or relationship status with the biological mother, nor legal or biological relationship with the child(ren), this has to be assessed rather than presumed. Whilst ‘lone mother headed household’ and ‘two parent biologically intact family’ appear to be distinct social categories and family forms, what the data reveal is that there is a degree of fluidity, with families changing form and structure over time. Thus, on-going assessment and awareness of the fluidity of family as being in process, rather than fixed or static, is needed if the *whole* family is to be engaged with. The reality of lived experience would seem to be that the whole family can be subject to change and impermanence. Thus, it would seem important that practitioners have some awareness

of their own construction of family and how this impacts on the assessment process, particularly when practitioners are working within a whole family approach.

What seems apparent from the case files is that the foundation for constructing the family structure is the biological mother. Whilst there is great diversity of family forms, with one or more biological fathers and/or step fathers or partners, what all the families have in common is a biological mother. Where the mother is a step mother to older children she is invariably also biological mother to younger children.

Men are present within families as partners, step/social fathers and biological fathers; although in six of the lone mother headed families there is no male identified, this may signify the absence of men within safeguarding work rather than the absence of men in families. It is worth noting the mitigating factors that may account for this absence in the team's local files. All of the files were included in data collection, regardless of whether the referred case was subsequently accepted or declined, and thus some files only contain minimal referral information regarding family structure. In addition, given data was collected from case files during the early establishment of the service there was general inconsistency in recording due to the evolving nature of the administrative systems and unclear expectations of recording requirements by practitioners. However, the most notable and consistent absence is when men are imprisoned. In all cases, even where the man had been actively engaged by the IFST practitioner prior to incarceration, once a father enters prison any engagement ceases. This may to some extent be a consequence of the focus of the therapeutic intervention within the home context and daily routines of family life from which fathers become excluded by dint of their incarceration and consequently excluded from the intervention.

8.3. The Co-construction of Family in Practice

Both the *Practice Manual* (Emlyn-Jones and Bremble 2010) and practitioner interview accounts present a tautology as to how family members are to be identified. Initially when practitioners were asked how they identified people who constitute family members they each invariably stated that 'the family identifies itself'. This accords with Furlong's (2001) formulation of 'family':

The term ‘family’ is being used inclusively and would find its definition in the subjective perceptions of the experientially involved participants. This deliberately local definition would put a potentially idiosyncratic, phenomenologically - derived focus upon ‘significant other relationships’ even if the most commonly accepted family formations would continue to be those most usually encountered by clinicians.

(Furlong 2001, p. 233)

Thus, ‘family’ is a localised co-construction between the practitioner and the family member tracing the network of interdependencies that serve as a source of protective (and risk) factors to the child(ren). It is the significance of the relationship rather than biological, legal or geographical proximity that is of importance to the quality of the relationship as being defined as ‘familial’. This construction of family is conceptually aligned to that noted in chapter 5, section 4 in relation to Welsh legislation and the extension of family beyond parents and child(ren) to include those people ‘connected’ to the parent(s) or child(ren). As previously noted with regard to Welsh legislation this facilitates parents (and/or children) to co-construct family composition with IFST practitioners on the basis of relational qualities, and as fluid and relatively unboundaried. This could be considered as akin to Pahl’s (2004) ‘families of choice’.

During practitioner interviews it became clear that the practice process initially involved talking to the referring social worker and the primary carer (usually considered to be the biological mother). Two of the practitioners reported a distinction between ‘formal’ family members who were involved in formal statutory processes and ‘informal’ family members who were frequently present (but not resident) in the family home and could provide a resource to the family, for instance in providing ‘hands-on care’ as in the extract below.

In one family a twin sister was often in the home, but hadn’t really been identified as part of the process of our intervention. Perhaps because she would often be there, she would talk with me and then we would talk together about what we were doing. Although she wasn’t formally part of that family and she didn’t live there and she wouldn’t be called to like

reviews and things, she was very much part of the work that we were doing and identified by mum as somebody she could talk to. So I guess there are sort of stages of it that is sort of 'formal family' if I can put it that way and 'hands on family' inverted commas.

(Female practitioner 2)

The practitioner interviews suggest that the 'formal' (or officially sanctioned) construction of family may be predicated on biological relationship and household composition, whereas, social relationships and the provision of 'hands-on' care are the basis for the construction of 'informal' families. In terms of how the family is identified and constructed the practitioners each recounted a very similar process, exemplified in the following extract:

Well, it's in steps I guess, because when we have a consultation with a social worker then they will introduce us to a family. In terms of who *they* think the family is, and that will always involve the children who are the cause of concern and the carer at the time, it's usually the mother, and then possibly fathers and extended family like grandparents. I've certainly gone in to families and talked to them about who they consider to be the important people in their family. And that's really where I would take my main cues from because whilst there might be a father saying he's involved and we go and find out that there's been a history of domestic violence and that relationship has for example, been a major cause of undermining the confidence in mum to be able to parent and to function. That father might still be in contact the children. But mum might not want him to be part of the intervention because she would see that as a, you know, it's something that would affect their ability to make progress. So I would take my cues from the family then and talk with them and you know, try to encourage them as well to sort of think about who actually can be helpful and to grow that family in any way that would be beneficial to them. But that's how the family is identified for me in working. It is by the family themselves.

(Female Practitioner 3)

The extract above also illustrates the positioning of the mother by the practitioner as performing a gatekeeping role (Allen and Hawkins 1999) not only to access the child(ren) but also in terms of determining who participates in the intervention, and to what extent they participate, based on the mother's perception of the importance of that person to the child's welfare. This too was a recurrent theme in practitioner interviews. Practitioners emphasize the importance of mothers determining father involvement in the care of their child(ren) and/or statutory intervention. However, mothers' preferences from the preferred futures accounts are that fathers should be engaged in the care of their child(ren) even where the romantic relationship has ended. Where there were non-resident biological fathers, all but one of the women expressed in their preferred futures account a desire for the biological father to be more involved with the children and to be included in family days out. Many of the women also expressed regret that the relationship with the biological father had broken down.

[Second Biological Father], the girls Dad would be around and [Older Daughter] would see a lot more of her Dad [First Biological Father], he could travel down to see her or she could go and see him. He would come and pick her up and take her back for a few days. He would want to, and like to, as his money and lifestyle would allow that. [Older Daughter] would be happy to go there and spend time with him as she loves and really likes her "punky" dad; she would look up to him, as he is such a character, as it is hard not to like him. He is important in her life and would love to see more of him.

(Extract from Biological Mother 28's Preferred Futures Account)

The overwhelming majority of mothers in this sample want biological fathers to be involved with their children but may have reservations and concerns following romantic relationship breakdown. Practitioners appear to work on the assumption that it is the mothers' responsibility to 'invite in' (or not) fathers and to resolve any issues that may be acting as a barrier in making the transition from romantic relationship to parenting partnership.

8.4. Parental gendered normative constructions of mothering, fathering and family life

Overwhelmingly, parental normative construction of fathering shared a dominant discourse of the fathers' role as 'provider'. For those mother's with partners the fathers role (whether biological father or non-biological) includes an element of being the financial provider. For the mothers, having the father in employment is not simply of financial importance but also a source of pride and self-esteem for them both.

[Biological Father] would either have a job at a gym, helping others to train or doing ground work or steel fixing. He would be bringing in the money which would make him feel better about himself and [Biological Mother] would not have to do so much.

(Extract from Biological Mother 30's Preferred Futures Account)

Both the mothers and the fathers consider the financial provider role to be a primary role for fathers and also that this is tied in with providing a home:

[Biological Father] would have a job and the house would be finished. [Biological Mother] would be living with [Biological father] and the kids as it is their house.

(Extract from Social Father 6's Preferred Futures Account)

In addition to the provider role there is an expectation that men will also assist with the domestic chores, such as cooking and cleaning:

In the evening [Non-biological Father] would return from work and begin to cook, the dinner would taste fantastic and would be grilled and not fried. The baby would be in his high chair smiling.

(Extract from Biological Mother 6's Preferred Futures Account)

And in childcare:

After dinner [Biological Mother] would bath and dress her baby and both her and [Non-biological Father] would read stories of adventure and fun until the baby fell asleep.

(Extract from Biological Mother 17's Preferred Futures Account)

So whilst the mothers generally do not see themselves as contributing to the financial provider role (the few that did express some interest in being in employment spoke of this in terms of self-fulfilment and self-esteem rather than increasing household finances), the mothers do have an expectation that men contribute to completion of domestic tasks and child care. Generally the women seem less concerned regarding financial worries than the men and this maybe because they see themselves as less responsible for the family income than the men.

The provider role is embedded within finance and paid employment and is recurrently portrayed as a great source of pride and self-esteem.

[Biological Father] would like working as it would give him a purpose in life and a feeling that he was doing something for his family.

(Extract from Biological Father 30's Preferred Futures Account)

The fathers' role as provider is also highlighted in the values cards that fathers chose.

You told me if there was not enough money the family would be in a financial crisis as there would not be enough money to buy gas, electricity and food. You feel that it is important to have nice things and for the family to have nice things for comfort.

(Extract from Social Father 30's Values Response)

The above extract further illustrates the interrelationship between core values and the fathering identity. Whilst for the men their sense of pride and self-esteem was partially invested in work, and thereby indirectly in the successful fulfilment of the provider role as a father, for the women their sense of self-esteem and personal identity was almost entirely invested in their parenting role - as mothers first and foremost. In all, except one of the accounts, the mothers are portrayed by the fathers as staying at home and

caring for the children, i.e. not in paid employment. Only this one account below suggests that the mother could perhaps have a choice between paid employment and staying at home with the children:

[Biological Mother] would either be working or be a full time housewife with the choice being hers.

(Extract from Biological Father 14's Preferred Futures Account)

Although two women expressed some interest in working all of the women saw their identities as inextricably linked to being a mother, particularly those mothers with babies or infants, rather than in paid employment, or other activities.

[Biological Mother] would be woken up by the sound of the baby. She would wake up feeling happy to hear the baby making nice noises. She would get out of bed and go over to the baby's cot to check that she was ok. [Biological Mother] would pick the baby up and would then get the baby ready for a day out. She would bath and dress the baby and would then take the baby to a mother and baby group where she would meet other mothers she has made friends with.

(Extract from Biological Mother 14's Preferred Futures Account)

In situations where some, or all of their children were in care this was very clearly and frequently expressed in terms of grief, loss, shame and sadness.

You told me that you would be in bed and you would be awoken by [Son] and [Son] jumping all over you in bed. You told me that you would "give your right arm for this to happen". (Son in care).

(Extract from Biological Mother 51's Preferred Futures Account)

In this day [Biological Mother] would feel complete as she would have her daughter with her. She would always know about her other kids but [New-born Baby] would help to take her mind off her situation. She would not feel down or depressed and she would be really happy. [New-born Baby] would be relying on her to look after her so [Biological Mother] would not

get into trouble with the police. She would not be drinking or taking drugs as she would be putting her daughter's needs first.

(Extract from Biological Mother 42's Preferred Futures Account)

This mother expresses that she would feel incomplete without her new born daughter. Further, that this newly born child cannot replace the children that have been taken into care but provides some distraction from dwelling on the grief, pain, loss and emptiness she feels as a consequence of the removal of her other children into care. In her preferred future she would no longer be depressed, which suggests that in the present she does indeed feel depressed. The suggestion is that to be a good mother one has to put the needs of your child first, i.e. that mother's self-sacrifice their own needs for those of their children. Also implicit in this statement is that the mother's own needs are to misuse substances to alleviate the pain of her own existence. Many of the mothers' accounts express grief and sadness:

You also described how you would be feeling refreshed mentally and physically as you would be following a healthy sleep pattern and you would not be experiencing any grief or sadness.

(Extract from Biological Mother 3's Preferred Futures Account)

Gibson (2013) suggests that shame and stigma are inherent for parents by dint of their involvement with child protection services, carrying as it does, the implication that they have 'failed' as parents.

Arguably, child protection social work inevitably induces shame in service users by the very nature of the work.

(Gibson 2013, p. 4)

Further, Gibson suggests that shame is internalized as 'inherent inadequacy' and thus lowers parental self-esteem and parents' perceptions regarding the ability to change behaviours. Guilt focuses on the behaviour as problem (rather than pathologising the individual) and can act as both a motivator to change one's behaviour and as a source of empathy toward those one has 'wronged' by that behaviour (Gibson 2013). The loss, grief and sadness that characterise many of these women's lives is not only due to

having children taken into care but also as a consequence of loss, estrangement and bereavement from other family members too:

You said that everyone would be smiling and your babies would be home with you all. You said that your relationships with [Older son] and [Older Son's Girlfriend] would be back to normal and the trust would be reinstated between you, [Older son] and [Older son's girlfriend].

(Extract from Biological Mother 42's Preferred Futures Account)

Most frequently grief and loss were attached to former partners who were now non-resident biological fathers:

You told me that [Biological Father] would still be abstinent from amphetamines and would still be playing a major role within the family unit.

(Extract from Biological Mother 51's Preferred Futures Account)

Frequently the women express fears about their own emotional health and well-being and talk of themselves as being depressed:

[Biological Mother] said that the big black cloud that you feel is currently above your head would have lifted and because of this you would feel a mental and physical improvement in your health.

(Extract from Biological Mother 51's Preferred Futures Account)

As Gibson (2013) highlights the intervention of social services can compound these feelings of inadequacy and low self-esteem and this is echoed in maternal preferred futures accounts:

You told me that you think that social services see you as a bad person and unfit mother as you previously hit [Son].

(Extract from Biological Mother 28's Preferred Futures Account)

You told me that social services make you feel like “shit” as you always feel that they are looking down on you and judging you.

(Extract from Biological Mother 52’s Preferred Futures Account)

Given the weight of loss, grief, shame, regret and guilt these women feel burdened with it is unsurprising that they feel depressed - literally, weighed down with emotional responsibility. A frequently occurring core value expressed by mothers was that of having a long and happy marriage (five occurrences). For some mothers a long and happy marriage is viewed as being the foundation of familial happiness:

Having a long and happy marriage is most important to [Biological Mother] because she feels that a couple need to be strong for their kids and for the family as a whole. She believes that as the head of the family if your relationship is happy everyone else in the family will be happy.

(Extract from Biological Mother 17’s Values Response)

This statement epitomises the underpinning philosophical principles of a whole family approach – that the sum is greater than its parts, i.e. that families are constituted and strengthened by the interrelationships between individual family members. Further this extract places the parental relationship at the heart of these interrelationships. Within this sample of mothers it is the women that feel responsible for creating and maintaining positive familial relationships and emotional bonding, in other words they perform an emotional housekeeping role within the family. The importance of the adult relationship has an enormous significance to self-worth and meaning within some of the women’s lives, and in relation to both their own birth families and the families within which they are the mothers:

[Biological Mother] feels that to have a long, happy marriage or relationship is what she has always wanted from life and when she was growing up she never wanted her parents to finish.

(Extract from Biological Mother 26’s Values Response)

The recurrent theme of loss and absence is also present in this extract. The absence of a ‘normal’ two parent, happy, family life in this woman’s own upbringing creates a void

that she hopes that experiencing her own long, happy marriage may fill. From these extracts it is evident that for some women marriage and family are intimately inter-linked and marriage forms the foundation for family – the feeling presented is that to the extent to which the marital relationship is enduring and happy so too will the family be happy and enduring.

One hypothesis is that the core values expressed are primarily expressions of absence, i.e. what has become of most important value to these women is what they do not have – a comfortable home, a close family, control of themselves and their own lives, and long and happy marriages. That these are things that are not distinctly different values or aspirations from what might be considered so in mainstream society is also significant. These are not outlandish, extra-ordinary, or unrealistic desires for one's own life and there is nothing distinctly different that could be said to be specific to the context of an in-care history, inter-generational cycles of poverty or substance misuse. The difference is perhaps that whilst the aspirations are the same as for many people in mainstream society these women may have had less personal experience of directly experiencing these things themselves from the inside, either when they were children or now that they are parents. The templates they can draw on are thus often external displays of family, such as family days out, the decor that makes a house a home and so forth.

There were four occurrences of being emotionally strong and having things safe and secure. The importance of being emotionally strong is encapsulated in the following extract:

[Biological Mother] knows that she needs to be emotionally strong and cannot be vulnerable as a parent. She needs to keep her guard up and be the strong one in order to protect her family.

(Extract from Biological Mother 17's Values Response)

This mother is clearly expressing that mothering means protecting her family. The relatively differing ways this might be interpreted, e.g. protecting her children from being taken into care by social services and/or protecting her children from risk and harm, which could be seen as one and the same thing by the mother, may be very

differently interpreted by professionals. Both being emotionally strong and having things safe and secure are linked with protecting children:

Having things safe and sure when the kids are growing up is very important to [Biological Mother] because they need to be protected from the outside world and have a safe environment for them to live in. [Biological Mother] feels that her children's safety is more important than her own.

(Extract from Biological Mother 24's Values Response)

The mothering moral identity is inextricably interconnected with keeping children safe and protecting them – both for the mothers themselves and the professionals who focus their attention on mothers.

Honesty is also linked with protecting children. In mothers' preferred futures accounts there is an articulation of the belief that without honesty there is no trust, without trust relationships breakdown and boundaries become permeable and unstable. The lack of honesty can also lead to personal burdens of guilt. The following extracts typify such responses:

You said honesty is important within the family because without honesty there is no trust. You said you feel that if there was no trust and honesty within the family unit there would be no boundaries and everyone would be living their lives separately.

(Extract from Biological Mother 24's Values Response)

You told me that honesty is now a very important part of your life. You said that you have not always been entirely honest with your family and the services that are involved with you. You said by previously hiding things issues they were not really being resolved and because of this family arguments would sometimes escalate and this would result in police involvement and you staying with other family members. You said that since you and [Biological Father] have been open and honest you are resolving your issues positively and are seeking the appropriate support.

You also said that you no longer feel guilty as things are now out in the open.

(Extract from Biological Mother 21's Values Response)

Honest communication is seen as holding the potential for resolution and dissipation of disputes before escalating into conflict.

'Home' is a prime concern for both men and women, for men this is conceived as being part of their role as material providers to their families and a pragmatic concern of property ownership and permanent accommodation, whereas for the women 'home' is the focus of their care and attention. Whilst home was a signifier of family for both men and women, the women provided much more detailed accounts of the furniture and decor and had clearly spent some time considering these things:

The room would be decorated in cream and brown wallpaper, with lovely pictures on the walls. There would be lovely wooden flooring and a brown leather three piece suite.

(Extract from Biological Mother 28's Preferred Futures Account)

The bedroom would be decorated with a feature wall, new curtains and blinds with lovely nets and a nice dressing table. The room would smell nice and bright and clean.

(Extract from Biological Mother 6's Preferred Futures Account)

Whilst there is great importance placed by both men and women on having a clean home, it is the women who are seen as being responsible for maintaining cleanliness and that this is perceived to be an integral part of mothering practices:

[Biological Mother] would then come back from the mother and baby group and tidy the house.

(Extract from Biological Mother 17's Preferred Futures Account)

The house would be clean and tidy but [Biological Mother] would still run the Hoover round, dust and wash up before she helped Son get dressed.

(Extract from Biological Mother 50's Preferred Futures Account)

Daughters are also expected to participate in cleaning and to see their mothers' cleaning behaviour as a positive role model:

[Older Daughter] would be helpful around the house and she would be learning through [Biological Mother]. [Biological Mother] would act as her role model and would be getting a lot out of the relationship. [Biological Mother] feels that if she was happy and content doing positive things Older daughter would want to do them as she could see happiness and good things could come from that.

(Extract from Biological Mother 50's Preferred Futures Account)

For mothers having a 'comfortable home' was the most frequently stated value, occurring eight times:

It is also very important for [Biological Mother] to have a *comfortable home* for her children and her. This means that she has a settee, beds, washing machine, food and hot water for baths. [Biological Mother] feels that it is her responsibility to make her home comfortable for the kids and [Non-biological father].

(Extract from Biological Mother 17's Values Response)

[Biological Mother] you really want your home to be a *comfortable* place to be. You've thought hard about how you would do it, what colours you want, how the home would be furnished and you are a creative person who enjoys making things look good. You would choose bright colours and want to get going as soon as possible with your decorating.

(Extract from Biological Mother 50's Values Response)

The importance of a comfortable home, both in the values and preferred futures questions responses', supports the idea of 'home' as a central construct in relation to 'family.' Home is the contextual environment in which the doing of family and daily family practices (Morgan 1996) take place and as such exert an environmental influence

on how, and what, family practices are embodied. For example, if you have no dining room and no table and chairs you cannot sit down and eat together other than on trays in the lounge with the television most likely on. This thus affects the type and nature of interaction during meals and minimises the necessity of all eating together at the same time. The relationship between 'home' and 'family', as constructs is further strengthened by the fact that the other most frequently occurring value, also at eight occurrences, is 'close family'.

As noted earlier in this chapter (section 2), whilst acknowledging that family should not be conflated with household and that not every family consists of members who live in the same household, the home provides the symbolic as well as the physical boundaries between private and public, between 'family' and 'non-family'. Homes are private spaces in which family members can pass through freely, safe to relax, express themselves candidly, show affection, enjoy sexuality and reinforce family ties and in which they are protected from the external world (Newman and Grauerholz 2002). The modern desire for the private expression of intimacy came to be particularly anchored in the home, especially in countries with northern climates. A great deal of effort, mainly undertaken by women, is expended on making the home a conducive environment in which to feel a sense of togetherness, comfort and security (Gullestad 1995). Thus, 'home' is not only a functional private space in which to engender family togetherness by the doing of family but also a symbolic signifier of that togetherness, belonging and intimacy. People outside the family have to be 'invited in' to this private, intimate space in order to be included as 'family'. These are also pertinent points in relation to the significance of home as the therapeutic environment as discussed in chapter 6, section 3.

All of the parental preferred futures accounts stress the importance of structure and rhythm to the daily routine and rituals of waking up, working, coming home, eating together and bed time routines for the children. As with many of the themes identified it may be that what is stressed within the preferred futures accounts are the very things that are currently absent in family life and therefore they are of greater importance in terms of how things could be different in the future. This would certainly make sense within the context of their therapeutic use as a means of generating cognitive dissonance between current and desired situation. Alternatively the narratives could be heavily informed by the expectations that others, including professionals, have required of the

parents in order for their children not to be removed into care or returned from care. In other words, the accounts may be genuine expressions of parental preferred futures and/or may be statements of what parents perceive to be other (professionals, or societal) normative expectations of them as parents, namely traditional normative constructions of mothering and fathering practice.

Embedded within the narratives of a daily routine are food and mealtimes, particularly breakfast and the evening meal:

They would see [Biological Mother] and him feeding the baby and they would have a set routine.

(Extract from Male Partner 51's Preferred Futures Account)

When [Biological Father] arrived home the house would be warm and he would be looking forward to settling down for tea with his family.

(Extract from Biological Father 30's Preferred Futures Account)

Whilst daily routine was a feature in both men's and women's accounts, the women's accounts gave more consideration to the age, stage and independence of the children involved, for instance the structure of day being based on school times for school age children, or feeding, play and bathing for babies and infants.

You would then go back up stairs and wake the children up to get ready for school and they would both get out of bed without arguing with you.

(Extract from Biological Mother 17's Preferred Futures Account)

[Biological Mother] would quietly wake the girls and take [Son] and [Daughter] downstairs to make their breakfast and a cooked breakfast for [Biological Father]. She would leave [Youngest Daughter] in bed until it was time for a bath which they would share together.

(Extract from Biological Mother 28's Preferred Futures Account)

The significance of food, and particularly good quality healthy food, was frequently stressed in the accounts, as the following extracts illustrate:

After this he would help with the evening meal by cooking healthy food, which would include salads, steak, jacket potato or boiled rice.

(Extract from Social Father 6's Preferred Futures Account)

Because she would have so much free time, [Biological Mother] would be able to prepare all the children's dinners before they got home so that they would not have to wait for ages for their food to be ready. [Biological Mother] would then collect the younger two from school and the older two would come home. They would all go out to play until 5.30 and then [Biological Mother] would call them in for their dinner and everyone would come in and the family would all sit and eat together. The children would all take their own plates out and then do their jobs before they went out to play a little more. There would be no fighting or arguing and the children would all show [Biological Mother] respect when she spoke to them.

(Extract from Biological Mother 17's Preferred Futures Account)

Food and mealtimes are a significant 'display' of family togetherness, of the love and care that has gone into the choice of food and meal preparation (Finch 2007). Rees, *et al.* (2012) suggest that mealtimes 'structure and demarcate family life' and can provide a form of social cohesion, particularly in reconstituted families. Meals are one of the few activities that bring families together on a daily basis and, as such, serve as an important site for the constitution and maintenance of family cohesion and familial roles (Kendall 2006). Cappellini and Parsons (2012) discuss the importance of mealtimes in strengthening and maintaining family bonds by dint of 'sharing', 'gift-giving', and 'sacrifice' (predominantly maternal sacrifice). The (paternal) funding of food, its (maternal) purchase and preparation and the ritualistic and symbolic (as well as functional) act of eating together promotes a sense of belonging and togetherness. In the preferred future scenario the men are able to provide funds for good quality healthy food to be bought, rather than poor quality processed convenience food. Both the providing of, and the quality of the food prepared and purchased can be interpreted as symbolic signifiers of good parenting. Women also see mealtimes together as a bonding family ritual. However, for women this is discussed more as a direct expression of love and care, whereas in the male accounts the focus was largely on being able to afford

good quality healthy ingredients. In the women's accounts it is the labour that goes into the preparation of the meal that is significant. This labour of love is most frequently portrayed as being done by the women.

You would then go home and make something lovely for tea for you all and after this you would all watch a film on the settee.

(Extract from Biological Mother 17's Preferred Futures Account)

You would wake up and go down stairs to make the children their breakfast.

(Extract from Biological Mother 52's Preferred Futures Account)

For the women food is also the main reason for gathering with extended family, the extended family being primarily female – maternal mothers and sisters.

You would then go for some lunch with your mum in town and maybe your sister would also be with you, they would both be happy with you because you haven't been drinking and there would be no arguments and you would arrange to meet again soon.

(Extract from Biological Mother 52's Preferred Futures Account)

[Biological Mother's] Mum would come up every Sunday for dinner so too her dad. Her Mum would have to get here by driving up here as [Biological Mother] would really help her work on that one, she would get her out of her routine and get her here. Her Mum would be eating and having chats and [Biological Mother] would be happier knowing she is eating and spending time with the family. This would remind her of the times when she was a child when the family would have Sunday dinner, even when she was sixteen and had left home she would return for Sunday dinner. [Biological Mother] would like this as her mother is getting older and family time would be important.

(Extract from Biological Mother 28's Preferred Futures Account)

Whilst extended family were expressed as important for both men and women, the men generally spoke in terms of being accepted by the maternal extended family as much, if not more than, by their own extended families. None of the women made reference to the paternal extended family but were keen for closer relationships with their own extended family (as notable in the extracts above).

Family outings are also a feature of all the accounts as displaying the epitome of family togetherness for the external world to see and witness, including disparaging extended family members who did not approve of the relationship. This could be seen to be exemplifying ‘family display’ (Finch 2007), in that it is not just the ‘doing of family’ (Morgan 2011) that is important to these parents but also the ‘being seen to be doing’, i.e. external display of family togetherness, that is important.

Then [Biological Father] and [Biological Mother] would take the three children, the baby, [Daughter] and [Son] out for the day. [Biological Father’s] family would have come to [Home Location] to visit the family and they would all go to the park with the children.

(Extract from Biological Father 14’s Preferred Futures Account)

Family days out were frequently portrayed by mothers as something done with fathers, rather than an activity the mothers would do with the children alone. Family days out were presented in the preferred future accounts as being part of the bonding and togetherness of the unit as a whole family, and fully inclusive of fathers.

When [Biological father] came home from work [Biological Mother] and [Biological father] would then take the baby along with daughter and son to the park. [Biological Mother] would be having regular contact with daughter and son and they would all be a happy family where life was fun.

(Extract from Biological Mother 26’s Preferred Futures Account)

However, family days out were a stronger feature in the men’s accounts, whereas there was a greater emphasis on the daily routine of caring within the women’s accounts, particularly shopping for food.

[Biological Mother] would get dressed and then she would bath the baby and get her dressed. She would take her out if it was a nice day and meet with her sister and go for a walk with her and her baby. She would possibly go to the park. [Biological Mother] would go shopping for food with the baby and then return to her flat. She would play with New-born baby and then get her ready for bed and put her in bed.

(Extract from Biological Mother 23's Preferred Futures Account)

For both fathers (whether social, or biological) and mothers, family preservation, i.e. keeping the family together, was an unquestioned value as notable in the extracts above. Clearly, as noted in chapter 5, this is a value of family preservation is shared between policy, practice and parents themselves. Fathers accounts have slightly more emphasis on keeping mothers happy than on keeping children happy. The mothers' accounts rarely focus on the happiness of the fathers and are almost exclusively centred on their children's happiness, with very little separation between the mothers' needs and those of their children, as if the two are inextricably linked and in some cases, one and the same:

You said that if six months from now if I looked in through your window and things were going well I would see [Son] laughing, playing and watching TV. You said that you would be more confident and would be talking and interacting with [Son] more.

(Extract from Biological Mother 28's Preferred Futures Account)

Consequently, friction in relationships with children are a significant stressor for women and the focus on more harmonious relationships is primarily in relation to mothers' relationships with their children:

[Daughter] would get straight out of bed and say 'good morning mummy', she would be really well behaved and would get dressed and eat her breakfast without behaving badly and swearing at you. [Son] would also get straight out of bed and he would be happy and smiling and would not have to tell [Daughter] off for swearing and misbehaving. You would then

walk the children to school and would enjoy this and [Daughter] would have behaved really well.

(Extract from Biological Mother 52's Preferred Futures Account)

There seems to be an expectation that mothers are emotional housekeepers for the children, and that any misbehaviour is the mother's responsibility to resolve. As noted in these and other extracts there is more mention of the importance of physical affection and cuddling as an indicator of family well-being in women's accounts than in men's, with the physical affection and closeness in women's accounts being a signifier of emotional closeness:

In the evening, the children would all come in and have their baths then get their pyjamas on ready for calm down time. The family would then all cwtch⁷ up on the sofas, [Biological Father] on one with two of the kids and [Biological Mother] on the other with another two, and they would swap over the next day. They would all sit calmly together watching telly and chatting and there would be no arguing, fighting or winding each other up.

(Extract from Biological Mother 24's Preferred Futures Account)

Having a close family is most important to [Biological Mother] because she feels that she needs her family more than anything. They give her support no matter what and she feels that this keeps her on the straight and narrow. When she was ill she did not see it and her family made sure that she got the right support and help. This has always been important for [Biological Mother], although when she was younger she thought that she didn't need them so much. [Biological Mother] feels that she is also there for her family no matter what and even when they have arguments they still remain close. When her sister and her were not close she felt gutted and really missed spending time with her.

(Extract from Biological Mother 22's Preferred Futures Account)

⁷ 'Cwtch' means 'cuddle' in Welsh.

The interdependence and reciprocity of individual, and familial needs, is evident in this latter extract, as is its self-sustaining nature. Family is a place where this mother feels she can always gain unconditional help and support, regardless of the current state of those relationships or her behaviours. This reflects the policy construction of families as self-sustaining, i.e. that the social capital and resources (at least in terms of emotional capital and resources) within families are on-going and sustainable, and that support from within the family should replace state support which is limited and finite, as well as costly. This also endorses a whole family approach to practice and the necessity of working with the interrelationships within families as ‘nested interdependencies’ (Kittay 1999). The interconnectedness of individual and familial needs is further exemplified below:

Having a close family is most important to [Biological Mother] because she feels that a family needs to be strong for their kids and for the family as a whole. She believes that in a family if your relationship is happy everyone else in the family will be happy.

(Extract from Biological Mother 18’s Preferred Futures Account)

The primacy of children as the focal point in mothers’ lives, and within this close family is evident in the accounts:

It is also very important for [Biological Mother] to have a kind and loving relationship with her kids because she needs to feel that they are loved and happy so that they feel stable growing up. If the kids are happy then [Biological Mother] is happy.

(Extract from Biological Mother 6’s Preferred Futures Account)

In reflecting on her own self- identified core values one mother exclaims:

But above all...”the kids are more important than all of the above...!”

(Extract from Biological Mother 44’s Values Response)

This further reinforces the theme noted within the preferred futures accounts regarding the interconnection between mothers’ happiness and that of her children, and that of

family preservation, i.e. mothers and fathers want to keep their families together. It has been argued that in late modernity there has been a ‘transformation of intimacy’ (Giddens 1992). In late modernity the breakdown in the emotional and financial security that adult romantic relationships were considered to provide has been replaced with parental love and the perception that relationships with children provide greater longevity and endure beyond intimate adult relationships (Giddens 1992).

A familial relationship can also embrace and encompass the parental relationship within it. The importance of the relationship between parents (whether biological mothers and biological fathers, or step/social fathers) is highlighted in the expressed need for adult partners to have quality time together that is separate from time spent with children.

[Biological Mother] and [Biological Father] would then be able to have some quality time to chat and watch telly together on their own before they go to bed. [Biological Mother] would go to bed calm and relaxed and without any worries about what the next day will bring. She would go to sleep happy and sleep really well.

(Extract from Biological Mother 17’s Preferred Futures Account)

Also emphasized, and apparent in these extracts, is the need for relaxation and restful sleep free from worry and stress. However, the attitude to having a partner is mixed and not all mothers consider having a partner desirable, and/or express understandable reservations on the basis of past experiences of abusive relationships:

She would have no worries of anyone else. [Biological Mother] would not be pleasing a boyfriend to keep them happy.

(Extract from Biological Mother 26’s Preferred Futures Account)

[Biological Mother] would be thinking how lucky she is to have her [Daughter] to look after and she would be thinking she does not want to lose her again. She would like to be with a decent partner, but if not she would be happy with [Daughter]. If she had a partner they would treat her well, not hit her, not take drugs and will respect her baby and her.

(Extract from Biological Mother 42’s Preferred Futures Account)

Where parents, and in these accounts predominantly mothers', have experienced abusive relationships, either with their own parents and/or partners there is some understandable ambivalence as to the contribution in quality of life such relationships might provide.

8.5. Conclusion

In this chapter parental gendered constructions of mothering and fathering have been explored by examining the thematic similarities and differences between men and women's narratives in preferred futures accounts. The nuanced differences highlight differing normative expectations, or moral identities, for men as fathers and women as mothers. However, for both men and women their perception of the others' parenting role was strikingly similar, i.e. both men and women shared the same traditional normative expectations of what mothering and fathering practices entail and that these were distinctly different. The father's perceived their role as predominantly about being a provider and thus about obtaining paid employment in order to pay for a home, food, family days out, etc. and to support the mother to care for the child(ren). Both men and women constructed the mother's role as being to generate family cohesion, love and warmth, i.e. a harmonious household. Thus, both men and women see the father's role as provider and the mother's role as emotional housekeeping. Thus, parental accounts can be seen to be highly gendered in terms of idealised normative mothering and fathering practices.

Parental accounts of family life as derived from miracle question responses centre on displays of family (Finch 2007) and these idealised aspirations for family life are constructed on the dominant discourse of traditional family ideology. This is perhaps not surprising in the context of scrutiny by child protection services and the desire to be seen to be functioning to societal family norms. Whilst the mediated accounts are co-constructed with practitioners for the therapeutic purposes of creating cognitive dissonance, the data in this study provides some illumination on parental constructions of family life.

It is evident from the data presented within this chapter that household composition and family structure as a means of constructing 'family' are too simplistic, rigid and fixed in

character to capture the fluidity of family form through time and spatial location. Nor do such constructions provide an indication of the relational quality within the interrelationships between family members. Further, nor does household composition or family structure reflect the lived experience of families themselves, as parents seem to characterise family as being fluid and relatively unboundaried. As Morris states:

The evidence from family decision making in care and protection suggest that the family networks being identified by children and their significant others are relatively unboundaried, with geographical location, blood ties and proximity not necessarily being key determinants of the membership of a child's family network (Morris *et al.* 2008). It therefore makes sense to adopt a fluid definition and to suggest that family networks will vary from child to child, regardless of any fixed professional understandings. The important point to note here is that the area under discussion is the child's family rather than just parents or immediate carers.

(Morris 2012, p. 907)

Thus, practitioners should be exhorted to adopt a fluid and flexible construction of 'family' that can accommodate and align with those of individual families. This necessitates that professionals interrogate their own conceptualisation of 'family' and that of family as constructed in policy in light of that of the family's own construction. In the next chapter, 9, practitioner constructions of the impact of gender on parenting in terms of mothering and fathering care practices are explored.

9. Chapter Nine – The Impact of Gender on Assessment and Intervention in Practice

9.1. Introduction

In chapters 3 and 5 respectively it was noted that both UK and Welsh policy tends to present a veneer of gender neutrality by utilising the term ‘parent’ rather than either mother and/or father, and further that this is often also conflated with ‘family’ (Daniel *et al.* 2005). This has the potential to obscure any differential effects by gender that child welfare policy may have. In chapter 8 it was highlighted that parental accounts of their preferred futures are highly gendered and aspire to traditional gendered normative constructions of parenting, namely that the fathers’ role is broadly and predominantly that of provider and the mothering role is that of (emotional) housekeeper.

This chapter explores IFST practitioners’ construction of parenting and any effects of gender IFST practitioners perceive in mothering and fathering care practices in order to address the question of what impact gender has on the assessment of parenting capacity and perceptions of risk, resource and absence in family life. This is an important area to research in order to understand the impact of gender on practitioners’ assessment of parenting capacity and perceptions of risk, resource and absence within family life and child protection processes. As highlighted in the *Fathers Matter* research (Ashley 2011; Roskill *et al.* 2008; Ryan 2006) not only are fathers marginalised in the child protection process but where fathers are included they felt that their parenting was inappropriately assessed against mothering care practices and thereby deemed as ‘failing’ or ‘inadequate’. Section 9.3 of this chapter then broadens the discussion to the impact of gender on the assessment of parents as risk or resource in terms of child welfare, before considering father inclusion within a whole family approach (section 9.4).

As noted in Chapter 4, Section 4, it is important to be aware that the findings presented within this chapter is based on practitioners’ own self-reporting from research interviews, and thereby constitute practitioners’ self-perception and beliefs regarding their practice, rather than necessarily the actuality of their practice.

9.2. Gender and the assessment of ‘good enough’ parenting

In order to explore what, if any, gendered expectations IFST practitioners had with regard to the gendering of parenting the practitioners were asked what they considered to be ‘good enough parenting’. The phrase ‘good enough’ was used as it is a concept that underpins the Common Assessment Framework (CAF) (Children's Workforce Development Council 2009). Winnicott posited that positive relationships contain traits of parallel engagement and responsivity, and he derived the phrase ‘good enough mothering’ (Winnicott 1986) to describe the quality of relationship that resulted when a caregiver was attuned and responsive to her infant’s physical and emotional needs. The key focus in assessing the quality of this parent-child relationship is the nature of the attachment bond. ‘Attachment refers to the enduring and reciprocal relational bonds between children and primary caregivers’ (Cohen Konrad 2013, p. 40). Bowlby (1969) identified four determinants of attachment relationships: ‘proximity maintenance’ or the desire to be close to those we feel attached to; ‘providing a safe haven’, i.e. the inner knowledge that one can return to secure relationships when faced with uncertainty, threat or fear; ‘providing a secure base’, i.e. the reliable presence of another who acts as a source of stability and comfort when the child explores his or her world; and finally, ‘separation distress’ exemplified in anxiety or distress in the absence of attachment figures(s).

Surprisingly, none of the practitioners related the use of ‘good enough’ within the interview schedule to its theoretical basis, although one made reference to it as a social services benchmark but with no apparent understanding of its location as a theoretical construct, or what the term meant. However, all of the practitioners included ‘safety and nurturing’ in their definition of ‘good enough’ parenting. This is perhaps not surprising within the context of child protection and not necessarily a reference to the second determinant of attachment relationships noted above. Only one practitioner referred to attachment theory. Overall practitioners tended to draw on their own experiences of parenting and being parented, rather than on any theoretical perspectives in responding to the set of interview questions regarding good enough parenting, good enough mothering and good enough fathering. All of the practitioners initially conflated good enough parenting with good enough fathering and good enough mothering as being one and the same thing, but on further reflection tended to provide a more gendered and

nuanced account of differences in mothering and fathering as care practices. The first of these questions presented to practitioners was, ‘what is good enough parenting?’

Good-enough parenting? Well, I suppose, ensuring that children are growing up safely, and developing to a level that I suppose society deems as appropriate.

(Male Practitioner 1)

For Male Practitioner 1, whilst safety is paramount, parenting is also about societal conditioning and integration and he went on to provide an example of a ‘swear boy’ and ‘educating’ the parents that this would inhibit the child’s ability to be accepted and make friends. This could be said to reflect the policy endeavour to assimilate the disenfranchised and make better future citizens who will not challenge societal norms or act out anti-social behaviours. This future orientated thinking not only reflects policy but perhaps may be a reflection of this practitioner’s own experience of being a generative father (Askeland 2006; Hawkins and Dollahite 1996). Whilst none of the female practitioners referred to a future orientation, all three of the male practitioners interviewed did this.

I think good enough parenting is parenting that’s able to meet the emotional, physical, practical needs of their children. And at the end of it, the adults that grew up from that and are able to function within another family, within the society, within the community, and feel they are loved and valued as people.

(Male Practitioner 3)

There is a clear orientation toward creating better citizens and parents for the future from the work undertaken with families in the present, and of breaking inter-generational cycles of poor parenting and (emotional) deprivation (if not poverty and material deprivation). The intention is that with good enough parenting the inter-generational transmission will shift:

...they will grow up feeling safe and secure in an environment, but then also from a developmental point of view, they will then pass that kind of on . . . part of our role as an IFST is to kind of break that cycle of, you

know, kids in care, grow up to be adults....Whose kids are in care. . . . you know?

(Male Practitioner 2)

Although no firm conclusions can be drawn from such a small sample, it is interesting to note that the male practitioners present with a larger macro perspective on the work they are undertaking and appear to mirror policy intentions in their beliefs regarding the nature and degree of change that can be effected. The basis for determining what is 'good enough' parenting is one that practitioners struggled to put in any absolute terms with most practitioners re-iterating that 'good enough' is a relative, contextual, professional judgement:

But you know, I think, again, it's a professional judgment, isn't it? That's making sure that the child is going to be emotionally cared for, physically cared for and you know their basic sort of physical needs of nourishment and clothing, et cetera, are probably being met. I would say that that was good enough . . . and obviously that they're kept safe, you know, they're not going to hurt themselves. So, all of those things are, are in place and, you know, that emotional warmth is there.

(Female Practitioner 1)

When then asked what good enough mothering and good enough fathering were the practitioner said that they were both the same.

So what is good enough parenting . . . it so bloody changes all the time (both laugh) then you've got thresholds. I find them amazing cos thresholds in child protection teams can vary so much. You know this family I was working with, her children were taken off her, she was meeting all the basic needs but placing her children at risk of abuse, what-once a year? But that once a year...well the severity of that once a year outweighed the long term neglect and I don't know to be honest what is good enough parenting but I just think that its providing a safe enough environment for your child to meet their milestones and development and

making sure their basic needs are met. . . . Just making sure your child is protected emotionally and physically from any harm.

(Female Practitioner 2)

The focus of good enough parenting for this practitioner is ‘a safe environment’ but this practitioner highlights inconsistencies in thresholds between child protection teams and also the incident driven nature of removal or ‘child rescue’ which is echoed in the academic literature. Fox Harding (1991) outlines the ‘child rescue’ approach as characterised as state intervention where parents are perceived to be ‘failing’ and therefore have lost the right to involvement in the child’s upbringing. This approach is predicated on individual pathologising of poor parenting and the idea that parents and children should be treated as separate individuals. This is a contrary position to the whole family approach in which parents and child(ren) are treated as a unit, and further that structural factors such as class, poverty, inequality, race and gender impact on parenting rather than simply individual pathology.

Featherstone *et al.* (2013) critique contemporary policy and practice for its ‘muscular authoritarianism towards multiply deprived families’ and the impact that a child rescue approach combined with a child-focussed orientation has on practice:

This orientation concentrates on the child as an individual with an independent relation to the state. In such an orientation children’s relationships with siblings, their parents, their family networks, friends and neighbourhoods become background. The complexities of relational identities, past present and future, are glossed and, indeed, as we are seeing in England currently, a powerful moral mandate can be provided for a child rescue project, reinforced by every terrible death...The strengths in family networks and communities are not recognised in a child rescue model.

(Featherstone *et al.* 2013)

Thus a child rescue approach is antithetical to a whole family approach. Female Practitioner 4 also considers good enough parenting a judgement call and firmly locates this judgement as contextual and relative to the family’s needs and resources.

I think sometimes, it's got to be within the capacity of that family. You know because if we said all families haven't got that...you know, we could say that, and then all children would be in care, but you just got to work within their limitations, or within their resources. You know it's good enough, you know, because it is...

(Female Practitioner 4)

There is also an indication of thresholds and service resources being influential in that contextual judgement. The implication is that whilst parenting might be less than ideal in most families there are other issues, such as the availability and quality of looked after care that also impact on making this judgement. Female Practitioner 4 went on to say that she felt it was more about *family* capacity than *parenting* capacity and that other relationships from the extended family, friends and neighbourhood could be utilised in child welfare.

For all the practitioners (male and female) good enough mothering is about safety and emotional warmth, manifested as emotional connection, attachment and bonding. The following extracts are typical of practitioner responses to the question 'what is good mothering?'

I think emotion. I think having that emotional bond and, you know, we talk about the sort of the attachment theories and things, you know, and I think, you know....But also, you know, obviously the safety side of things, and that as well. But I think the attachment thing is more important with that, you know, that the child grows up, you know, with that loving connection, and, really...and that emotional connection.

(Male Practitioner 2)

Safety is the huge thing in there I suppose. And by safety I mean physical and emotional safety. So creating an environment for the child to be able to grow and push the boundaries in a way that's safe to do. To look after without suppressing or being oppressive. And I mean love is a funny sort of word to describe I suppose but yeah, that sort of unconditional love,

really that, but bearing mind that there are boundaries and safety issues that you have to work with within that. But not where mistakes are made, being able to recognise what those mistakes are yourself and by the children and working with those, you know, that you and children learn to grow together, I suppose as parent and child.

(Female Practitioner 3)

During the interview Female Practitioner 3 began by using mothering as the benchmark of good enough parenting but then went on to say that both mothering and fathering are the same. Whilst understandably in this child protection context safety was the predominant issue, clearly underlying was ‘sentiment’, or what perhaps a child protection social worker might refer to as ‘attachment’, that is perceived to be the safeguard in ensuring that children have their needs met. In her response the practitioner is affirming that both parents love their children equally, namely, that ‘the sentiment’ is the same.

I would say good enough parenting that you know when you ask about mother, I guess what I’m saying there is parent, so I’m answering the question as a parent from the female parent then it would be exactly the same.

(Female Practitioner 3)

In attempting to be non-discriminatory mothering is conflated with parenting thereby rendering mothering as the benchmark for parenting. There is no distinction made for any effects made by gender and a reluctance to generalise socialised gendered constructions lest that be considered stereotyping. When asked if ‘fathers bring anything different to parenting?’

No, I think the sentiments are the same and I wouldn’t want to differentiate mothers and fathers, really. I would differentiate people. That different people would bring it in different ways. But that, that baseline would be the same and that, you know in the way that I talked about the family where the girls went to live with their father, his style of parenting would be very different from mum’s style of parenting but they both have

things to offer and you know together. I mean I suppose people talk about the ideal where there are two parents. I mean I don't know. I think you know, I think if you've got a very strong individual parent, I think it's hard on them sometimes to be the mother and the father but I think it's entirely possible to be that in the same way that it's entirely possible to be a mother and a mother in the same sex relationship or a father and a father. So whatever you call it, I think, doesn't really matter if they try to both bring that package of care. And it can be outside that as well. That part that you were saying, what is the family, where maybe, an individual doesn't have something that can be brought to that parenting role that's ideal, that they find it from somewhere else. I was never great at getting on the floor and playing with my children but I always talked a lot to my children. My husband doesn't talk much but he'll do things with the children. So I guess they were fortunate in that they had somebody who was a doer and somebody else who was sort of a communicator. Now if I'd been on my own or if he'd been on his own then yes, I guess they would've missed out in some way. Not necessarily because they didn't have a mother or a father, but maybe they didn't have a communicator or a player. So you know it's about the best that you can do with what you have, I suppose. But if the sentiment behind that is to do the best that you can do with what you have and what you don't have you look for, then that would to me be good enough parenting.

(Female Practitioner 3)

Whilst ostensibly the discourse is one of gender neutrality in not wanting to differentiate between mothers and fathers, as noted previously, the benchmark for parenting is seen to be mothering in terms of nurturing and safety. Thus, by logical extrapolation fathers are expected to, and are measured against, mothering care practices as typifying essential parental care practices (Ashley *et al.* 2006). This practitioner presents any differences that are present in care practices as *individual* difference rather than difference being a function of effects made by gender, in other words a gender neutral approach. There is a strong discourse of two parents as a team being the normative ideal, or at least a network of individuals from whom resource can be drawn to meet the child's needs. Sex and gender are conflated – a man as a father can parent equally as

well as a woman as a mother, and presumably mothering practices and fathering practices may be different but equivalent. In this practitioners' discourse it is not sex or gender that determines differing parenting styles but individualism. Thus the dominant discourse is that of individual liberalism. However, when the practitioner draws on her own parenting experience as a benchmark a clear gender distinction is made between the active, 'doing' fathering practices and the talking 'communicating' mothering practices. Overriding is a sense that as long as parents love their children they will find means to meet their child(ren's) needs but in differing gendered ways. This practitioner draws on her own experience of parenting as a benchmark or model of parenting practices. Indeed, all the practitioners drew on their own personal experience in reflecting on parenting, either in terms of their own experience of being a parent and/or of being parented, thus clearly illustrating the use of self in professional practice and the intertwined nature of personal and professional values in clinical judgement making.

Emotional proximity in terms of warmth, love and emotional closeness are generally characterised by the practitioners as essential to positive parental relationships but as more characteristic of maternal care practices than paternal practices, to the extent where there is some surprise expressed as being contrary to the norm when fathers demonstrate these practices.

I've worked with some families where the father is able to meet the child's needs a lot better than what the mum can. So, the father responds to the child when he's crying and the father changes his nappy. The father cwtches⁸ and kisses the child.

(Female Practitioner 2)

Male Practitioner 2 spoke in terms of mothers providing this type of care and that only where the mother is incapacitated, or absent, are others sought to provide this warmth and nurturing. In doing so he used the example of his own relationship with the biological mother of his older child who he felt lacked maternal warmth and so he fulfilled that role with his child. Whereas with the mother of his younger child he felt she did provide maternal warmth and as such felt he was consequently not required to

⁸ 'Cwtch' means 'cuddle' in Welsh.

do so. Both in this example and, generally in the extracts discussed above this would seem to construct fathers as ‘alternate mothers’, rather than in terms of either ‘partnership’, ‘luxury’, or as having a ‘unique fathering role’ (Daniel 1999) as discussed in chapter 3, section 4. Each of the analytic frameworks that Daniel (1999) presents suggests a different orientation and engagement to the involvement of men in child protection work and provides a useful lens through which practitioners can reflect on their practice in terms of gender inclusivity.

All practitioners put some emphasis on emotional warmth as a key function of parenting practices and at least three indicated that it was an inability, or lack of capacity, to express emotional warmth appropriately that was problematic for good enough parenting. One practitioner saw this as a reflection of the parents’ own lack of emotional development and inexperience of warmth, love and care. Just as expressing warmth was problematic for some parents, concomitantly the setting of boundaries in order for children to take risks within safe parameters becomes problematic. Where parents are relating to their children as friends or siblings the expression of love becomes the removal of boundaries or restrictions, i.e. letting the loved one do as they please (even though they may not have the capacity or developmental ability to know how to use that freedom and thereby put themselves at risk). For other parents the lack of obedience in adhering to parentally set boundaries is perceived by parents as a lack of love and respect and thereby rejection on the child’s part and leads to frustration and/or aggression on the parents part. The expression of strong emotion, be that of love or aggressiveness, can be interpreted as love and care or at the very least a strong attachment and emotional investment. As such, how parental love is expressed is very different for different people depending on their own experiences of parental love and may not generate the safety and warmth that is presented as the normative ideal but rather present risks to the child(ren’s) welfare.

To some extent for all the practitioners there was an underlying view that the father’s role is predominantly to reinforce and support the mother and/or to act as a substitute mother when the mother was incapacitated or unavailable, either permanently or temporarily, i.e. to act as an ‘alternate mother’ (Daniel 1999). What, if any, distinct fathering practices were expected, i.e. ‘a unique fathering role’, was not articulated by any of the practitioners. This may have been due to a desire as a professional to be seen

as gender neutral (although this simultaneously, inadvertently, exalted mothering practices as the epitome of parenting practice). As with all the practitioners, Male Practitioner 1 makes no distinction between good enough mothering and good enough fathering.

I think it's actually that stuff again. I don't think it's just a mother thing, I think it's, you know, everything about the mother there as well, but, you know... being a sort of, you know, a father figure and...you know, and to be there to support the mother as well, and to reinforce boundaries and things like that, you know.

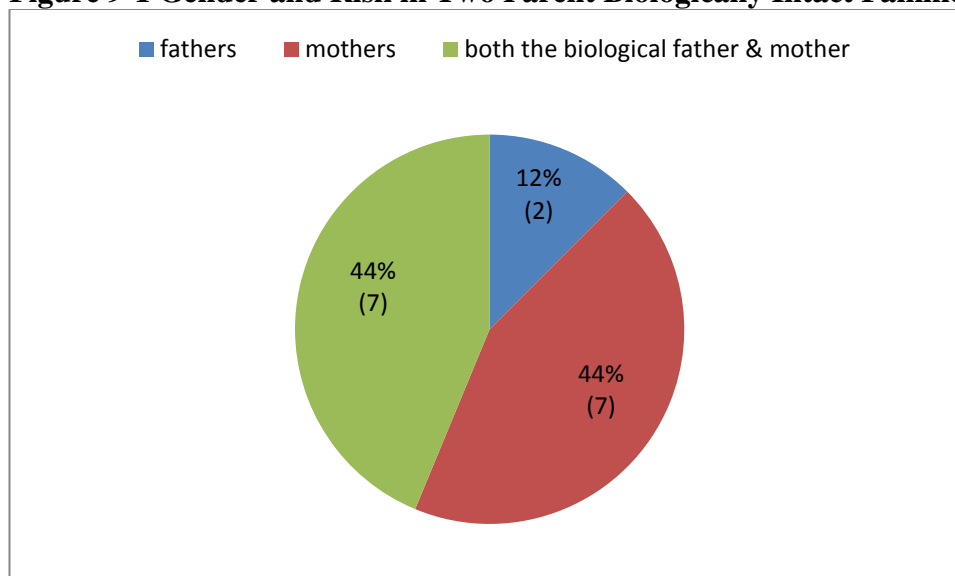
(Male Practitioner 1)

The implication is that the family is a 'nested interdependency' (Kittay 1999) with father providing for mother and mother providing for child. The nature of that provision, and how families themselves perceive this, may be somewhat different to that of practitioners, as noted in Chapter 8.

9.3. Gender and the family – Assessing Risk, Resource and Absence

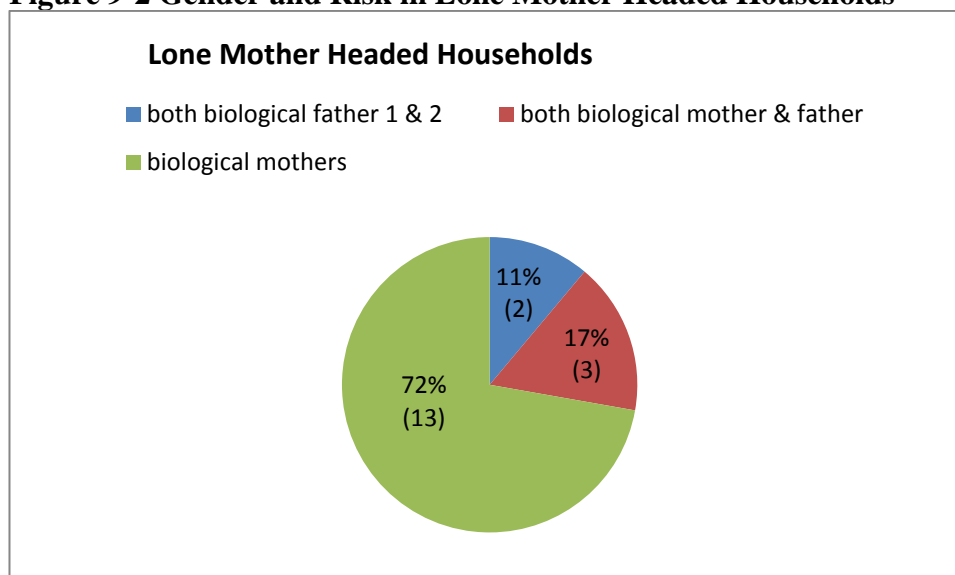
It is evident from the case files that parents of both genders are considered as neither wholly a source of risk, nor wholly of resource and that thorough assessment is needed in order to determine parental capacity in terms of the degree of risk and resource within each parents' capacity. The gendered construction of fathers within the case files does not present them as predominantly 'threat', or 'risk' or 'useless' as Scourfield's (2003) earlier study found. Rather the picture is more of a complex interweaving of risk and protective factors within each parent (whether mother or father), and within the extended family and community. If there is any tendency to bias it is a rather rosy view of extended family and community networks as an open resource to the family and source of support. Thus the analysis below is a simplification on the basis of which parents (mothers or fathers) were perceived as primarily posing the presenting risk factors to the child(ren). It should be stressed that this risk, as presented in the case files, was primarily in terms of substance misuse undermining the parents' (most frequently the mother's) ability to care for the child(ren). This is also reflected in the high occurrence of neglect as the form of abuse on the Child Protection Register (Cawson *et al.* 2000).

Figure 9-1 Gender and Risk in Two Parent Biologically Intact Families



Within this sample of ‘two parent biologically intact parents’ only 12% of fathers (2 fathers) were perceived by practitioners as presenting the sole or main parental risk to child welfare outcomes, whereas, mothers were perceived by practitioners as presenting the main or sole risk factor in 44% of the sample of families (7 mothers). However, in another 44% of the families both parents were perceived to be a risk to child welfare outcomes.

Figure 9-2 Gender and Risk in Lone Mother Headed Households



As noted in chapter 2, section 2, families labelled as ‘lone mother headed households’ are not a homogenous group and within lone mother families a diversity of family forms may exist that may include current and former partners. Whilst it is perhaps not surprising that mothers are perceived as the most frequent gender presenting as a risk

within 'lone mother headed households' it is noteworthy that non-residential biological fathers are also identified as presenting a risk, either in isolation or alongside the biological mother. Within the context of low engagement with non-residential fathers these percentages may be a significant underestimate. What is absent in the case file recordings of assessment information is what, if any, presenting risk current male partners/social fathers present. There may be a number of reasons for this, for instance the perception that the partners of lone mothers are 'just passing through' and/or that these men do not constitute part of the 'family' but are external to it and predominantly denoted as romantic relationship or intimate partner, rather than as having any involvement in the welfare of the child, either as risk or resource. However, within a relational ontological approach to practice, and/or a whole family approach such rationales are spurious as these men are meeting the needs of the mothers (at least as women, if not as mothers) and will therefore, either directly or indirectly, impact on child welfare and are a significant part of the mothers' interconnectedness and interrelationships as noted by Brandon *et al.* (2005) in the analysis of serious case reviews.

So whilst the common perception is that men are perceived by practitioners as risk to children (Scourfield 2003) they do not appear to be perceived as the main source of risk within these families, indeed it is mothers' abuse of substances that is overwhelmingly perceived as the primary risk factor. This may however be an effect of the gendered expectation that women provide care and nurturing and that their incapacity due to substance misuse undermines their ability to fulfil this function. This perception would certainly tally with the fact that the majority of the children are on the child protection register under the category of neglect for which mothers are generally held responsible (May-Chahal and Cawson 2005). This is reinforced by the fact that it is the mothers who are primarily made the focus of behavioural change in the goals at the point of referral as was noted in chapter 7, section 2.

By dint of the eligibility criteria, all families referred to IFST had at least one parent involved in substance misuse which was assessed as impacting on their parenting capacity. The case file analysis revealed high levels of substance misuse within these families. In the 16 two parent biologically intact families sampled: in 10 of the families both parents misuse substances, in three families it was only the father, and in a further

three it was only the mother. In the 18 lone mother headed households sampled: in 11 of the families only the mother misused substances, while in the remaining eight families both biological mothers and their partners/step fathers/biological fathers, misused substances. Whilst the majority of parents were using a mixture of drugs and/or alcohol, for some parents alcohol was the only substance misused – three of the biological mothers in two parent biological intact families and two of the fathers, but not both parents only using alcohol; three of the biological mothers of lone mother headed households were misusing alcohol, none of the fathers and in one instance both biological mother and biological/stepfather.

From the case file analysis it is evident that the cumulative, interrelated factors outlined in UK and Welsh policy are evident within these families, with substance misuse and its impact on parenting capacity being to the fore. However, other significant risk factors were clearly evident in the case file analysis. Domestic violence was a feature of 8 out of the 16 two biological intact parent families, i.e. 50% of families; and a feature of 3 out of the 18 lone mother headed households. Offending and/or imprisonment was a feature of 3 of the two biological intact parent families and only related to the men in the families; whereas of the 5 lone mother headed families where offending or imprisonment was a feature only one was male and the other four were biological mothers. Mental health was an issue for four of the biological mothers in lone mother headed households; and for two of the two biologically intact parent families. None of the men were identified as having a mental health issue. Poor housing, debt and poverty were factors for most families with very few parents (only a few fathers and no mothers) in employment.

Repeatedly in the case files strong emotional bonds of love and warmth were noted by IFST practitioners within the family. This is presented as the main protective factor. The risks as presented are interconnected, and interrelated, within and between individuals. Thus generating change within one area has a consequent effect on other issues that may not necessarily be helpful in facilitating change towards overall goals. Therefore, such complex needs require assessment and intervention at the points of interface for change to be moving in a consistent direction rather than being counterproductive to one another. This could also be said to be true of change within individuals impacting on the family system as a whole and thus any behavioural change in relation to one individual

has to be considered in terms of the other relationships and individuals within that system, particularly given the nested dependencies of need and resource.

9.4. Father inclusion in a whole family approach: ‘*Maternal Gatekeeping*’, ‘*opting out*’ and ‘*passing through*’

All of the practitioners interviewed stated that it was ‘very important’ to include fathers in a whole family approach. The predominant reason given for the importance of involving fathers was that fathers could provide a support to mothers in caring for the child(ren). This support could either be direct in terms of childcare, and/or indirect in terms of caring for the mother’s needs. In either case this support was considered to be pivotal in ensuring sustained change.

I think the successful cases would be where both parents support each other through change. So, it could be a feeling of support . . . I think, males have a big part to play in interventions, definitely.

(Female Practitioner 2)

This could be viewed in terms of parenting as a gender neutral activity and parenting as a team working endeavour in which care and support is multi-directional and reciprocal between both parents. However, most practitioners framed this support as uni-directional and linear, i.e. father supports mother, which enables mother to support and care for the child(ren). This constructs fathering as primarily indirect support to the child’s welfare via the care provided to the mother. Direct care for the welfare of the child is thus constructed as a predominantly maternal moral responsibility and part of mothering practice. Practitioners consistently highlighted that it was the degree of the father’s ability to sustain and reinforce behavioural change in mothers that determined the extent to which practitioners considered it useful to engage individual men in the intervention. The following extract typifies such responses.

How they could affect change really or you know, *not* affect change. Because you know, it’s much more difficult for that mum to continue to be drug free if her partner’s still using.

(Female Practitioner 2)

The interconnectedness of needs and resources is inherent within the nature of a close relationship. The whole family approach constantly reinforces this need to consider the ‘nested dependencies’ (Kittay 1999) between individuals, particularly between fathers’ and mothers’; and mothers’ and their child(ren).

We’ve had lot of cases with unborns and them being taken away at birth with the view to rehabilitate the child back into the family’s care. We work with mum and the dad. You never work with just the mum. If they’re going to be in a relationship, you’ve got to work with them both together.
(Female Practitioner 2)

Whilst a biological father may no longer be emotionally involved with, or living with, the biological mother he may continue to have a significant involvement with the child(ren). It is the degree of the biological fathers’ current involvement with the child(ren) that is the determining factor for practitioners in the decision to engage with fathers, and to what extent to engage with the fathers. Thus it is the measure, or assessment, of the degree of emotional and physical proximity to the child(ren) and/or the mother, i.e. the degree to which individuals are interconnected in relation to the welfare of the child(ren) that determines the degree of involvement within the intervention.

Like I was saying about that couple who have split. They don’t have involvement with each other but both parents very much have involvement with the children. So it’s important to include both of them because they both have an effect on the children. But if he’s not at all involved with the children why would you?!
(Female Practitioner 1)

This extract acknowledges that it is the current, or pre-existing, state of connectedness with which practitioners are concerned. Most practitioners articulated this in terms of the family itself determining who is in the family and who is involved in the child(ren’s) welfare. However, on closer scrutiny it becomes apparent that practitioners invested mothers with a gatekeeping role (Allen and Hawkins 1999) in the construction of family, as noted in chapter 8, section 3. This role largely determines to a great extent

who is included and who is excluded. Unfortunately this maintenance of the present status quo in relation to who is involved in the child's welfare also confirms existing gendered norms and may lead to overlooking biological fathers, and potentially other men such as social fathers, as a potential source of risk or resource to the family as a whole. This approach to father inclusion also fails to consider the impact that (father) absence can have on child welfare – materially, emotionally and psychologically (Amato and Gilbreth 1999; Flouri 2005).

A useful distinction can be drawn between romantic relationship and parenting partnership. Even where the romantic relationship has broken down a parenting partnership can still be maintained or developed. However, this can be problematic due to acrimony and recrimination about the ending of the romantic relationship. This presents an even greater challenge to the development of relational skills and the communication of feelings in a safe environment that is at the core of the whole family approach. In such instances even the sharing of physical space in terms of working with the whole family in the same room at the same time may not be a viable option.

Well, there's a case at the moment, for example, where the parents are separated and it's very acrimonious and everything gets conducted through the courts. Right. So, with some children living over here and some children living over there, and they swap... you know what I mean? Now, clearly, with that family, you're not going to do any work with them all together. So we're working through how we do that while still making sure that everybody gets equal say because what both parents don't do, or do, effects, you know, the well-being of the children and, you know. So both their behaviours have an impact on the children and their behaviour to each other has an impact on the children. So, that's the focus of our work. But it wouldn't be a case where we could bring those people together. So, you know, we always got to think like that, but is this..."Is there somebody who is the father but he just doesn't live there?" In which case we'll be having that conversation with mum, "When does dad come around," you know, "Can he be around on Thursday?" Sort of thing, you know? And also speaking to dad and having, having some sessions just

with dad, but trying to have as many as possible with him, like, around at the home, even if he doesn't live there.

(Female Practitioner 1)

It is clear that this practitioner does not consider it her role to re-unite the separated couple romantically and her engagement with each of them is purely in terms of the impact that their behaviour individually, and in relation to each other, has on the welfare of the children. In this instance, both parents were equally involved in direct childcare, and as such both have an equal impact and therefore equal importance in the welfare of their child(ren). Thus, the practitioner's discourse is about engaging with both parents '*equally*'. However, it is also evident that it is the mother who is given a gatekeeping role in the involving of the father and that the mother is expected to mediate contact between the practitioner and the father. Similarly, the anticipated site of any therapeutic work, and thereby the 'family' home is considered to be the mother's residence, even though the children are living in both parental homes. Given the acrimonious relationship with the mother, for the father to meet with the practitioner in the mother's home may be problematic, disempowering and unappealing and thereby create a barrier to involvement, presuming that the mother is willing and able to invite him as per the practitioners' expectations. This approach puts the onus and responsibility on the mother to mediate the fathers' relationship with the practitioner, at least in the first instance. Also, it is likely to engender suspicion on the fathers' part that the practitioner has a relationship with the mother that has precedence over any relationship he might develop with the worker in the future and that there may be collusion between the mother and the practitioner. This could be further exacerbated in the father's eyes by the fact that both practitioner and mother are women.

The positioning of women by practitioners in a maternal gatekeeping role can potentially create a barrier to father inclusion if the mother does not want the father to be involved. In the literature maternal gatekeeping is frequently constructed as solely a barring or excluding role and uni-directional, i.e. that the mother has control over opening or closing 'the gate', however, Trinder's study (2008) suggests that gatekeeping is a dynamic transactional process rather than a linear and uni-directional process running from mothers to fathers. In actuality it may be more accurate to say that the role is more akin to inviting or barring access. Practitioners place women in the

position of mediating practitioners' access to, and initial engagement with men as fathers. An (unintended) consequence of this is transferring the power of inclusion or exclusion to the mother, i.e. gatekeeping access and involvement, and perpetuating the expectation of women being emotional housekeepers for men, in other words that women mediate and organise men's emotional lives and relationships.

In addition to maternal gatekeeping nearly all of the practitioners interviewed articulated a discourse in which men as fathers had an 'opt out' of family life and parenting that women as mothers do not. As such men may choose to distance themselves emotionally, financially and/or physically – whereas women have no such choice. Physical and emotional proximity can be interlinked but are not necessarily correlated – a father may be non-resident i.e. not in close physical proximity and therefore not able to participate in daily physical care but may be emotionally close to, and involved in the child(ren's) life, and vice versa. However, it is also possible for fathers to be distant physically and emotionally even whilst being resident. In the extract below the practitioner discusses a biological father who is distant emotionally and physically, whilst the social father/mother's partner does engage in daily care of the children – in order to support the mother the social father gets involved in the care of the child(ren).

So, it could be, for example, if it was mum's partner who was living there, he would be...he would take part of the ownership for the primary care of the children. Sometimes, biological fathers choose not to see the children, you know, for various reasons so they wouldn't be part of the intervention.

(Female Practitioner 5)

The practitioner's rationale for casting mothers in the role of gatekeeper is the value of self-determination - that the 'family' determines who is included in the family, and therefore involved in the intervention. However, 'family' in this instance is being conflated with 'primary carer' which in this case is the mother – mother as primary carer becomes the manager of care and pivotal in deciding who is involved in the child(ren's) welfare and who is not.

I think if they have a father's role, if they have a role in the family whether it be distant, like on a weekend or whatever or they're in situ in the home or you know, what if they don't live together but they are, you know, they come around every day or whatever, then yes, I think it is important. If the father is, is not like, on the scene at all, I don't really know whether that would be, you know, useful to include them because that would be, you know, that's for the family to decide that and you know I would obviously talk to mum about that and, "Is this a person that you want to be involved in your family?" If she's saying no, I don't really see how that's my place then to, you know, drag this person into their lives, if that's the choice that she's made.

(Female Practitioner 1)

Similarly,

It's very much family led so that's the family's decision. So I'd ask whether mum wants the partner involved or not.

(Female Practitioner 2)

This is coupled with a perception that fathers distance themselves.

. . . the dads are so distant in so many of the families.

(Female Practitioner 3)

Frequently the practitioners spoke of a breakdown in trust and communication contributing to the distancing and/or exclusion of biological fathers.

You know, like for example I had a previous family, [AN Other IFST practitioner], ended up working with, where the mother didn't want the father involved. They had split up. They were divorced and she didn't want the father involved . . . because she didn't trust him.

(Male Practitioner 1)

The focus on mothers as gatekeepers in constructing family, and thereby who is included and excluded in the intervention, may be a consequence of the (real or perceived) belief that mothers are the main carers of children. These themes of distant dads (Clarke and O'Brien 2004; Lister 2009; Silverstein and Auerbach 1999) and maternal gatekeeping (Allen and Hawkins 1999; Cannon *et al.* 2008; Fagan and Barnett 2003; Gaunt 2008; Hauser 2012; McBride *et al.* 2005; Schoppe-Sullivan *et al.* 2006; Trinder 2008) are well rehearsed in the academic literature on father inclusion. However, the practitioners frequently noted the difference that a whole family approach can make to the inclusion of men as fathers involved in the welfare of their children. Working within a whole family approach requires practitioners to consider the family system in its entirety not just focussing on one individual be that child or adult parent/mother. This, in and of itself, is insufficient to ensure father inclusion but could form a good starting point to greater father inclusion. Most practitioners were aware of the discourse of mother blaming in mainstream child protection practice.

One of the main things is that I think for all of us in the IFST, we are a lot more mindful of the role of dad, than, maybe the referral social workers are. I think that dad can basically do what he likes but its mum who gets punished if she doesn't protect the child. The focus is still on mum to do it, you know, "You must do this, you must meet the child's needs," and there isn't any real pressure on dad to play his part. So I think, you know, gender still does play a big role in child protection as a whole, I think, and in the society as well.

(Female Practitioner 1)

The more systemic approach to engaging families does seem to encourage greater father inclusion but only where the father is already involved in the child's welfare, rather than in situations where the father may be more distant or is an untapped resource. Female Practitioner 4 states: 'We don't automatically go well it's all mum's job to change. You know, we're looking at what dad can do to help support mum.' Thus, the underlying value is that father's role is indirect support for the welfare of the child via their support of the mother – it is mother who retains primary carer responsibility and with that both the responsibility/blame and concomitantly the right to invite or bar inclusion of other carers. In other words, the mother retains the role of care manager delegating and

overseeing care practice which she has relinquished to others. As with any delegation of authority the responsibility and accountability (blame) still resides with the mother and the implication is that this responsibility resides solely with the mother, even following delegation of care she retains a moral responsibility for the quality of the care provided. For practitioners it was very clear that fathers have a right to (and frequently do) ‘opt out’, whereas mothers have no such option. The phrase ‘opt out’ was frequently used by practitioners and clearly indicates that this is perceived to be a self-determined free and conscious choice on the part of fathers. The construction of a self-determined ‘opt out’ on the part of fathers means that practitioners can consider father exclusion as a consequence of self-determination – either on the mother’s part in terms of maternal gatekeeping, or on the fathers part in terms of ‘opting out’. In either case, this legitimises fathers being excluded from the intervention. For most practitioners the importance of father inclusion was predicated on minimising mother blaming rather than on the basis of children’s rights, or gender equality, or paternal rights.

I feel as if the fathers think they can *opt out* of certain things. . . it’s the mother who takes the children to the child protection conferences, and so, you know, it’s the mother’s fault if things haven’t worked out and all the rest of it, you know. So I think it’s really important for us to kind of work with the dads.

(Male Practitioner 1)

One of the barriers identified by practitioners in engaging fathers was that they had historically been excluded and were hard to reach, or even identify, as being involved in the child(ren’s) care.

We get given cases that have been with social services a long time and they’ve excluded dads and it’s really hard to get dads involved . . . The trouble is... I’ve found with fathers is they are not involved at all so we never know who they are, or we never know where they are or anything like that.

(Female Practitioner 4)

Fathers were also perceived as minimising and downplaying the child protection concerns or the potential for the child(ren) to be at risk of entering care resulting as a lack of motivation to engage with the intervention – if there is no problem then there is nothing that needs changing. The motivation for engagement is engendered by seeing the positive impact of change, i.e. that regardless of whether there is a problem, or not, there is room for improvement that is realistic, achievable and beneficial to all concerned.

Yeah, the men definitely take a step back. From my experience, the women are usually most eager to work with us because they want to keep their children and they don't want their children to go into the care of the local authority whereas usually, sometimes, the men will play the issues down a little bit, you know. I would say the men tend to not want to engage with social services, you know, "I'm the man of the house, I can manage my own family, thank you very much," you know, "I don't need anybody to come in and, you know, tell me what to do and...."

(Female Practitioner 5)

Where fathers are encouraged to engage, this apparent distancing or opting out, may have an underlying cause that results from the fathers own needs and vulnerabilities rather than a (gendered) assumption of dads as being 'feckless' or 'lazy' (Silverstein and Auerbach 1999).

One of the dads that I was working with was thought to be very laissez-faire, very lazy, didn't really stump up to the mark with the children. After working with him, it became clear that the reason why he was not doing an awful lot was because he had two disintegrated discs in his back and he actually needed surgery; and he had neglected for a long time to go to the doctors to have this injection. He just hadn't been going to the doctors. In realising that, he went off and got himself sorted for injections and got his back sorted; through that he was more physically able and was then more able to take his children out, because he was saying, "I want to go and take my kids to school but I can't move off the flipping sofa," but the perception was that he just sat on the sofa, watching TV.

(Male Practitioner 2)

Another barrier to engaging men was the rapidity of change in partners and the perception of men just ‘passing through’ rather than being a permanent feature of family life.

When they split up, I contacted Owen and said, “Look you know, can we meet up?” And he said, “Why? You know I’m not part of the family anymore...”. . . . But there’s been two new men on the scene. And we’re talking in less than a month, really. Before I went on leave, she was going out with John and I came back and now she’s going out with... I can’t remember, but he’s a plasterer.

(Male Practitioner 1)

A whole family approach facilitates the understanding of the interconnectedness and inter-dependence of need and available resources. This has the potential to de-construct gendered assumptions regarding behaviours when coupled with a willingness to empathise and understand what the underlying causes of non-engagement are rather than taking behaviours on face value. For instance, in situations such as that described in the following extract in which the father’s non-attendance is perceived as habitual. ‘Dad was always saying he was going to be there but never turned up. He was always somewhere else or whatever’ (Female Practitioner 3). Such perceptions require closer scrutiny as to the barriers to participation and potential enablers. However, the shift to focussing on the family as the unit of analysis rather than individualised case work does appear to have some potential for greater engagement of fathers (to the extent that the individual father is already engaged in child welfare, either directly or indirectly via care of the mother) and also, thereby, a concomitant shift from mother blaming to constructing child welfare as a ‘*family* responsibility’ rather than solely a maternal responsibility.

I just think in terms of, child protection it’s just fundamental in terms of - it’s not just a mum or dad’s responsibility. . . it’s a *family* responsibility to keep the child safe, you know, and it’s working together that will only do that.

(Female Practitioner 4)

Thus, it is the interconnectedness of needs and resources that is both the cause of presenting risks and of sustainable strengths and resources to minimise those risks. In the context of family preservation this begs the question as to who comprises the family unit that is being preserved. This issue can be a particularly acute concern when relationships are largely fluid, for instance, when men are perceived to be ‘opting out’, or just ‘passing through’. It is the very lack of positive, stable familial relationships that is frequently both the cause of child protection concerns and a barrier to engagement of family members, particularly men. There is apparent a dilemma between maintaining the family unit as it is and the inclusion of fathers who may have become marginalised, as including fathers may actually de-stabilise the current family unit, rather than preserve it.

9.5. Conclusion

Whilst practitioners were keen to present themselves as being gender neutral in their accounts of expectations regarding good enough parenting there are evident in the data gendered expectations of mothering being the source of emotional warmth, bonding and safety for children and that this is used as the benchmark for good enough parenting practices for both mothers and fathers. There is also a suggestion that parenting care practices can be diffused across a wider network of (broadly familial) relationships to meet child welfare needs. As noted in the previous chapter, 8, the construction of family by practitioners is largely in alignment with that in policy and legislation in that it focuses on the interconnectedness and interdependence of needs and resources and has a future orientation necessitated by location within a social exclusion framework. These interdependencies are presented as nested one within another – father supports mother, mother supports child(ren). Thus the paternal involvement in child welfare is predominantly perceived as being indirect through support to the mother. Only where the mother is absent or incapacitated, either permanently or temporarily, does the father take on the role of emotional warmth and nurturing (‘alternative mother’ (Daniel 1999)). To some extent both parents are viewed as having a safety or protective role, however, the type and nature of that protection may be seen to be gendered.

Male practitioners appear to have a more future orientation in relation to the longer term impact of intervention in breaking cycles of intergenerational transmission of poor parenting and anti-social behaviour than seems apparent in female practitioner accounts. This may be a consequence of a more political, macro perspective on their endeavours as professionals, or as a consequence of having a personal perspective on fathering as generative. However, on the basis of such a small sample such hypotheses are conjecture and would require further research in order to determine the validity of such claims.

Frequently mothers are cast as gatekeepers by IFST practitioners, this is somewhat counterbalanced by working within a whole family approach in which the practitioners engage the wider care network more than is usually the case in traditional statutory childcare social work practice. Whilst re-focussing practice on the family as the unit of analysis, rather than individual family members, has the potential for greater father inclusivity this is limited to the extent that gendered hierarchies and power relations are factored into therapeutic practice and acknowledged in the construction of current caring networks and parental care practices. Thus it may be helpful for practitioners to more explicitly consider the impact of gender on practitioners' own assessments and in terms of the gendering of mothering and fathering practices. Whilst using gender neutral terms such as 'parent' in policy and practice may provide a veneer of gender equality, it can in actuality have the opposite effect in rendering invisible gender inequity and differences in needs, resources and presenting risks to mothers and fathers.

There is evidence in the practitioner interviews of a discourse of fathers 'opting out' and/or 'passing through' which, whether real or perceived, may act as barriers to engagement with men. Mothers are perceived to be the bedrock of family and as barring or inviting others into the family and determining who is involved in child welfare and to what extent. The practitioners perceive their role as being to work with the existing configuration of family rather than to intervene by inviting in others without the sanction of parents, predominantly mothers.

Whilst some practitioners are clearly aware of the tendency towards mother blaming the solution adopted appears to be that of gender neutrality rather than gender awareness. However, the whole family approach does appear to open up the potential for re-

focussing from individual pathologising and mother blaming to a wider familial and community responsibility for child safety and protection than individual casework facilitates. In addition, the analysis on perceptions of risk and gender would seem to suggest a more balanced and holistic view of men (and women) as a more complex and nuanced mix of risk and resource.

During interviews practitioners struggled with issues of gender and the construction of family and the impact that that may have on their professional judgement and also on family dynamics and relationships. These, along with the use of a whole family approach, would seem to be areas requiring further research and of greater emphasis in education and training within professional practice.

10. Chapter Ten – Discussion and Conclusion

10.1. Introduction

This chapter discusses the research findings within this study and compares and contrasts these with existing theoretical and research literature in relation to the research aims and objectives initially outlined in chapter 1. The aim of this research was to explore what a whole family approach is in Welsh policy and practice; how ‘family’ is constructed in policy, practice and by parents themselves in this context; and what the impact of gender is on practitioner and parental normative constructions of mothering and fathering practices. The research findings in relation to each question will be considered sequentially. On the basis of this discussion some conclusions are drawn and recommendations made for policy, practice and further research. Before commencing this discussion it is important to note the limitations on the research design as highlighted in chapter 4, section 4, particularly as these relate to the generalisability of the findings. Firstly, family voices are only present via practitioner-mediated data such as preferred futures accounts, values card sorts and case file data rather than more direct evidence such as interview data from parents and/or children. Secondly, there is a caveat regarding practitioner interview data and case file data, namely that these are the practitioners’ espoused perceptions of their practice rather than direct evidence of practice obtained via, for instance, direct observation of practice. Finally, as a consequence of deciding to obtain data from a single instance of an IFST there are limitations on the extent to which findings in relation to the IFST model of practice and IFSTs’ use of a whole family approach are generalisable. Such issues could be addressed by extending this research with comparative cases both from within IFSS and, in relation to the exploration of a whole family approach, other services that also espouse its use within its practice.

10.2. Discussion

10.2.1. What is a whole family approach in Welsh policy and practice?

As noted in chapter 3, sections 2, a plethora of terms exist for practice with families which are frequently used interchangeably, such as family-centred, family-driven and family-focussed practice. These approaches share six common characteristics, as identified by Allen and Petr (1996): family as unit of attention, family choice, family strengths focussed, full partnership working relationship between family and

professional, a holistic view of families' needs (and resources) and individualized tailored service. In relation to families Goldfarb *et al.* (2010) identify similar characteristics of family-centred practice whilst placing a greater, central emphasis on the relationship between families and professionals as the key characteristic. They describe this relationship between families and practitioners as entailing full and involved partnerships with families, willingness on the part of professionals to listen and learn and individualized planning and approaches. In addition, family-centred practice involves professionals being sensitive to and considerate of the 'different places, different journeys' that families are on in terms of their understanding, experience and engagement with professionals and the issues they face as a family; and finally, professionals need to be mindful of the differing cultural needs that families may have. From the data analysed in this research these attributes of family-centred practice apply equally to whole family approaches. The overlapping similarities between family-centred practice and a whole family approach as identified within this research could be summarised as:

- Family as the unit of analysis and point of intervention.
- Central importance of full and involved partnership working with families as a whole system.
- Strengths based approach to working with families.
- Individually tailored approach to assessment, intervention and service provision.
- Holistic approach and understanding of the inter-connectedness of family members' needs and resources.
- Enabling family choice and self-determination.

The process of family-centred treatment as discussed by Painter (2010) similarly reflects the process of practice as articulated by IFST practitioners in this study. Initial engagement focuses on 'joining and assessment'. This is followed by therapeutic intervention based on 'restructuring' family functioning, primarily via building individual relational competence in communication and empathy, 'value change' and 'generalization' (Painter 2010). However, on the basis of the findings within this research there are some attributes of a whole family approach that distinguish it from family-centred practice. Firstly, there is a greater emphasis within a whole family approach on the inter-connectedness of family needs and resources and on

interrelationships between family members as the point of intervention than is evident within *family-centred* practice, and certainly more so than in *family-minded* practice which is a somewhat more diluted version of *family-centred* practice. Within a whole family approach the family is considered the unit of analysis, in other words, it is treated as a micro-system in which the sum is greater than its parts.

In both UK and Welsh policy there are a further two features that distinguish a whole family approach from other forms of family-centred practice: its location within a social exclusion framework and the focus on intervention targeted at strengthening the interrelationships between family members in order to generate social capital. Finally, from the findings presented in this study the main and central distinctive feature of a whole family approach in practice, when compared with other forms of family-centred practice, is that the primary vehicle of intervention are **both** the professionals' relationship with the family members **and** the interrelationships between family members. Whilst both family-centred practice and whole family approaches are premised on relationship-based practice a whole family approach does not privilege the professional and client relationship as the primary vehicle for change but also utilises existing, 'significant other' relationships within the family system therapeutically (Furlong 2013). Thus, a whole family approach as embodied in IFST practice has a relational ontology of mutual interdependence and connectedness which mirrors that of an ethic of care, rather than an autonomous, independent individualist ontology as expressed in an ethic of justice. Whilst risk and resilience can provide a framework for practice, relational practice (as distinct from relationship-based practice) would seem to provide a potentially fruitful avenue to explore in terms of the therapeutic process and underpinning knowledge and skills.

Hansson, Jones, and Carpenter (1984) propose a model of the kinds of personality variables that might be considered to contribute to one's level of relational competence in that they influence a person's ability to construct, access and maintain important support relationships, i.e. the ability to generate social capital. Subsequent research conducted by Kugler (1988) identified relational competence as a key variable of presenting parental risk in the context of child abuse and recommends that practitioners include an assessment of parental personal and social competencies in order to identify those individuals who are lacking the relational competence to access, construct and

maintain support networks that generate social capital. In other words, those parents who appear to lack self-esteem, are shy, who are less assertive in parent-child interactions, or who are less empathic and less able to control their emotions may need particular therapeutic intervention in order to re-establish a degree of control and empathy in the parent-child interaction and other familial and social relationships upon which social capital are reliant. Thus, there is a connection between one's relational competence and the ability to build and sustain connected networks of relationships of mutual reciprocity of care and obligation that is the source of social capital. As such policy in the form of the social exclusion framework directly informs practice within a whole family approach, and the micro practice goals of building relational competence are in alignment with the policy goals of family preservation and strengthening families to generate social capital and combat poverty, cycles of deprivation and inter-generational transmission of abuse and poor parenting.

10.2.2. How '*family*' is constructed in policy, practice and by parents themselves?

The UK policy construction of family within a whole family approach is one in which families are both 'troubled and troubling' and requiring state intervention both in terms of care and control. The use of a whole family approach is intended to have an impact at both a macro and micro level and these goals are thought to be synergistic. At a macro level the targets of intervention via a whole family approach are worklessness, poverty, inter-generational cycles of deprivation, criminality and anti-social behaviour. However, at the micro level the use of a whole family approach is intended to improve family functioning by strengthening family relationships in order to minimise harm and abuse within the family and to meet its own needs sustainably without (over) reliance on the state. In addition these changes are intended to also bring about pro-social behaviours toward others – in the family and wider community. In other words, the family is seen as the building block of society and in order to achieve social cohesion within society what is required is social cohesion within the family.

Whilst UK family policy presents a more conflicted construction of these families as both troubled and troubling, the Welsh enactment of a whole family approach in policy and legislation appears to place greater emphasis on this small minority of families as having complex interrelated needs requiring intervention to improve family functioning and there is less emphasis on intervention as targeting anti-social behaviour. Both the

UK and Welsh governments' approaches locate such practice within a social exclusion framework and take as an assumption that improved family functioning will lead to the generation of social capital in terms of the quantity and quality of intra and extra-familial social connections that families can draw resources from (and are obligated to). Within Welsh policy however, the use of social capital as a construct is less explicit than in UK policy, as noted in chapter 5.

As highlighted in chapter 3, section 2, the Social Exclusion Taskforce review (Social Exclusion Taskforce 2007) of models and approaches to family-based policy and service provision for those at risk of social exclusion suggests three distinct categories in terms of whole family approaches. In the first category are approaches that seek to strengthen the ability of family members to offer support to a primary service user within that family. In the second category, family members are recognised as having their own specific and independent needs arising out of their relationship with the primary service user. The third category of whole family approaches are distinguished as being 'approaches that seek to work with the family unit as a collective in order to focus on shared needs, and develop strengths and address risk factors that could not be dealt with through a focus on family members as individuals' (Hughes 2010, p. 546). This thereby shifts the focus from the individual to the interrelationships between individuals; the client or service user being the family in its entirety (*whole*) rather than any specific individual or dyadic pairing, such as parent (usually mother) and child which are often conflated as 'family'. This focus on the *whole* family as a system of interconnected relational networks would seem to accord with the practice undertaken within the IFST model of practice. However, there is a caveat that the focus in relation to outcomes is child-centred, in the sense that the overall aim is to minimise risk factors and maximise protective factors in relation to child welfare outcomes and family preservation. In short, that the global goal is to preserve the family as a sustainable resource for meeting children's needs, emotionally, physically and psychologically.

The definition of 'family' used in Welsh legislation emphasizes the inter-connectedness of individuals as the defining characteristic of familial relationship, rather than that of biology, household, legalistic or other constructions. Inherent within the concept of connectedness is the potential for fluidity and a dynamic construction of family form in and through, time and therefore the construction of family is relatively unboundaried

and leaves considerable scope for practitioner judgement in co-constructing the ‘family’ with family members. This emphasis on inter-connectedness of needs and resources is also evident in the practice construction of family.

The practice construction of family within the IFST model that is evident in the practitioner interview data and case file analysis is one that is based on a ‘complex family’ conceptualisation in which the family is the expert in its own needs and also a source of resource to meet those needs on an on-going and sustainable basis. The approach taken is primarily a strengths based empowerment approach, rather than an individualised, pathologising, deficit model of family. The physical composition of the family is derived from family members themselves identifying those individuals with whom the relationships are supportive (or create stressors) and who provide a resource (and/or present risks) in meeting the needs of the family. The consequent mode of engagement is that of a full partnership approach in which families are empowered to make decisions. Morris (2012) makes a similar distinction in approach to the construction of family as being one in which the family is perceived as being either the ‘subject of intervention or partner for change’. From the data analysed in this study the approach taken by IFST practitioners is one of ‘partner for change’. Indeed family members are engaged in a co-productive, therapeutic alliance in which shared goals, values and reciprocity are nurtured thereby modelling the restructuring of family functioning that is being sought. Whilst the family is being ‘preserved’ in terms of children not entering the care system, the family functioning is being restructured and the process of intervention is consequently a period of family change and transition rather than static ‘preservation’. As noted in chapter 3, section 2, this process might more accurately be termed ‘family recovery’, rather than ‘family preservation’ (Tew 2013). Not only does the practitioner engaging in therapeutic relational practice focus their emotional labours on restructuring family dynamics but also practitioners provide ‘a safe reflective space’ in which they are ‘holding’ the family during this period. For practitioners this clearly requires an intensity of emotional labour and use of self.

From the descriptive statistical data provided in chapter 8, section 2, it is evident that family structure and composition, whilst presenting challenges of diversity and fluidity, conform to normative constructions of a two parent nuclear family more than might have been anticipated. A stereotypical construction of lone mother headed families as

the dominant family form within this group is not supported by the research data. Further, the descriptive labelling of family form can actually serve to obfuscate the reality of family relationships. For instance, the category 'lone mother household' may have the potential of masking existing relationships with men and impede their engagement in intervention. Lone mother headed families are not a homogenous group and mothers may be lone parents due to a variety of factors including widowhood, partner incarceration, and so forth; or they may indeed be in relationships which the practice/service construction of the family on the basis of family structure and household then masks. The placing of greater emphasis on relational identities and interrelationships during the on-going assessment process would illuminate significant other relationships in a way that individual focussed practice based on independence and autonomy does not necessarily do.

On the basis of the findings of this research two key points emerge. Firstly, there needs to be a constructive conceptual alignment across policy, practice and the lived experience of families themselves as to what the term 'family' denotes in terms of distinctive qualities of familial relationships such as love, affection, belonging, endurance through time (stability) and reciprocity of care and obligations that create and maintain sustainable bonds. Secondly, there is a recognition in policy and practice of the fluidity and unboundaried nature of familial relationships particularly as this relates to the identification of family forms as dynamic, rather than static, family structures. As demonstrated in the practitioner interviews, engaging with the *whole* family requires practitioners to attend to the specific family's own construction and self-identification of familial relational networks, and individual family members' relational identities. From the data analysed within this study the relational network of familial risks and resources is one that is co-constructed between practitioner and the family itself.

Whilst Morris (2012), in the quotation below, is discussing the complex challenges faced by families of children who need care and protection services, these challenges could equally be said to be confronted by practitioners in engaging with families.

There is limited knowledge about family life where care and protection needs are present and the lived experience of such families is under-researched. They are facing contradictory policy and practice messages –

with complex consequences for family life and for the child that are not yet understood. Thus, the knowledge base for practice is thin and, often, the actual level of engagement in practice is limited.
(Morris 2012, p. 915)

As Morris (2012) states, ‘Extended understandings of family and the ability to respond to complex multiple identities are required if practice is to move forward’ (p917).

10.2.3. What is the impact of gender on practitioner and parental normative constructions of mothering and fathering practices?

It is apparent from the gender analysis of policy and legislation documents undertaken via *Trace* methodology discussed in chapter 5 that the use of the term ‘parent’ renders invisible the differential gender impact of policy on mothers and fathers both at the macro and micro levels. Gender impact assessments on policy directives would be beneficial in illuminating any differential effects of policy in terms of gender.

On the basis of the analysis of the preferred futures accounts and values card-sort statements, parental aspirations of mothering and fathering care practices, and of family life, very much conform to the normative ideals of family practices. In comparing the themes evident in mothers’ and fathers’ preferred futures accounts and underpinning values card-sort statements, some features were strikingly similar in both male and female parents accounts: the importance of home, daily routine, food and mealtimes, family days out, family cohesion and harmonious households. However, there were noted some nuanced differences in the way these are discussed, with some gender effects in terms of differences of emphasis and how these are discursively constructed in terms of their meaning. The predominant aspirational construction of mothering is that of emotional housekeeper and of fathering as predominantly that of a provider role.

It should be noted that mothers’ accounts of fathering practices and fathers’ accounts of mothering practices were in accord; as were mothers and fathers own expectations of their gendered roles as mothers and fathers. In other words, parental expectations of mothering and fathering (as represented in practitioner-mediated data) are indeed gendered normative constructions that conform to traditional sex roles of fathering being inclusive of the provider role and mothering as focussed on emotional labour and

physical care, such as mealtimes, cleanliness, mediating familial relationships and so forth. Thus, parental normative constructions of mothering and fathering are gendered, with each gender holding shared expectations that what fathers 'do' is different from (and complementary to) what mothers 'do' in terms of care practices.

As noted in chapter 9, the espoused position of practitioners during interviews was largely one of gender neutrality/indifference in their accounts of expectations regarding good enough parenting. However, there were evident normative gendered expectations of mothering as the source of emotional warmth, bonding and safety for children and that this was used as the benchmark for good enough parenting practices for both mothering and fathering care practices. There was also a suggestion in practitioner accounts that parenting care practices can be diffused across a wider network of (broadly familial) relationships to meet child welfare needs, but this too may remain gendered, for instance, grandmothers acting as substitute mothers where the birth mother is incapacitated or 'failing' to do so. Thus, the practitioner perspective is broadly that of considering others (particularly fathers) as providing 'alternative mothering' (Daniel 1999) only in those instances where the mother is incapacitated or perceived to be 'failing'. In addition practitioners held a perception that fathers have an 'opt out' of family life in a way that mothers do not and that male involvement in family welfare may be transitory – that men may be just 'passing through'. This perception (whether real or actual) can act as a barrier to engaging with men. Further, as practitioners work with the existing family form as co-constructed with the families themselves (primarily the biological mother) this maintains the status quo, and may, therefore, potentially reinforce maternal gatekeeping and the marginalisation of men in family life and in the child protection process itself.

Whilst neither mothers nor fathers are characterised as wholly risk or resource in terms of practitioner perceptions of parents, gender does play an influential factor in practitioners' perceptions of risk and resource, as nurturing, safety and emotional bonding are perceived to be traits of mothering care practice but taken as the benchmark of parenting care practice. This fails to acknowledge the impact that gender may have on differing parenting practices for men and women.

10.3. Conclusion

What is evident from this study is that a whole family approach does not necessarily, in and of itself, provide a panacea to the anti-social behaviour and complex, interrelated support needs that this minority of families are portrayed in policy as presenting. However, a whole family approach can potentially serve as a therapeutic tool in restructuring family relationships and functioning by enhancing individual relational competence in order to generate the social capital that is assumed by policy makers to provide the means for counteracting both anti-social behaviour (normative, social regulation) and complex, interrelated support needs (generation of social capital by maintaining, enhancing and utilising resources from intra and extra familial affiliations). Nor does a whole family approach, in and of itself, provide a panacea for gender equity and awareness with regard to the assessment of parenting practices, nor in terms of gender inclusivity and father engagement in child protection services. The construction of family as articulated by practitioners in this study is one of engagement, and therapeutically working with, the *existing* network of significant other relationships. This, then, has the potential to replicate and reinforce existing gender normative expectations and forms of behaviour rather than challenging them.

The 'family' as a political, moral and emotional discursive construct has become a unifying symbol in an increasingly fragmented world.

The family is a symbolic signifier, rather like democracy or justice, which image calls up a whole range of emotional and moral responses to which people feel allegiance. It exceeds the dominant familial form with which it is often discursively associated, such that commitment is not dependent on it . . . It provides the means of voluntary regulation of modes of intimacy and care, it sets the parameters for social tolerance and the points of external intervention.

(Somerville 2000, p. 244/245)

Thus the ideology of the family continues to remain a powerful rallying cry in generating social consensus for state intervention to strengthen familial bonds when child neglect and abuse presents the risk of family breakdown that

precipitates child entry into care. As Melton (2010) highlights, relational attachments

. . . are critical to purpose in life, sense of personal fulfilment, and identity as both an individual and a member of a family or a clan, a religious community, and a nation or an ethnic group – in effect the ingredient in personhood.

(Melton 2010, p. 165)

However, as Furlong (2001) identifies from his research with mental health practitioners it is these very human qualities and needs for love, affection and belonging that are given scant attention in practitioner and psychotherapy assessments and the subsequent therapeutic intervention. A whole family approach provides a means of refocusing on these intrinsically human core values for love and belonging in turning attention to the quality and quantity of interrelationships that are the substance of social capital. This emphasis within a whole family approach on relational practice – utilising the existing network of interconnected significant other relationships at both the micro and macro systems level- could be said to be putting the human back into human services and re-orientating practice from problem focussed to person-in-relational environment focussed.

On the basis of the research findings and existing theoretical and empirical research literature a number of recommendations are provided below for policy, practice and further research.

10.4. Recommendations

10.4.1. Recommendations for Policy

Where policy pertains to family life and/or child poverty it may be useful to consider using gender impact assessments to identify any differential impact the policy may have in terms of the gender of the parent. Similarly, it may be beneficial to consider whether terms such as ‘parent’, ‘mother’, ‘father’, and ‘family’ are being conflated, in order to ensure greater conceptual clarity and consistency in the usage of terminology and to minimise any effects made by gender.

10.4.2. Recommendations for Practice

Whilst ‘lone mother headed household’ and ‘two parent biologically intact family’ appear to be distinct social categories and social forms what the data in this study reveal is that rather than being diametrically opposed these categories are in actuality fairly fluid, with families changing form and structure over time. Also, as noted within the thesis, the construction of family within policy, practice and families themselves is primarily relational, fluid and relatively unboundaried rather than based on household, biological relationship, legal sanction, or geographical proximity. Further, as articulated by practitioners interviewed for this study, the starting point in constructing, understanding and engaging with families is, and should be, the family itself. Practitioners could be encouraged to adopt a fluid and flexible construction of ‘family’ that can accommodate and align with those of the individual families with whom they are engaging. For family intervention to be effective this may entail professionals critically reflecting on their own conceptualisation of ‘family’, and that constructed in policy, in light of the family’s own construction of relational dynamics.

Practitioners may also want to give greater consideration to the impact of normative gendered assumptions regarding parenting in their assessment of parental capacity. Re-focussing on ‘care practices’ rather than gendered constructions of mothering and fathering practices may provide greater capacity to focus on risks and resources in relation to caring rather than on the gender of the carer – be they parents or others.

In terms of child-focussed practice within a whole family approach, this could perhaps entail considering the child as a relational entity situated within relational networks. In other words, practitioners may want to place greater emphasis on the construction of family from the child’s perspective. This would require direct work with children to ensure full partnership and understanding of the child(ren)’s lived experience of family life.

Based on further research evidence a more thorough theorisation and articulation of the practice process entailed within a whole family approach could be disseminated via social work qualifying and post qualifying education. This would aid the cultural shift in practice from individualised case work to whole family relational practice. Similarly, the IFST training and practice manual could perhaps place greater emphasis and

explanation of a whole family approach both in terms of knowledge and skill base required.

10.4.3. Recommendations for Further Research

Given the limitations of this study in focussing on one single IFST it would be constructive for further research to be conducted within one or more IFS teams, so as to compare the findings with those within this study and ascertain what are variations of local practice within the IFST model itself and between different manifestations of a whole family approach.

Further comparative research, for instance, comparing and contrasting the construction and use of a whole family approach in other programmes and interventions would be useful in determining what features (knowledge, skills, values and outcomes) are specific to a whole family approach. This comparative research would also be able to distinguish what findings, if any, were distinct to the specific client group location, namely parental substance misuse and child protection, or whether the nature of the family grouping has little or no impact on the whole family approach as a therapeutic process. Also, such comparative research would identify what the core, or essential features, of such an approach are and what are local practice variations. This research could be strengthened by including observations of practice in order to develop further the articulation of a whole family approach in practice from direct evidence as opposed to the self-reporting provided by practitioner interviews and case file recording..

Further research that was fully inclusive of the family voice in articulating the therapeutic process of a whole family approach alongside that of the practitioner's voice would also be beneficial in understanding how a whole family approach impacts on both engagement and (gender) inclusion as well as on outcomes. The sample for this research could be drawn from differing family compositions, e.g. lone mother headed households, two parent biologically intact families and so forth, who were post intervention and in the maintenance phase. At the time the data collection concluded for this project the pool of potential participants able to provide such a sample was exceedingly limited and impractical. However, both of these sources of data could provide rich material if this research were extended further. Narrative interviews with parents would provide rich data on the experience of a whole family approach and the

lived experience of parents and the gendering of parenting practices and family life within the context of parental substance misuse and child protection concerns.

There is also scope for further research into the levels of family engagement within traditional child protection practice and that within services that espouse a whole family approach. Such research should go beyond practitioner self-reporting via practitioner interviews and encompass the views of families and direct observation of practice. Methodological tools that could be used for such enquiry might include similar data collection sheets as constructed for this research and/or the use of eco-maps for data analysis purposes that would clearly illustrate whether engagement was with dyadic pairings, household, extended family and/or community.

Given the policy belief that improved family functioning (strengthening families) leads to greater generation of social capital, further research into the impact that family functioning has on the generation of social capital would be beneficial. In addition, exploring family structure (and its stability over time) as a mediating variable in family functioning impacting on social capital would also be helpful (Freistadt and Strohschein 2013). The policy aims and intentions should be used in further research to evaluate the outcomes of a whole family approach for the families themselves.

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Appendix A - Ethical Approval

Cardiff School of Social Sciences
Director Professor Malcolm Williams
Ysgol Gwyddorau Cymdeithasol Caerdydd
Cyfarwyddwr Yr Athro Malcolm Williams



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5th July 2010

Our ref: SREC/625

Jacqueline Lee
PhD Programme
SOCSI

Dear Jacqui

Your project entitled "*The Whole Family Approach and Gender Inclusivity: An Ethnographic Investigation into How Policy is Being Put into Practice in Integrated Family Support Teams*" has now been approved by the School of Social Sciences Research Ethics Committee of Cardiff University following its meeting on 11th June 2010 and you can now commence the project.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the SREC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group of potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers).

All ongoing projects will be monitored every 12 months and it is a condition of continued approval that you complete the monitoring form.

Please inform the SREC when the project has ended.

Please use the SREC's project reference number above in any future correspondence.

Yours sincerely

Professor Tom Horlick-Jones
Chair of the School of Social Sciences Research Ethics Committee

cc: E Renton
Supervisors: K Henwood
J Segrott

Appendix B - Access Letter

Ms Jacqueline Lee
5 Ladysmith Road
Penylan
CARDIFF
CF23 5DT

27 April 2010

Dear Ms Lee

RE: PHD RESEARCH PROJECT

TITLE:

**THE WHOLE FAMILY APPROACH AND GENDER INCLUSIVITY:
AN ETHNOGRAPHIC INVESTIGATION INTO HOW POLICY IS BEING PUT
INTO PRACTICE IN INTEGRATED FAMILY SUPPORT TEAMS (IFST'S)**

Following the preliminary meeting held on 1 April 2010, I am happy to grant you access to the City Council's Care services as outlined in the research proposal. Whilst understanding that the project is being undertaken as a doctoral study and that you are independent of the Local Authority, this project has the potential to benefit the Local Authority in providing information in relation to three key areas:

- *Target population:* exploring the construction of 'family' in relation to the families with complex needs referred to the IFST;
- *Whole Family Approach:* describing the model of whole family approach used within the IFST;
- *Gender inclusivity:* exploring whether the whole family approach as utilised within the IFST is gender inclusive, particularly in relation to fathers.

This will also enable us to consider how the model of whole family working utilised within the IFST might be promoted across the City Council and the extent to which such an approach may be helpful in engaging men in social care services, and in the promotion of child welfare in particular.

I understand that in order to undertake the study you would require access to:

- service user case files in both statutory childcare teams and the IFST;
- staff within each of those settings;
- a sample of mothers and fathers who are members of families referred to IFST;
- key informants in the policy and implementation of the IFST, such as the National and local IFST Steering Boards.

I will facilitate initiating contact with key individuals in order for you to identify appropriate participants. I understand that individual participation will be on the basis of informed consent and that participants may choose to withdraw at any point if they so wish to do so. In the first instance, I have agreed to initiate a meeting between you and the Head of Children's Services, Mike Nicholson.

I have discussed issues of data protection, secure storage of data and confidentiality with you and understand that you have a current CRB check and are a registered social worker. Further, that no data collection will commence until Ethical Approval has been obtained. You will be supervised by Professor Karen Henwood and Dr. Jeremy Segrott in undertaking the project.

Yours sincerely

Copy to:

Page 2 of 2

Appendix C - Overview of Documents Analysed

This overview of the documents analysed also provides a time line of the development of IFST from policy into practice. All documents were commissioned by what was at the time the Welsh Government.

Evaluation and On-going Monitoring of Practice and Service Delivery

| Date | Authors(s) | Title | Purpose | Target Audience | Comments |
|------|---|---|--|----------------------------|---|
| 2007 | Forrester, D., Pokhrel, S., Mc Donald, L., Copello, A., Binnie, C., Jensch, G., Waissbein, C., Giannou, D. | Evaluation of Option 2 – Final Report | To evaluate Option 2 and provide recommendations for Option 2; for further research and for policy. | Commissioned by and for WG | '... our central conclusion is that in Option 2, Wales appears to have a ground-breaking asset of national and potentially international significance. It has the potential to be developed and expanded to address the needs of some of the most vulnerable families in society'. P8 |
| 2008 | Forrester, D., Goodman, K., Cocker, C., Binnie, C., Jensch, G. | What is the impact of care on children's welfare? A focussed review of the literature | To review the literature on the impact of receipt into care for children's welfare and preventative services for entry into care as part of the Option 2 evaluation. | Commissioned by and for WG | Review co-incides with publication of Care Matters: Time for Change White Paper (2007) in England and review consequently has a broader focus and greater influence on policy. |

Legislation and Policy

| Date | Author(s) | Title | Purpose | Target Audience | Comments |
|------|--------------------------------|--|--|---|--|
| 2008 | Welsh Government; NHS Wales | Stronger families - Supporting Vulnerable Children and families through a new approach to Integrated Family Support Services | Consultation on a proposal to establish the legal framework to require local authorities and their health partners to provide Integrated Family Support Services (IFST) for vulnerable families. | Local authorities, NHS Trusts, Local Health Boards, Children and Young People's Partnerships, Local Safeguarding Children Boards, Community Safety Partnerships, Local Health, Social Care and Well Being Partnerships, Substance Misuse Action Teams and Substance Misuse Service providers, Adult Mental Health Services, Voluntary Sector Organisations working with children and families, Children's Commissioner for Wales, Welsh Local Government Association, Welsh Assembly Government Police Liaison Office, Youth Offending Teams and CAFCASS CYMRU. Designated Family Judges, HMCS – Courts in Wales, President of the Family Division and Head of Family Justice. As this was a public consultation comments were invited from any person or group who had an interest in this area. | Breadth of audience targeted within public consultation and brevity of time of consultation: August to October 2008 Policy proposals outlined in this consultation appear in Part 2 and Part 3 of the Measure |
| 2008 | Welsh Government | Taking Action on Child Poverty | Consultation on WG proposals to take action on child poverty. This includes making new legislation to introduce a | Local Authorities, the Welsh Local Government Association, NHS Confederation, Local Health Boards, the Children's Commissioner, and other organisations with an interest in child | Consultation ran from June to September 2008. Policy proposals set out in this consultation appear in Part 1 and Part 4 of the Measure. |

| Date | Author(s) | Title | Purpose | Target Audience | Comments |
|----------------------|--|--|---|---|--|
| | | | duty on public agencies in respect of child poverty, to provide free childcare places and other early years' services in specific places, to match the guidance under which the Cymorth grant is provided and to introduce a strategy to support vulnerable children. | poverty. | Therefore, this document was not included in the documentary analysis. |
| March 2009 | Dr Brian Gibbons, Minister for Social Justice and Local Government | Legislative Statement on the Children and Families (Wales) Measure | Introducing the proposed Measure | Welsh Assembly Members and general public | The aim of the Measure is to deliver a strategic and joined up approach to eradicating child poverty. The Measure places for the first time a statutory duty on Welsh Ministers to develop a new Child Poverty Strategy for Wales. |
| June 2009 | Welsh Government: Legislation Committee 2 | Proposed Children and Families (Wales) Measure. Stage 1 Committee Report | To consider and report on the general principles of the proposed measure. | Welsh Assembly Ministers | Stakeholder evidence demonstrates general consensus in favour of the proposed legislation |
| February 2010 | Welsh Government | Children and Families (Wales) Measure 2010 | Broad aims are working towards the eradication of child poverty | Primary Legislation | The documentary analysis focussed on Part III which provides the legal framework for IFST, however, its location within this statute clearly situates it within a justice ethic of eradicating child poverty. |
| Nov 2009 | Jointly prepared by the Department | Children and Families (Wales) Measure 2010 Explanatory | Sets out the background to the policy objectives, the provisions of the proposed Children and | Welsh Assembly Ministers | The preparation of the document across different Government Departments reflects the joined up strategic |

| Date | Author(s) | Title | Purpose | Target Audience | Comments |
|------------------|--|---|--|-----------------------|--|
| | for Social Justice and Local Government, the Department for Children Education, Lifelong Learning and Skills and the Department for Health and Social Services | Memorandum and Children and Families (Wales) Measure 2010 Explanatory Notes | Families (Wales) Measure and explains its scope. | | approach which is also reflected in the integrated nature of IFST. |
| June 2010 | Welsh Government | Children and Families (Wales) Measure 2010 (Commencement) Order 2010 | Specifies the date of commencement of IFST teams in specified Local Authorities and within limited eligibility criteria, namely parental substance misuse. | Secondary Legislation | The commencement order enables the pioneer areas to commence service delivery as of 1 st September 2010 |
| June 2010 | Welsh Government | Integrated Family Support Teams (Composition of Teams and Board Functions) (Wales) Regulations 2010 | Specifies the composition of IFST teams and the role and remit of IFST Boards | Secondary Legislation | |
| June 2010 | Welsh Government | Integrated Family Support Teams (Family Support Functions) (Wales) Regulations 2010 | Requires Local Authorities to set up one or more IFST' in their area and requires Local Health Boards to participate in establishing | Secondary Legislation | Prescribes integration both vertically and horizontally between Local Authorities and Local Health Boards |

| Date | Author(s) | Title | Purpose | Target Audience | Comments |
|------------------|------------------|--|--|-----------------------|----------|
| | | | these. | | |
| June 2010 | Welsh Government | Integrated Family Support Teams (Review of Cases) (Wales) Regulations 2010 | These Regulations establish requirements about how local authorities must review the cases of the families who are supported by Integrated Family Support ("IFS") teams. | Secondary Legislation | |

Statutory Guidance, Regulations and Practice Toolkits

| Date | Author(s) | Title | Purpose | Target Audience | Comments |
|-------------|---|--|---------|--|----------|
| 2010 | Welsh Government's Departments of Social Justice and Local Government, Department of Children Education and Lifelong Learning and Skills, Department of Health and Social Services, | Integrated Family Support Services: Statutory Guidance and Regulations | | <p>Audience: Within the Newport, Merthyr Tydfil, Rhondda Cynon Taf and Wrexham local authority areas:</p> <p>-Health, local authority and third sector professionals and agencies (statutory and other) that commission and provide services in relation to safeguarding and promoting the welfare of children and young people, children in need (including children in need of protection and looked after children) and who deliver them.</p> <p>-Health, local authority and third sector professionals and agencies (statutory and other) who provide commission and deliver services in relation to adults who are misusing substances.</p> <ul style="list-style-type: none"> • Regulatory and inspection bodies. • Justice agencies responsible for adults and children. | |

| | | | | | |
|-------------------------------|---|--|--|--|---|
| Version 2; August 2010 | Rhoda Emlyn-Jones OBE and Dr. Amanda Bemble, IFST Central Resource, on behalf of the Welsh Government | Integrated Family Support Services: Supporting the Pioneer Areas in Wales Practice Manual | ‘This practice manual is designed to assist practitioners delivering a service to families from an integrated family support service. The manual covers the clinical work of the IFST and the structures that surround it but first and foremost it is designed as a resource for practitioners. It describes, in order of sequence, the whole intervention to families. It describes the evidence based skills and the strategies that will have the greatest chance of engaging families in a process of change; changes that can lead to stability for children within their own families.’ | IFST Practitioners | Whilst providing a detailed account of what activities are used and the skills used in these activities there is very limited explication of theoretical perspectives, particularly in relation whole family working. |
| January 2010 | Prof. Donald Forrester, Professor of Social Work Research, The Tilda Goldberg Centre for Social Work | Evidence Based Interventions and “Stronger Families”: <i>Recommendations and Lessons from a Review of the Evidence</i> | ‘This report sets out key issues in using and developing Evidence Based Interventions (EBIs) in delivering effective services for families affected by serious parental substance misuse and | Senior managers, leaders of Intensive Family Support Teams (IFSTs) or others involved in delivering the programme of work. | The report provides an overview framework for thinking about the evidence based interventions to be used by the IFSTs, the wider system change the teams are intended to create and key issues in delivering such services as well as |

| | | | | | |
|----------------------|---|--|--|--|---|
| | and Social Care, University of Bedfordshire Prepared for the Welsh Government | | child welfare concerns. It has a particular focus on the <i>Stronger Families</i> initiative in Wales and is aimed at those who have some responsibility for putting the interventions associated with Stronger Families into place’. | | identifying the approaches that it considers to be most strongly supported by research evidence. This report will be complemented by a variety of more practical guides to delivering specific interventions and evaluating whether your service is producing the results that you are aiming for. |
| February 2010 | Prof. Donald Forrester, Professor of Social Work Research, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire Prepared for the Welsh Government | Integrated and Inter-professional Working: <i>A Review of the Evidence</i> | This report is based on a review of the literature on integrated and interagency working. The review is based on a number of recent thorough reviews of the research and selective reading of key research studies. It is intended to be an aid for thinking about issues in integrated working rather than a thorough review of the evidence in this area. The review aims to answer two key questions: what is known about the impact of integrated working? And, what are the key lessons for developing | Senior managers, leaders of Intensive Family Support Teams (IFSTs) or others involved in delivering the programme of work. | Findings: Very little research on the impact that more integrated working has on service users. Key factors: <ul style="list-style-type: none"> • Strong leadership with a shared and agreed vision. • High quality staff. • Good communication. • Time. Overall the characteristics of successful integrated services are similar to those of non-integrated services. This suggests that it is not the level of integration that is key to creating better outcomes for service users as much as a focus on supporting staff in delivering excellent services in whatever structure is chosen. |

effective integrated or interagency working? It then draws out messages from the literature for the successful implementation of the Integrated Family Support Services (IFST) in Wales.

| | | | | | |
|-------------------|--|--|--|---|--|
| April 2010 | <p>Prof. Donald Forrester, Professor of Social Work Research, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire</p> <p>Prepared for the Welsh Government</p> | Evaluation and On-going Monitoring: A Practical Guide for IFST Teams | <p>This document provides a brief guide to some of the key elements of a potential evaluation of the IFST teams. It is important to note that the guidance in this document is focussed solely on the impact of the service on the families worked with.</p> | Local Authorities, Senior managers, leaders of Intensive Family Support Teams (IFSTs) or others involved in delivering the programme of work. | <p>The report is based 'loosely on the author's experiences in evaluating "Option 2" and involves adapting elements of that evaluation for use in an on-going manner by services'. The focus is solely on the impact of the service on the families worked with and not on the broader IFST aim of wider systems change on which the National Evaluation will be focussed.</p> |
| May 2010 | <p>Prof. Donald Forrester.</p> <p>Prepared for</p> | Motivational Interviewing for Working with Parental Substance | <p>This short guide provides information for agencies and</p> | Managers and practitioners | |

| | | | | |
|------------------|---|--|--|----------------------------|
| | the Welsh Government | Misuse: A Guide to support the IFS Teams | individuals attempting to put MI at the heart of their practice and policy. | |
| May 2010 | Prof. Donald Forrester, Professor of Social Work Research and Anne Williams, Research Assistant, Cardiff University Prepared for the Welsh Government | The “Option 2” Model and Homebuilders: A Guide to support the IFS Teams | This guide is intended to provide a brief introduction to Option 2 for practitioners and managers interested in developing this way of working. It might be useful to the pioneer areas setting up their Integrated Family Support Service, other areas subsequently developing IFST or simply agencies wishing to develop a service such as Option 2 in their area. | Managers and Practitioners |
| July 2010 | Prof. Donald Forrester, and Sarah Wadd, Research Fellow, The Tilda Goldberg Centre for Social Work and Social Care | Social Behaviour and Network Therapy and Parental Substance Misuse: A Practical Guide for IFST Teams | This guide reviews the appropriateness of SBNT for use in IFST teams or child and family work more generally and makes practical recommendations for developing the use of SBNT in practice. | |

Appendix D - Case File Data Collection

Introduction

Having met with the Business Support and Development Manager and explored some of the IFST case files (which are held on a shared drive and are split between an admin folder (not shared with clients) and a Family File (of materials which are shared with the family in the form of hardcopies); and some of the related case files held on the Integrated Children's Services (ICS) electronic file system it became apparent that much of the data that I had anticipated being readily available on the ICS system, particularly as it related to childhood of parents, such as parental in care history, or networking to adult file systems on, for instance parental substance misuse.

File Data Collection

Two levels of case file data collection tool were developed to successively increase depth and focus of data collected.

1. Policy into Practice: Family structure and household composition

- b. **Sample** – All families referred between 1st September 2011 and 31st May 2011, totalling 46 Families
- c. **Purpose** –
 - i. To identify any patterns (differences or similarities) between families in terms of structure, nature of substance misuse, nature of child concern, etc.
 - ii. To identify any patterns (differences or similarities) between families in terms of structure, nature of substance misuse, nature of child concern, etc. and the type and level of IFST involvement e.g. declined
 - iii. To identify any patterns (similarities or differences) in terms of kinship ties/biological relationships and social familial relationships
 - iv. Genders within the family – are households predominantly female; or headed by lone mothers; what is male involvement (type and level) within family life, as risk, resource, absent or neutral; what gender are primary carer(s); how are mothers characterised?
- d. **Strengths** – Provides a broad overview of family structure and household composition of families referred to IFST and any differences in structure and composition to families who do not access the service and those that do.
- e. **Limitations**-

- i. Structure and household composition information is reliant on what is available within IFST files, and at the point of referral consultation it will be based only on information provided by the childcare social worker.
- ii. Whilst the Statutory Guidance and Regulations (2010) 7.32 page 25 lists the supporting documentation which includes items such as the care plans, chronology, etc. anecdotally this is often not provided or used. IFST practitioners seemingly wanting to come to the family 'fresh' with few pre conceived ideas thus with the hope and values inherent in some of the tools used such as Motivational Interviewing that require practitioners to emphasizes strengths, focus on the person not the problem, etc.
- iii. Sample limited to first nine months of the service being operational and embedding process so practices and procedures still emerging and likely to be less standardisation of approach and culture?

II. Policy into Practice: Whole Family Approach and Gender Inclusivity – end of Phase 1

a. Sample - All families completing Phase 1 of IFST intervention 1st September 2011 and 31st May 2011, totalling 14 Families

b. Purpose-

- i. Policy into Practice – How do global goals conceptually align with policy intentions; and family goals as identified in the case file?
- ii. To begin to explore the whole family approach:
 - 1. By identifying the extent of differing family members' involvement and engagement in the 'whole family approach' as it is presented within the file.
 - 2. By exploring any relational impact on family dynamics evident within the case files
 - 3. By identifying any changes in the nature of the structure and composition of the family as a consequence of working within a whole family approach, e.g. greater involvement/identification of a non-resident father with parental responsibility.
- iii. To begin to explore gender inclusivity by identifying any gender effects, or patterns (similarities or differences), for instance:

1. Gender of practitioner- any discernible impact of gender of worker and gender of family members and levels of engagement with those family members; or their identification of nature of relationships or family structure; etc.

c. Strengths –

- i. Provides data for analysing conceptual alignment between policy, practice and service user who is the recipient of the implemented policy.
- ii. Identifies any impact on perceived composition of the family/household and relationships within the family as a consequence of IFST intervention.
- iii. Should signpost which families might be most helpful to focus on for more in-depth analysis and/or interview.

d. Limitations

- i. Information gathered limited to involvement in paper outcomes and may not be indicative of actual involvement in process.

I. Policy into Practice: Family structure and household composition

Introduction

As much detail as possible was included e.g. noted when data was missing or not available in file; and the source of the information, e.g. the family plan, working agreement, safety plan, etc.

N.B. included family members who are deceased (and indicate they are deceased).

Illustrative Template of Blank Data Collection Sheet 1

| | 1.Family ID | 2.IFST practitioner ID | 3.Mother(s) | 4.Father(s) | 5.Child(ren) | 6.Extended Family | 7.Significant Others | 8.IFST involvement to 31 st May 2011 |
|----|-------------|------------------------|-------------|-------------|--------------|-------------------|----------------------|---|
| 01 | | | | | | | | |
| 02 | | | | | | | | |
| 03 | | | | | | | | |
| 04 | | | | | | | | |
| 05 | | | | | | | | |

Illustration of Completed Data Collection Sheet 1

Sample – Convenience sample of all referrals from 1st September 2010 – 31st May 2011, total =??

Formatting Key

Bold font means living in household with child(ren) at risk/in need

Blue means primary carer, thus **blue and bold** means a primary carer living in the household

Red is a risk factor/threat to child(ren) and/or parent (mother or father) – please specify. Thus a person who lives in the household and is a risk factor is both **red and bold**

Green means this person is a resource to child. Thus a person who is a resource to a child and lives in the household is both **green and bold**

| | | | | | | | | | |
|----|-----------|------|---|---|--|-------------------------|--|--|---|
| 01 | TPI MC | MCSW | BM Alcohol use Resulting in DV | BF Resident Prescription drugs (back pain) Some/intermittent illegal drug use. Depression/Anxiety | | | | | No referral form. Mother presenting risk – alcohol use resulting in domestic violence Focus on parental relationship and impact alcohol usage of mother damages that relationship and impacts on parenting capacity |
| 02 | | | | | | | | | Absent from files |
| 03 | LM H | | BM Substance Misuse | BF1 BF 2 | Daughter 6yrs old CIN Older son 14yrs removed and put in fathers care | Maternal Grandmother | | | <p>Trigger for referral bereavement issues following death of partner from sleep apnoea. Now living with maternal grandmother and doesn't want to return to flat.</p> <div> <p>Referrer's/Family's Expectations of Outcome of IFST Intervention:</p> <p>For BM to receive on-going support in relation to parenting skills and boundaries and of how to implement these successfully into her family's life.</p> <p>For family to receive support so daughter attends school on a regular basis.</p> <p>To support BM in relation to her active substance misuse issues and how they are impacting on her parenting and family life.</p> <p>Possible support in relation to bereavement issues.</p> <p>For BM and daughter to move into a suitable property in the near future.</p> </div> |
| 04 | | | | | | | | | Nothing in the file |

Column 1 – Family Structure

- I. Fictitious family Name? Need encrypted key code for fictitious and actual family names.
- II. **Family A, B, C, etc.** (alphabetical sequence corresponding to numerical sequence used on IFST case file ID but does not correspond to ICS file ID)
- III. **LF** – Lone Father headed household
- IV. **LM** – Lone mother headed household
- V. **TPI** – Two biological parents intact
- VI. **CHC** – Co Habiting Couple (?yrs.) i.e. CHC (3yrs) means co habiting 3years
- VII. **MC** – Married couple(?yrs.) i.e. MC (3yrs) means married for 3years
- VIII. **D** – Divorced(?yrs.) i.e. CHC (3yrs) means divorced 3years
- IX. **S** – Separated (?yrs.) i.e. CHC (3yrs) means separated 3years
- X. **MNM** – mother never has been married, i.e. single and always has been

Column 2 – IFST Practitioner ID

- I. M – Male IFST practitioner
- II. F- Female IFST practitioner
- III. CSW – Consultant Social Worker, thus MCSW would be a male consultant social worker
- IV. CPN – Community Psychiatric Nurse
- V. HV – Health Visitor
- VI. PO – Probation Officer
- VII. Add to list as required; also need separate encrypted key code for fictitious names if I use them

Column 3 -Mothers

- I. **BM** – biological mother 1, 2, 3 etc. indicate which child(ren) they are biological mother to
- II. **SM** – step/social mother – 1, 2, 3 etc. (chronologically)
- III. Residential /Non-residential– if not resident nature of contact with child(ren)?
- IV. Age of parent at referral
- V. Substance Misuser – Yes /No; if yes, nature of substance misuse?
- VI. **Abuser/Risk/Resource/Primary Carer/shared care?**

- VII. Violence or imprisonment?
- VIII. In care history
- IX. Involvement with SSD for other child in need/at risk cases
- X. Employed, if so, what? In receipt of benefits?
- XI. Qualifications
- XII. Housing situation
- XIII. Any disabilities or mental health issues?

Column 4 - Fathers

- I. **BF** – Biological Father 1, 2, 3 etc. (chronologically by age of child oldest first) indicate which child(ren) they are biological father to
- II. **SF** – social/step father
- III. Residential / Non-residential – if not resident nature of contact with child(ren)?
- IV. Age of parent at referral
- V. Substance Misuser – Yes /No; if yes, nature of substance misuse?
- VI. **Abuser/Risk/Resource/Primary Carer**/shared care?
- VII. Violence or imprisonment?
- VIII. In care history
- IX. Involvement with SSD for other child in need/at risk cases
- X. Qualifications
- XI. Housing situation
- XII. Any disabilities or mental health issues?

Column 5 – Child(ren)

- I. Number of children
- II. **BC** – Biological child to which mother and which father
- III. **SC**– social/step child to which mother(s) and which father(s)
- IV. Age of child – pre-birth; 0-2; 3-5; 6-8; 9-11; 12-14; 15-17
- V. **R/NR** - Residential / Non-residential – if not resident nature of contact with biological and step mother(s)/father(s) and other siblings (step and social)?

VI. Age of child at IFST referral

VII. Nature of childcare concerns for each child –

- a. Accommodated, if so nature of accommodation, length of time; number of periods of accommodation, etc.?
- b. Child protection and category – physical, sexual, emotional or neglect?
- c. Child in need

VIII. Any disabilities or mental health issues?

Column 6 – Extended Family

- I. **PA** – Aunt i.e. sister of BF (biological father)
- II. **MA** – Aunt i.e. sister of BM (biological mother)
- III. **PU** – Uncle i.e. brother of BF (biological father)
- IV. **MU** – Uncle, i.e. brother of BM (biological mother)
- V. **MGF** – Maternal grandfather
- VI. **MGM** – Maternal grandmother
- VII. **PGF** – Paternal Grandfather

Column 7 -Significant Others (non-professionals)

Use full words to describe nature of social relationship, e.g. catholic priest friend of mother; drinking mate of father; etc.

Column 8 – IFST Involvement to 31st May 2011

- I. **R** – Consultation referral only and not accepted so case not on-going
- II. **CR** – Consultation referral has only been completed so far but case accepted and on-going
- III. **CA** – Completed 72 hour assessment and Safety Plan
- IV. **Ph1** – Case in Phase 1
- V. **EndPh1 – Phase 1 complete**
- VI. **Ph2+1, or +3, or +6, or +12** – Phase 2 +1month review, or 3month review, or 6month review or 12month review.

II. Policy into Practice: Whole Family Approach and Gender Inclusivity

Sample – Convenience sample of all families in which Phase 1 was completed between 1st September – 31st May 2011. Total Number
Introduction

Please see II. Policy into Practice: Whole Family Approach and Gender Inclusivity data collection sheet below. One sheet to be completed for each family with whom an IFST practitioner completed a Phase 1 intervention with between 1st September and 31st May 2011. Insert family members as per data collection sheet (I) **Policy into Practice: Family structure and household composition**. Please indicate whether the family member in that column was involved (I) and/or signed (S) and/or is Named (N) in the piece of work indicated for that row. Totals can be collated at the ends of rows and of columns to compare paper indicators of activity and engagement levels with differing family members.

Illustrative Template of Blank Data Collection Sheet 2

| | Famil y ID | IFST Practitione r ID | Biologica l Mother | Biologica l Father | Step/Socia l Father 1 | Step/Socia l Father 2 | Chil d 1 | Chil d 2 | Chil d 3 | Chil d 4 | Extende d Family | Significa nt others | T o t a l s |
|--------------------------|---------------|-----------------------------|-----------------------|-----------------------|--------------------------|--------------------------|-------------|-------------|-------------|-------------|---------------------|------------------------|----------------------------|
| Code ID | | | | | | | | | | | | | |
| Working agreement | | | | | | | | | | | | | |
| Safety plan | | | | | | | | | | | | | |
| 72hour report | | | | | | | | | | | | | |
| Letters addressed to | | | | | | | | | | | | | |
| Whose Preferred Futures? | | | | | | | | | | | | | |
| Preferred | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |
|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| futures Question | | | | | | | | | | | | | |
| Values Cards | | | | | | | | | | | | | |
| Strength Cards | | | | | | | | | | | | | |
| Goal Cards/Booklets | | | | | | | | | | | | | |
| Goal Setting | | | | | | | | | | | | | |
| Crisis Card | | | | | | | | | | | | | |
| Weekly Plan | | | | | | | | | | | | | |
| Closing Report | | | | | | | | | | | | | |
| Family Plan | | | | | | | | | | | | | |
| Face to face contacts | | | | | | | | | | | | | |
| Add any other tools used | | | | | | | | | | | | | |

Time point 1 Global goals at referral – constructed by IFST Practitioner and childcare social worker

Time point 2 – Goals at end of Phase 1 -Family Goals Identified by family with IFST practitioner at end of Phase 1

Comment Box - Whole Family Approach - Impact on Family Cohesion. Any significant changes in structure and/or relationships between referral and end of Phase 1, e.g. any other family members or significant others identified? Changes to family dynamics; parenting; family cohesion; etc.?

Any other observations/comments:

Illustration of Completed Data Collection Sheet 2

| | Family ID | IFST Practitioner ID | Biological Mother | Biological Father | 4 Children |
|----------------------------|-----------|----------------------|--|--|------------|
| Code ID | 01 | MCSW | | | |
| Working agreement | | | | | |
| Safety plan | | | x | x | |
| 72hour report | | | | | |
| Letters addressed to | | | X Ending letter | X Ending letter | |
| Whose Preferred Futures? | | | | | |
| Preferred futures Question | | | | | |
| Values Cards | | | | | |
| Strength Cards | | | | | |
| Goal Cards/Booklets | | | 1) Alcohol usage. 2) Housing 4) Parents meeting children's needs 5) Parents satisfying relationship | 2) Housing 3) Fathers health and emotional well being 4)Parents meeting children's needs 5) Parents satisfying relationship | |
| Goal Setting | | | | | |

| | | | | | |
|--------------------------|--|--|--|--|--|
| Crisis Card | | | | | |
| Weekly Plan | | | | | |
| Closing Report | | | | | |
| Family Plan | | | | | |
| Face to face contacts | | | | | |
| Add any other tools used | | | | | |

Time point 1 Global goals at referral – constructed by IFST Practitioner and childcare social worker

Not noted in file.

Time point 2 – Goals at end of Phase 1 -Family Goals Identified by family with IFST practitioner at end of Phase 1

All goals were given equal priority at highest level i.e. 10

- 1) Mothers Alcohol usage.
- 2) Housing
- 3) Fathers' health and well being
- 4) Parents meeting children's' needs
- 5) Parents relationship

Appendix E - Practitioner Interview Guide

Opening remarks

- Thank participant for agreeing to be interviewed and for finding the time to be interviewed.
- Briefly summarise aim of research and areas for interview:
 - o Aim – To investigate the whole family approach in policy and practice; the construction of family and any effects made by gender on parenting practices.
 - o Topic areas for interview:
 - Personal and Professional Background including IFST involvement;
 - The whole family approach; and
 - The Family and gender.
- Ask participant if they have any questions or concerns before we begin.
- If participant is happy for interview to take place ensure consent form completed and signed (if not already done so). Return one signed copy to participant.
- Tape recording
- Explain interview anticipated to be about 60mins and check participants' availability.
- Reiterate to participant that:
 - o They can stop the interview at any time;
 - o They do not have to answer any questions which they would prefer not to;
 - o And everything they say will be treated as confidential and any identifying names or places or persons will not be included in the transcription.

Topic Areas

Personal and Professional Background including IFST involvement

Please can you tell me a bit about yourself - Age? Professional qualifications?

Previous work experience?

How long have you been in IFST?

What is your role in IFST?

What have you found most helpful in understanding your role as an IFST practitioner?

What is the IFST? Its' role and purpose?

What have you found most helpful in understanding the role of IFST?

What is the model of working/practice?

What have you found most helpful in understanding the model of practice?

Whole Family Approach

How does a whole family approach fit into the IFST model?

What is a whole family approach?

How is a whole family approach different to other approaches to practice?

Please can you give me some examples of working within a whole family approach?

How do you decide which activities, e.g. preferred futures question, values questions, etc. to do with which family members?

When would you do an activity, e.g. preferred futures question, values questions, etc. with different family members together rather than individually?

How do you go about identifying who the family members are in each case?

Generally, is the mother the first family member you make contact with and gather information from?

Does working within the family home effect who is included in the intervention?

If so, how?

The Family; and effects made by gender on parenting

What is a family?

What is the role and purpose of family?

What is 'good enough parenting'?

What is 'good enough mothering'?

What is 'good enough fathering'?

How important do you think it is to include fathers within a whole family approach?

Why do you think its un/important to include fathers within a whole family approach?

Closing Questions

Is there anything you would like to say that you have not had an opportunity to say about gender and/or working within a whole family approach?

Are there any key points you want to emphasize from our discussion?

Any points you want to clarify?

Closing Remarks

Thank participant for attending and taking part in the interview.

Appendix F - Information Leaflet and Consent Form for practitioners



Research Project –

Integrated Family Support Teams: policy into practice

What is the research project?

I am investigating the process by which policy is translated into practice, particularly around understandings of gender, family and a whole family approach as it relates to Integrated Family Support Teams (IFSTs). I am not evaluating individual practice, or the effectiveness of the service.

Who this information leaflet is for?

You have been given this leaflet because you work in the IFST, and are being invited to participate in the research project.

What is involved? How much time will be involved? Where?

I would like to invite you to participate in an interview about working with families with parental substance misuse and child protection concerns. You will determine the length of the interview and a time, date and place that is convenient to you. I can provide a venue outside of your work place if you would prefer that. I would anticipate the interview being approximately 1 hour.

I would also like to observe practice within the workplace, such as group supervision, and some direct work with families in order to understand the IFST approach to whole family working. Any observations of work with families would only be undertaken with both your consent, and that of the family members involved.

It may be necessary to do a further follow up interview but agreeing to participate in the initial interview does not necessitate you participating in a second interview, or in observations of practice. You may withdraw at any time, should you want to do so.

How will the completed study benefit you?

The completed study will provide information to policy makers, service managers and health and social care practitioners on the development and implementation of policy into practice; and a greater understanding of families with parental substance misuse and child protection concerns as well as a better understanding of a ‘whole family approach’ as applied in this context. I am particularly interested in whether a whole family approach facilitates gender inclusivity and greater engagement of men and fathers in child welfare services. This information will be useful for improving health and social care practice.

Will information be kept confidential?

Interviews will be audio recorded and typed up to provide a written record (transcript). The transcript of the interview will be anonymised. Both the audio recording and transcript will be kept in a secure place. The final thesis, presentations of information or any subsequent publications will not contain any identifying information in relation to you as an identifiable individual, or any particular families that you refer to. If you would like a copy of the transcript so that you can check it for accuracy and anonymity I will be happy to supply it on request.

Whilst your employer will receive a presentation of the findings in relation to the research project your employer will not be given any information from individual interviews with the exception of any information disclosed that causes serious concern in relation to your own health and safety or that of someone else, e.g. in relation to damaging and dangerous practice or that contravenes the Care Council of Wales Code of Practice for social care workers in which case the matter would need to be referred to the appropriate authority.

What if I change my mind about participating?

You can change your mind about participating at any time and withdraw your consent.

Who am I?

My name is Jacquie Lee. I am a qualified social worker working in a local Higher Education Institution as a lecturer. I am doing this research project for my PhD study and being supervised by Professor Karen Henwood at Cardiff University and Dr. Jeremy Segrott from the Centre for Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer) which is part of Cardiff University.

Contact information

If you would like to discuss the project or your participation please do not hesitate to contact me on 078***** or by email jlee@***** I will be happy to answer any questions that you may have. I look forward to meeting you.

Consent form

Integrated Family Support Teams: from policy to practice

Name of Researcher: Jacquie Lee

| | Please Initial |
|---|-------------------|
| 1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. | |
| 3. I agree to take part in the study. | |
| 4. I agree to the interview being audio recorded and transcribed. | |
| 5. I agree to being observed in the workplace. | |
| 6. I agree to being observed in direct work with service users. | |
| 7. I agree to the anonymised Extracts from the transcription being used in the PhD thesis, publications and presentations. | |

Name of Participant (Block Capitals) Date

Signature

Name of person taking consent

Date

Signature

2 copies: 1 for participant and 1 for research file

Appendix G -- Parental Information Leaflet and Consent Form (Draft)

Research Project – Integrated Family Support Teams: policy into practice

Information Sheet for Parents

Who this information leaflet is for?

You have been given this leaflet because your family have received, or are receiving, services from the Integrated Family Support Team (IFST).

What is the research project?

I want to understand about your experience of family life and to hear your views about being a parent.

I am carrying out this project independently and am not employed by the Local Authority, Health or Social Services. Your views as an individual will not be fed back directly either to the services or social workers involved. Your participation in the project will not in any way affect the services you receive now or in the future.

Why should I take part?

By agreeing to be interviewed you will help improve the support that parents and families get by giving policy makers and practitioners a better understanding of what parenting and family life is like from your perspective. This will help health and social care professionals improve how they work with families.

What is involved? How much time will be involved? Where?

The length of the interview will depend on how much you want to say but I anticipate the interview taking about 1 hour of your time. We will agree between us a time, date and place that is as convenient for you as possible. I am happy to interview you at home but if you would rather we met somewhere else I can arrange somewhere else for us to meet.

Will information be kept private?

Interviews will be recorded and then typed up to provide a written record. The written record will not contain any identifying information and all names will be changed. Both the recording and written record will be kept in a secure place. The final project report, presentations of information or any subsequent publications will not contain any identifying information. The only information that may be shared is if it relates to someone's health or safety, for instance the safety of a child, in which case I am obligated to follow the University's Child protection procedures. If you would like a copy of the written record I will be happy to supply a copy if you ask for one.

What if I change my mind about participating?

You can change your mind about participating at any time and withdraw your consent.

Who am I?

My name is Jacquie Lee. I am doing this research project for my Phd study and being supervised by Professor Karen Henwood at Cardiff University and Dr. Jeremy Segrott from the Centre for Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer) which is part of Cardiff University.

Contact information

If you would like to discuss the project or your participation please do not hesitate to contact me on 07806782491 or by email jlee@cardiffmet.ac.uk I will be happy to answer any questions that you may have. I look forward to meeting you.

Consent form

Integrated Family Support Teams: from policy to practice

Name of Researcher: Jacquie Lee

| | Please Initial |
|---|----------------|
| 1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. | |
| 3. I agree to take part in the study. | |
| 4. I agree to the interview being audio recorded and transcribed. | |
| 5. I agree to the anonymised extracts from the transcription being used in the Phd thesis, publications and presentations. | |

Name of Participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix H- Parental Interview Schedule (Draft)

Opening remarks

- Thanks for agreeing to meet with me and allowing me into your home.
- I'm not employed by Social Services or IFST. Anything you say will not be identifiable as being said by you, nor will it be reported back in your name to either Social Services nor IFST.
- I am not here to evaluate IFST or assess your parenting. Although, if you do say anything that raises my concern for your safety or someone else's, or your child(ren)'s safety then I have a responsibility to refer the matter on, ideally having discussed that with you first, but that is not why I wanted to meet you or to come here today.
- My aim is to understand more about parenting and families;
- Ask participant if they have any questions or concerns before we begin.
- If participant is happy for interview to take place ensure consent form completed and signed (if not already done so). Return one signed copy to participant.
- Tape recording
- Explain interview anticipated to be between 60mins-90mins and check participants' availability.
- Reiterate to participant that:
 - They can stop the interview at any time;
 - They do not have to answer any questions which they would prefer not to – we can just move on to the next question;
 - And everything they say will be treated as confidential and any identifying names or places or persons will not be included in the typed up version of the audio recording.

Schedule

1) Thinking back to before *IFST practitioner* started visiting what were your relationships with other people in your family like? (prompt question if needed - how did you get along with other people in your family)

1a) What were family relationships like while *IFST practitioner* was working with you? (optional prompt if parent doesn't mention this)

2) Please tell me what your relationships with other people in your family are like now.....

3) Please can you tell me about your experience of being a mother/a father(whats it like being a mum/dad? (prompt question if needed)

4) Thinking back to your own childhood, can you tell me what family life was like for you growing up?

5) Finally, please can you tell me what you like best about being a mum/dad?

Closing Question - Is there anything you would like to add to what you have already said?

Closing Remarks-Thank participant for attending and taking part in the interview.

Appendix I - Glossary of Acronyms

| | |
|-------------|--|
| BSFT | Brief Solution Focussed Therapy |
| CA | Children Act |
| CAF | Common Assessment Framework |
| CBT | Cognitive Behavioural Therapy |
| CCW | Care Council for Wales |
| CPN | Community Psychiatric Nurse |
| CPR | Child Protection Register |
| CSSIW | Care and Social Services Inspectorate |
| CSW | Consultant Social Worker |
| DBS | Disclosing and Barring Service |
| DCSF | Department for Children, Schools and Families |
| EBI | Evidence-Based Intervention |
| FCT | Family-Centred Treatment |
| GAS | Goal Attainment Scaling |
| GOVA | Government of Wales Act |
| ICS | Integrated Children's Services |
| IFSB | Integrated Family Support Board |
| IFSS | Integrated Family Support Services |
| IFST | Integrated Family Support Team |
| LA | Local Authority |
| MI | Motivational Interviewing |
| SETF | Social Exclusion Task Force |
| SFP – 10-13 | Strengthening Families Programme 10-13 years |
| UNCRC | United Nations Convention on the Rights of the Child |
| UK | United Kingdom |
| WAG | Welsh Assembly Government |
| WLGA | Welsh Local Government Agency |
| WFA | Whole Family Approaches |
| WG | Welsh Government |